CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Melissa Standen
Hearing dates:	27,28,29,30 & 31 August 2018
Date of findings:	25 September 2018
Place of findings:	State Coroner's Court, Glebe
Findings of:	**State Coroner Les Mabbutt**
Case number:	2015/13188
Catchwords	CORONIAL – Manner of death. Assessment of beds for children with physical and cognitive disabilities.
Representation:	Ms A Bonnor Counsel Assisting instructed by Ms Geddes Crown Solicitors Office Mr J Morris SC for Ms Tin Ho Ms M Bridgett instructed by McCabe Curwood lawyers for Mr Bruce Standen Mr B Kelleher instructed by Colin Biggers & Paisley for Allowah Hospital Ms Haider for Ms Veronique Jadoul Mr Packer for Ms Sharyn Wood Mr Naylor for Mr Scott Hurren

Introduction

1. On 13 January 2015, 13 year old Melissa Standen was in respite care at the Allowah Presbyterian Children's Hospital, Perry Street Dundas Valley. Melissa was a child with profound physical and cognitive disabilities. At 11.55pm Melissa was located by nursing staff outside the confines of her bed having fallen out of the

bed. Melissa was hanging by her t-shirt that had caught on the outside corner of the bed. Melissa's knees were on the ground but Melissa's upper body was suspended just above the floor of the ward by her t-shirt that had moved up around her neck. In that position the t-shirt had obstructed Melissa's airway.

2. An emergency was called and urgent attempts were made to resuscitate Melissa by nursing staff. Paramedics attended and Melissa was transferred to Westmead Children's Hospital at about 12.30am.Tragically all attempts to resuscitate Melissa were unsuccessful and Melissa died at 1.28am on 14 January 2015.

Why was an inquest held?

3. The role of the Coroner pursuant to s 81 of the *Coroners Act* 2009 is to make findings regarding:
    - The identity of the deceased
    - The date and place of that person's death
    - The cause and manner of that person's death

4. A Coroner may also make recommendations in accordance with s 82 of the Act concerning any public health or safety issues arising out of the death. An inquest was conducted into Melissa's death to determine the manner of her death and to investigate the circumstances of what occurred.

Background and medical history

5. Melissa was born on 4 April 2001. Shortly after her birth Melissa's parents Ms Tin Ho and Mr Bruce Standen discovered Melissa had global delays and after a lengthy period of diagnosis and assessment were informed Melissa was diagnosed with "mosaicism". This is a congenital condition of non specific severe cognitive and physical disabilities. Melissa suffered from cortical blindness, hypotonia (low muscle tone), epilepsy, short stature, sleep disorder, severe mental retardation, developmental delay, gastric reflux and feeding difficulties.

6. Melissa required a high level of full time care and her parents and other members of the family cared for her 24 hours a day, seven days a week. The family had ongoing consultation with various health professionals. Melissa's parents assisted with physiotherapy and other tasks. Melissa has two brothers. Her family loved

and cared for her deeply and undertook the onerous full time responsibilities of caring for a child with severe disabilities.

7. Melissa's weight and size was well below that of a child of her age. At 13 years of age Melissa's weight 14.9kg was the average weight for a three and a half year old child. Melissa had a very small head circumference and stature. Melissa was unable to sit up by herself. She could move her arms and legs in very stiff motions. When unsettled or in pain Melissa would arch her back and wiggle around in a spontaneous or uncoordinated way. Melissa was non verbal, she made sounds that informed people of how she was feeling, she could smile and laugh or cry. Melissa would often cry and move around by arching her back when her gastric reflux caused pain.

8. In 2009 Melissa had a percutaneous endoscopic gastrostomy feeding tube inserted in her stomach to receive fluids, because she had difficulty swallowing.

History of admissions at Allowah Presbyterian Children's Hospital (Allowah)

9. In 2009 while Melissa was in hospital for surgery, her parents were informed about respite care available at Allowah located in Dundas Valley in Sydney. Melissa had a lot of medical problems that year and was in and out of hospital. Melissa would cry a lot at night which was attributable to gastric discomfort. That combined with other challenges meant that the family were exhausted and needed assistance.

