Victorian Institute of Forensic Medicine

# Residential Aged Care Communiqué

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## EDITORIAL

Welcome to the third issue for 2015. In this issue we focus on a single tragic event that most readers will already be familiar with concerning arson in a Residential Aged Care Service. The event received national media attention when a nurse in the RACS deliberately set fire to RACS.

There are many issues this event presents that assists us to be better prepared for improving care for residents and staff. If you read the details of the Coroner's finding, a 75-page document, you will see aspects relevant to all who are involved in aged care. A significant feature of the Coroner's finding was a personal description of each individual victim of the fire. This helps to bring a greater sense of the people and the loss felt by family and friends.

The Coroner highlighted an aspect of each person's life achievements and family relationships, noting each had experienced real hardship in their lives. Many of the victims had grown up in the Depression and Second World War, migrating from all around the world to Australia. This compassionate approach is important and should always be recognized when using this event to improve care.

We should not dismiss this as a tragic 'one-off' event due to the criminal behaviour of one person. Instead, we should examine the issues it raises around preparedness and management of fire safety in the RACS; recognition and assistance of impaired health professionals; credentialing and scrutiny of an employee's qualifications and credentials.

Don Garlick, an experienced and skilled Fire Safety & Disaster Coordinator provides our expert commentary. Don is a recipient of the Country Fire Authority 25 Year Long Service Award and an Australian Federal Government award, the National Emergency Medal, for service rendered during the 2009 Black Saturday Bushfires.
We also include a short summary of a recent research study into injury-related deaths of residents reported to the Coroners Court.

It would be remiss not to mention the trauma to the family and staff involved in this event. There is little information in the public domain about the personal aftermath experienced by each of them.

# Call the fire brigade

Case Précis Authors: Carmel Young RN, Ballarat Health Service; and
Joseph Ibrahim PhD FRACP, Monash University

## Clinical Summary

In September 2011 a registered nurse (RN) approached an accredited RACS that provided high-level care for residents, many of whom had dementia and some were bed ridden, requesting to work night shifts.

The RN provided a resume describing his most recent nursing position as working at an acute public hospital four years earlier and the referee was a person he worked with in the year 2000. The RN's registration was current with the nurses' board and following a satisfactory police check he was employed with a three-month probationary period. The night shift at the RACS was typically staffed with one registered nurse who was in charge, and four assistants-in-nursing.

In mid-November on the night shift, the assistants-in-nursing noticed that the RN had spent a lot of time in the treatment room where the drugs of addiction or schedule 8 drugs were stored. Towards the end of the shift one of them entered the treatment room and noted a lot of blister medication packs had been opened with some resealed with sticky tape. The RN explained he had been fixing a mistake the day staff had made with the medication packs. The following day the nursing staff routinely checked the number of schedule 8 drugs and found 237 tablets of Endone to be missing. The RACS managers were informed and a report was made to the police. The police attended the RACS but were called away to more urgent matters and were unable to return that night. The RACS manager viewed CCTV footage that was used to monitor the entrance of the treatment room, confirming that the RN was the likely culprit.

The RN returned to work the night shift and discovered an investigation was underway into the missing medications. Later that night an extensive fire consumed the RACS with multiple fatalities. During the evacuation of residents the RN made numerous attempts to re-enter the RACS and was taken to the local hospital for treatment of smoke inhalation.

The police informed the RN he was a suspect, after which, he admitted to lighting the fire. The RN had obtained another staff member's cigarette lighter, and set alight a sheet on a bed in an unoccupied room. He had re-entered the RACS during the fire to steal the two schedule 8 registers from the treatment room, which he had later destroyed at his home.

## Pathology

In November 2011, a fire was deliberately lit in the RACS by a recently employed member of nursing staff causing or contributing to the deaths of 14 residents.

Mr G was an 87 year old male resident with a history of dementia who died in an acute hospital seven days after the fire due to the effects of smoke inhalation.

Mrs J was a 79 year old female resident with end stage renal failure requiring dialysis who died three weeks after the fire due to a combination of natural causes with contributing factors including the stress of being disconnected from a dialysis machine and of being removed from the RACS.

Ms N was a 102 year old female resident with dementia, arthritis, and impaired vision and hearing who died about one month after the fire due to 'extreme old age' or natural causes.

Ms EW was a 97 year old female resident who died in an acute hospital one day after the fire due to smoke inhalation and burns.

