

“FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 23rd and 24th days of November 2009 and the 14th day of May 2010, by the Coroner’s Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Arthur John Hutton.

The said Court finds that Arthur John Hutton aged 87 years, late of St Laurence’s Aged Care Facility, 10 Terminus Street, Grange, South Australia died at St Laurence’s, Grange, South Australia on the 16th day of January 2008 as a result of asphyxia due to neck entrapment...

Mr Hutton was an amputee having had a leg amputated many years ago. At the time of his death he also suffered from dementia. He had a known propensity to fall from his bed to the extent that his bed had been lowered and a mattress had been placed on the floor next to his bed in order to lessen the impact of a fall.

Mr Hutton was located deceased on the morning of 16 January 2008. It is evident that he had fallen from his bed at some time during the night. The fall had caused his neck to become entrapped in the space between a vertical bedpole and the side of the bed mattress. A bedpole, sometimes referred to as a bedstick, is a device utilised to assist a person’s mobility and independence in bed and is widely used in nursing homes and other aged care facilities and in the community generally.

These preliminary findings are intended to serve as a warning to those institutions, persons and entities who utilise bedpoles that in certain circumstances there is an element of risk involved in their utilisation. In particular, and without intending to limit the circumstances in which a bedpole may place a user at risk, the evidence before me demonstrates that bedpoles should not be used in circumstances where there is a gap between the bedpole vertical component and the mattress, or potential gap if the device or the mattress moves, and / or where the intended user has a history of recurrent falls from bed, has a cognitive impairment, with or without limited mobility, or where the intended user’s faculties are compromised by medication. Any person or organisation that utilises bedpoles must ensure the use of a bedpole is risk assessed in each application.

6. Recommendations

6.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

6.3. I would made the following general recommendations:

1) That the manufacturers, suppliers and distributors of the KA524 bedpole apparatus ensure that consumers of the product are provided with written instructions as to the correct installation of the product that deal with the following:

i The desirability of ensuring that sufficient weight is placed upon the apparatus to ensure minimal movement of the apparatus while the user is in bed;

ii. That in respect of reclining beds, that the apparatus should be placed beneath the mattress at the foot end of the bed with the U shaped section of the frame pointing towards the foot of the bed and should not be placed beneath the raised section of a bed;

iii. That any gap between the bedpole vertical component and the mattress be eliminated;

iv. The desirability of frequent checking of the position and stability of the apparatus as installed in the bed.

2) That the manufacturers, suppliers and distributors of the KA524 bedpole apparatus ensure that consumers of the product are provided with written instructions as to the dangers posed by the utilisation of the KA524 bedpoles with specific reference to:

i. The need for any person or organisation that utilises bedpoles to ensure that the deployment of the bedpole is risk assessed in each application;

ii. That the product should not be utilised in respect of persons who have a history of falling from bed;

iii. That the device should not be used by persons who have a cognitive impairment;

iv. That the device should not be used by persons who have no access to immediate assistance;

v. The fact that a gap created between the vertical bedpole and the side of the bed has resulted in a fatality by way of head and neck entrapment.”

The Finding can be viewed in its entirety at www.courts.sa.gov.au (go to Coroner’s Court and then Findings).