10. Allowah provides services to patients with profound physical and intellectual disabilities up to 18 years of age that require a high level of care. The assessment process for admission to Allowah involved a meeting with health professionals, the family and staff from the Hospital. A Childcare Management Plan and Intervention Pathway were documented and implemented following meetings with staff and Melissa's parents.

11. Melissa commenced respite periods at Allowah in December 2009. Her patient risk profile recorded a risk of limb damage and that Melissa wriggled in her cot. The plan to address that risk was for a padded cot at night. On the patient risk profile, "falling" was not circled as a risk.

12. In May 2010, Allowah staff completed a sleep diary for Melissa over five days which showed intermittent daytime naps, periods of being awake up to four hours a night on occasions and inconsistent wake and sleep times.

13. On three separate occasions it was noted Melissa has been involved in incidents and "near misses" relating to her movements in the cot and the following entries were recorded:

14. On 22 January 2012 *"big bruise on* [left] *leg and a red mark on* [right] *knee. May have been from leg getting in between cot bars. Have put padding on cot*."

15. On 3 March 2012, "*child was in wooden open side bed side lying with bumper over face and legs hanging out the side. Moved to cot. Hazard form filled out*." "[c]*hild side lying with bumper over face, feet through bars*".

16. On 24 January 2013, "*found with cot side down".*

Admission on 19 September 2014 and transition to a bed

17. In late 2014, Melissa transitioned into a bed at home a Pitchoune Kalin Bed. On 19 September 2014 Ms Ho took Melissa to Allowah to be admitted. RN Veronique Jadoul spoke with Ms Ho and admitted Melissa that evening. Whilst there is some dispute about the exact conversation that took place Ms Ho informed RN Jadoul that Melissa was now in a bed at home. Following that conversation Melissa was placed in a bed at Allowah from that point on.

18. There was no formal risk assessment process in place at the Hospital at that time regarding the assessment of appropriate beds for the children with disabilities who attended Allowah. The Hospital relied on the nursing staff to determine the suitability and adaption of available beds. There was no involvement in that process by Occupational Therapists or other persons.

19. An admission form was completed by RN Jadoul that included the "fall risk assessment". That form recorded that Melissa's risk score was "1" on the basis Melissa was completely immobile. There was no option to record a child who did not mobilise but who moved about in bed.

20. The bed Melissa was placed in was a Medicraft brand hospital bed, model number PB (Paediatric Bed) 2000 with metal rails fixed to the side. This bed model was registered in 2004 on the Australian Register of Therapeutic Goods administered by the Therapeutic Goods Administration (TGA) as a Class 1 medical device. In 2006 Medicraft was taken over by Hill-Rom. Registration of the bed was cancelled in 2011. The TGA had no record of any adverse event, safety issues or cancellations. An investigation subsequent to Melissa's death by the TGA did not reveal any failures, defects, design or regulatory non compliance with the bed.

21. This bed had a 23-25cm gap between the vertical end of the bed rails at the top of the bed and the bed head. Melissa's bed was adapted by the hospital with padding placed on the inside of the rails to prevent limb entanglement or injury in the bed rails in the case of a patient seizure. The cushions were tied into the side rails with Velcro. The padding/bumpers had been custom made by an Upholstery and Motor Trimming company as requested by the Hospital as it was considered commercially available bumpers were too thin.

22. The upholsterer was given dimensions, a sample was provided and trials conducted of the custom made bumpers. Orders were placed. The bumpers ran the entire length of the bed from the foot to the head and the 23cm gap from the bed head to the rail was covered by the padding.

23. Ms Ho had concerns about the bed that Melissa was placed in. RN Jadoul was informed that Melissa's bed at home was configured in a V shape to prevent Melissa moving around to address falling from the bed. A V shape means both the head and foot of the bed is raised to restrict movement from the middle of the bed. The PB 2000 had that capability.