Mrs DW was an 85 year old female resident with Alzheimer's Disease who died in the RACS on the same day as the fire due to smoke inhalation and burns.

Mrs UA was an 86 year old female who died in an acute hospital two days after the fire due to the effects of smoke inhalation.

Mrs DB was a 96 year old female resident with a past history of breast cancer who died in an acute hospital three days after the fire due to the effects of smoke inhalation.

Mrs LB was a 96 year old female resident who died in an acute hospital the same day as the fire due to the effects of smoke inhalation and burns.

Mrs EC was an 86 old female resident who died in an acute hospital a few months after the fire due to multi-organ failure probably due to sepsis resulting from a hospital-acquired infection following admission for the effects of smoke inhalation.

Mr CG was a male resident who died three days after the fire due to the combined effects of acute exacerbation of chronic airways limitation precipitated by smoke inhalation and an infarction of the colon.

Ms S was a frail 73 year old female resident with severe ischaemic heart disease and emphysema who died at the RACS the same day of the fire due to smoke inhalation.

Ms D was an 80 year old female resident who died at the RACS the same day of the fire due to smoke inhalation and burns.

Mrs NV was a female resident who died in an acute hospital four days after the fire from the combined effects of smoke inhalation and a fracture of the cervical spine incurred by falling out of bed in hospital.

Ms W was an 83 year old female who died in an acute hospital eleven days after the fire from the effects of burns and smoke inhalation.

## Investigation

An inquest into the deaths was held almost three years later in September and October 2014. The nature of the inquest and the coroner's role was to determine the causes of death. The inquest also explored a number of related issues including:

- The employment and professional performance of the individual nurse at the RACS
- The questions of how the individual ignited the fire and how the fire spread
- The fire safety design features of RACS
- Fire protection equipment and fire safety training of staff
- The response of firefighters
- Lessons to be learnt from this incident

The subsequent police investigation discovered the RN had been subject to past employment disciplinary action and disputes. In April 2007, the RN had a dispute with a supervisor at the acute hospital and a month later the supervisor's car was found damaged with paint splashed over it and screws lodged in the tyres. The RN resigned before an investigation was launched.

A review of the RN's own medical records indicated he attended 10 different GPs and was prescribed medication by most of them in 2011.

In June 2011, at a private acute hospital the RN was suspended from work because of disheveled appearance and slurred speech. Three days later when interviewed by the Director of Nursing and the Nurse Unit Manager, the RN reported he had a diagnosis of a mental health disorder and a recent change in his prescribed medications. The RN's General Practitioner (GP) provided a clearance that the RN was fit for work. The RN was taken off night duty and placed on the day shifts roster, at which point the RN resigned. The RN had omitted this period of employment from the resume he provided to the RACS.

The other points of interest to emerge were that the RN did not undergo a medical screen, which was a requirement of RACS when employing new staff.

Also, at the inquest, a number of staff expressed concerns they had about the RN, noting in the months before the event the RN had - "come to work with a blank face"; awoken a resident to give Endone when this medication had not been requested; attended the RACS somewhat disheveled with one shirt button out and that his shirt was not buttoned up to match button holes; and had been behaving in an erratic manner including ranting about his landlord.

Only one staff member reported their concerns before the fire and believed that nothing was done about it because "they had been desperate to find and keep a night RN".

The impact of these crimes on the families and staff are difficult to predict and require a supportive approach and the ability to seek professional assistance as required.

A review of the RN's own medical records indicated he attended 10 different GPs and was prescribed medication by most of them in 2011. At inquest one of the GPs stated that the RN was being treated for anxiety and panic disorders. However, the RN had not been referred to a specialist psychiatrist.

A court appointed expert psychiatrist diagnosed the RN with (1) Poly Substance Abuse, (2) Adjustment disorder and (3) Cluster B Personality disorder – Mixed Type with narcissistic and histrionic features.

## Coroner's Recommendations

The Coroner made a number of recommendations to address aspects of emergency, fire and rescue services; the RACS response to fire, clear fire exits, staff training and evacuation of residents; the scrutiny of employment records and checking of staff credentials; the need for identifying impaired health practitioners and understanding the obligation around mandatory reporting to AHPRA; the management of Schedule 8 medications in RACS; and education of staff about many of these matters.