24. RN Jadoul ensured this information was recorded in two areas; firstly in the section on the admission form regarding changes since last admission, she wrote "…*sleeping in bed at home... Head/feet UPRIGHT*". Secondly to ensure a proper record was made and future shifts would be aware of the need to place Melissa's bed in a V shape she recorded the following entry on the computerised hand over sheet "*To sleep in bed with head/feet elevated simultaneously. Padding on side. Please monitor."*

25. The handover sheet is printed out from the computerised system and each staff member of the following shift is provided a copy to ensure they are aware of changes and requirements for all patients. The management of this information by the Hospital at the time meant any RN or the Director or Deputy Director of Nursing could edit/delete and transfer it onto the computerised "Master Copy" to ensure a permanent ongoing record of a patient's clinical needs.

26. The Master Copy ensured following discharge of the patient, that important information would be immediately available upon the next admission of the patient to nursing staff. Such information is critical for the patient cohort at Allowah given the complex special needs and level of care required for the children.

27. The entry made by Ms Jadoul on the handover sheet had disappeared from the computerised system by 25 September, but partially appeared again on 26 September. It had disappeared altogether by 4 October when Melissa was discharged. The information had not been transferred from the handover sheet to the Master Copy prior to being deleted. It cannot be ascertained who deleted the information.

28. A further system error identified was Melissa's Childcare Management Plan (CMP) should have been updated with this information. The CMP was not updated.

29. Both these serious errors occurred due to failings in the systems at the Hospital. Further, there was no clear allocation of responsibility for oversight of the integrity of those records/systems. Ms Sharyn Wood the then Deputy Director of Nursing gave evidence that she thought it was her responsibility. However that was clarified in that any of the RN's could have transferred, amended or deleted the information. Effectively all the RNs had a part to play in transferring information to the Master Copy. Ms Wood could not say why the notation had been removed.

30. The result of these system errors was when Melissa was next admitted to Allowah, that critical information provided by Ms Ho and recorded by RN Jadoul was not on the Master Copy or the Childcare Management Plan and available to nursing staff.

Admission of 23 December 2014

31. On 23 December 2014 Mr Standen attended the Hospital with Melissa who was being admitted for respite care for several weeks. Mr Standen spoke with a nurse

and signed paperwork as part of the admission process. Part of the paperwork signed was a “falls risk assessment” that rated Melissa once again at “1” and indicated she was completely immobile. When Mr Standen left Melissa was still in her stroller and had not been allocated a bed. Later that evening Melissa was once again placed in an adapted Medicraft PB 2000 bed.

Events leading up to Melissa’s death

32. On 13 January 2015, Melissa was in Room 6, bed 6B. Room 6 had four beds, and bed 6B was located on the far left of the room furthest from the door.

33. Ms Falvey an enrolled nurse was on the evening shift. She said Melissa was crying a lot that evening. Ms Falvey spent quite some time going in to degas and settle Melissa down. Melissa was crying at around 10pm during the shift handover. The three staff on nightshift that evening were RN Mullholland, enrolled nurse Ms Thomas and Ms Brown an assistant in nursing. Hearing Melissa crying Ms Brown started to go in to Melissa, but was told Melissa had just been degassed and settled. Melissa was quiet about 5 minutes later.

34. Melissa was last checked at 11.15pm by Ms Brown. Melissa had a pillow and a sandbag in her bed. The pillow was between her legs and the sandbag was on her right side. The side rails were up and the two large bumpers in place against the side rails. Ms Brown stated Melissa was asleep in the middle of the bed, on her back, although in her statement she said that Melissa was on her side. Melissa was not distressed, and Ms Brown heard her breathing.

35. At 11.30pm, Ms Brown and Ms Thomas commenced rounds that involved feeding, changing, turning the children and filling up bottles. At about 11.55pm, Ms Brown and Ms Thomas went into Melissa’s room. The curtain was drawn around Melissa’s bed, as staff considered (incorrectly) the light would irritate her, Melissa had very limited vision. Of the four children in the room Melissa was the last child to be checked.

36. Ms Thomas stated when she pulled back the curtain, she could see Melissa was not in her bed, and then noticed Melissa hanging from the top right corner of her bed, on the outside of the bed. The bed rails and bumpers on the side of the bed were up. Ms Thomas stated that Melissa was facing towards the foot of the bed with her feet facing the wall at the head of the bed. The back of Melissa’s t-shirt

was hooked on the corner of the bed, her knees were touching the ground and her head was leaning forward such that the t-shirt was putting pressure on her throat area. Ms Thomas describes it as a forward kneeling/praying position with the weight of the upper half of her body supported by the t-shirt around her throat. Melissa's head was suspended approximately 2-3 inches from the ground.