## Editor's Comments

The issues surrounding the need for employment checks and reporting of an impaired practitioner are not new. Recall the case of the surgeon Dr Patel who withheld information about his medical registration and scope of practice when employed at Bundaberg Hospital. The hospital also failed to appropriately vet his employment record and references.

From a forensic medicine view the causes of death can be divided into three different categories (1) direct and immediate due to the fire, smoke inhalation and burns; (2) direct and delayed e.g. complications such as sepsis related to inhalation and burns and (3) indirect e.g. contribution to worsening of underlying disease. Other important aspects include the potentially protracted nature of the injuries. That is, the need for repeated operations for skin grafts with the associated risks of multiple general anesthetics and poor healing. For any survivors there are ongoing issues of long term scarring and disfigurement.

The cultural diversity of the deceased residents who were born in Australia, England, Philippines, Malta, Egypt and Holland reminds us of the importance of person-centered care, as supporting family and friends in managing bereavement would have been a specific challenge for the RACS staff after the fire.

Finally we need to be mindful that there will be additional emotional and psychological impacts because of the crimes of arson and homicide. The impact of these crimes on the families and staff are difficult to predict and require a supportive approach and the ability to seek professional assistance as required.

# Fire safety expert commentary

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The fire that occurred at the RACS on the 18th November 2011 was not unprecedented. Lethal fires in multiple occupant accommodation occur with alarming regularity representing a known risk to residents, staff and emergency services.

Whilst the circumstances surrounding the ignition of this RACS fire were somewhat unique (multiple ignition points set by the person in charge of the facility at the time of the fire) the consequences were entirely predictable and provide a reminder of the importance of fire safety in Residential Aged Care facilities.

The major contributing factor to fire related deaths in aged care facilities worldwide is related to uncontrolled fire spread. Traditionally this problem was managed by instructing staff to alert fire services whilst others used fire extinguishers to limit the spread of the fire to allow for evacuation. Over the past few decades these approaches have been augmented by engineered solutions such as fire and smoke compartmentalisation and installation of automatic fire detection, alert and suppression systems.

## Staff members must be able to identify the fire safety features of their facility, locations of emergency exits and assembly areas.

It is interesting to note that these changes have rarely occurred without being a direct response to one disaster or another, nor have they been implemented universally at the same time. This has often led to an expectation of fire safety from residents, families, staff and fire services personnel that may be unrelated to the actual fire safety features of a particular building.

Engineered solutions to fire risk are a critical element to fire safety. There is no doubt that a properly installed and maintained fire sprinkler system limits the spread of any fire to the room of origin greatly mitigating injury or death of occupants.

Coupled with an automated fire detection and alert system, a fire sprinkler system will save lives.

The lack of a fire sprinkler system at this RACS was a significant factor in the numerous fatalities. This finding led to NSW mandating the installation of sprinkler systems in all aged care facilities, new and existing; an approach other states have had for a number of years.

In contrast to this improvement in fire safety, a worrying trend detected in some aged care facilities is the disconnection of the automated alert of smoke or heat detector activation to the fire brigade; this is in part a response to being charged for false alarms by fire services. Whilst the practice is legal (it is predicated on the facility having a fire sprinkler system that will automatically alert fire services when a fire sprinkler bulb has broken), it is reliant on staff understanding that they must complete certain actions because fire services are unaware of the situation.

## Another area of concern is staff training for emergencies. Increasingly there is a reliance on electronic learning and assessment tools to provide staff with fire safety training.

The risk is that low flaming fires (fires that produce lots of smoke and little heat) can easily result in suffocation of residents and staff before the fire builds enough heat to activate an alert to the fire brigade. It is imperative that owners and managers of RACS ensure the timely installation and ongoing maintenance of fire sprinkler systems as well as reconnection of detection systems to automated fire brigade activations.

Rather than turning off vital fire alert system to avoid false alarm activations and the associated financial charges for fire service call outs, RACS managers should ensure development and adherence to fire safety processes, such as safe cooking practices and fire system maintenance.

Another area of concern is staff training for emergencies. Increasingly there is a reliance on electronic learning and assessment tools to provide staff with fire safety training. While this type of learning has a place, it is no substitute for practical based training.

Staff members must be able to identify the fire safety features of their facility, locations of emergency exits and assembly areas. Importantly they need to push beds to designated assembly areas, understand (and remove if able) potential obstructions to movement inside and outside the building, and practice using their systems. This will ensure that all residents will be accounted for and that they can confidently escalate the response to fire services and senior management.

## Correctly installed and maintained fire detection, alert and suppression systems coupled with trained, confident staff members will prevent the injury and death of residents in fire situations.

These drills do not need to be overtly detailed or prolonged, nor do they need to involve actual residents (if they are incapable of participating). Involving residents and families in drills does however, provide a level of realism to any drill, engaging and educating all the participants, whilst identifying and rectifying problems before any actual incident.

This fire reminds owners and staff members of RACS that fire safety must be a continuous focus of quality provision of care. Correctly installed and maintained fire detection, alert and suppression systems coupled with trained, confident staff members will prevent the injury and death of residents in fire situations.

## Premature deaths in RACS

The first comprehensive study into injury-related or premature deaths of residents was published in the Journal of the American Geriatrics Society in May 2015.

The study found that between 2000 and 2012 there were 1296 deaths in Victoria due to falls (n=1,155, 89.1%), choking (n=89, 6.9%), suicide (n=17, 1.3%), complications of clinical care (n=8, 0.6%), and resident-resident assault (n=7, 0.5%). The number of inquests held to investigate a death as a matter of public interest was small (n=24, 1.9%).

The investigators concluded a significant proportion of nursing home resident deaths are due to external causes and are potentially preventable. A shift in community attitudes is required towards an understanding that premature death of a RACS resident from injury is not a natural part of life.

## Resources

1. **Coroner's finding:**
   Coroners Court (NSW) Inquiry Fire at Quakers Hill Nursing Home, Findings of Deputy State Coroner H.C.B. Dillon.
   Available at – http://www.coroners.justice.nsw.gov.au/Documents/finding,%20recommendation%20and%20reasons%20-%20quakers%20hill%20fire.pdf

2. **Cultural diversity in aged care:**
   Center for Cultural Diversity in Ageing which has a number of resources.
   Available at http://www.culturaldiversity.com.au/resources/practice-guides/palliative-care

3. **Palliative care and RACS:**
   Palliative Care Australia Residential Aged Care hub.
   Available at - http://www.caresearch.com.au/caresearch/tabid/2256/Default.aspx

4. **Credentialing:**
   Australian Commission for Safety and Quality in Health Care. Credentialling for Health Professionals.
   Available at - http://www.safetyandquality.gov.au/our-work/credentialling/

5. **Notifications:**
   That is making a complaint or a concern about a registered health practitioner:
   Australian Health Practitioner Regulation Agency.
   Available at - http://www.ahpra.gov.au/Notifications.aspx

6. **Seeking help for impaired health practitioners in Victoria:**

   **a)** Nursing & Midwifery Health Program Victoria (NMHP) which supports nurses, midwives and students with their sensitive health concerns.
   Available at - http://www.nmhp.org.au

   **b)** Victorian Doctors Health Program is a confidential service for doctors and medical students who have health concerns such as stress, mental health problems, substance use problems, or any other health issues.
   Available at - http://www.vdhp.org.au/website/home.html

7. **Victims of crime:**
   Available at - http://www.victimsofcrime.vic.gov.au

8. **Premature deaths of residents:**
   Ibrahim, J.E., Murphy, B.J., Bugeja, L., Ranson, D. (2015). Nature and Extent of External-Cause Deaths of Nursing Home Residents in Victoria. Australia. Journal of the American Geriatrics Society. 05/2015; 63(5). DOI:10.1111/jgs.13377

9. **Hospital inquiries:**
   Dunbar JA, Reddy P, Beresford B, Ramsey WP and Lord RSA. In the wake of hospital inquiries: impact on staff and safety. Med J Aust 2007; 186 (2): 80-83.
   Available at - https://www.mja.com.au/system/files/issues/186_02_150107/dun10843_fm.pdf


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### FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in clinical practice. Please email your comments, questions and suggestions to:
racc@vifm.org

### DISCLAIMER

All cases that are discussed in the Residential Aged Care Communiqué are public documents. A document becomes public once the coronial investigation process has been completed and the case is closed.

We have made every attempt to ensure that individuals and organisations are de-identified. The views and conclusions are those of the authors and do not necessarily represent those of the Coroners, Department of Health, Victorian Institute of Forensic Medicine or Monash University.