37. Ms Thomas told Ms Brown to hit the emergency button and get the emergency trolley. Ms Thomas unhooked Melissa's t-shirt, laid her on the floor, lowered the bed and side rails, placed Melissa on the bed and commenced CPR.

38. Ms Mulholland came in after Ms Brown hit the button and commenced intermittent positive pressure resuscitation. Ms Brown called an ambulance. Paramedics attended and Melissa was transferred to Westmead Children's Hospital at about 12.30am. All attempts to resuscitate Melissa were unsuccessful. Melissa died at 1.28am on 14 January.

Cause of death

39. A post-mortem was conducted at the Department of Forensic Medicine Glebe on 15 January 2015 by Forensic Pathologist Dr Johan Duflou. The cause of death was determined as hanging.

How did Melissa fall from the bed?

40. Evidence at inquest established Melissa could move in bed, despite the rating on the admission form as "*completely immobile"* In a video interview on 20 September 2017 Ms THOMAS stated *"Melissa did move a lot. A lot of the time. But she was a very windy child, you had to de-gas her all of the time and when she had pain she arched, and when she arched she seemed to walk up to the end of the bed [indicated top end of the bed]. Even when she is in the cot, her head was always up the end of the bed and you were constantly pulling her down."*

41. I find on the evidence between 11.15pm and 11.55pm Melissa moved herself up the bed after being checked by Ms Brown and ended up in the top right hand corner. Melissa was small enough to fall through the gap between the vertical end of the triangular rail and the bedhead. Padding covering the approximate 23-25cm gap between the bed head and rail was not supported or secured effectively. The bumper was not designed to be a fall prevention device. Melissa fell through that gap. The bottom of Melissa's t-shirt caught on a plastic disc on the right top corner

of the bed and her t shirt slipped up around her throat restricting her airway. Whilst Melissa's knees were on the floor, her upper body was suspended by the t shirt around her throat.

Was the bed adapted in an appropriate way for Melissa's needs?

42. It was conceded by the Hospital during inquest that the bed was not adapted in an appropriate way for Melissa's needs given her age, physical stature, mobility and medical conditions.

43. The Court obtained an expert report from Ms Michelle King, Occupational Therapist who stated:
"As stated above, the bed Melissa was placed in with bed rails and adaptations that included padding and the use of sandbags were not appropriate to mitigate the risks of entrapment associated with Melissa's use of the bed.

If Melissa were the size of an adult she would have still been at risk of entrapment however she likely would not have fallen from the bed. The 23cm gap between the bed head and bed rail would have placed an adult at risk of entrapment of the head, neck or chest.

Melissa was placed in a bed inappropriate for her need. She had a documented history of movement in bed, was extremely small for her age and placed in a bed with a large gap between the bedhead and the bed end."

The bed bumpers

44. The two bumpers attached to the bed rails utilised were to prevent injuries from or entrapment in the bed rails, not to prevent falls. The DVD demonstration on 20 September 2017 clearly demonstrated how easily they could be moved to allow a child to fall from the bed.

Height of the bed

45. The evidence from Ms Brown and Ms Falvey satisfy me the bed was not at the lowest setting (nearest the floor) to address any risk of falling by Melissa. I find the bed was set at approximately hip height to facilitate ease of access and procedures by nursing staff.

Was the bed tilted or the bed head raised?

46. There was conflicting evidence by the nursing staff on this issue and the adjustment of Melissa's bed that evening. The notations made by Ms Jadoul had disappeared from the records by 13 January, 2015. No witness suggested the bed was configured in a V shape. I find on the evidence the bed was not in a V shape.

47. It was suggested by the nursing staff the bed head was either elevated or the entire bed was flat but tilted with the top end higher. Either position was nominated by nursing staff to address the known concerns that Melissa might move up to the bed head area due to movement resulting from reflux pain/discomfort. I am unable to make a finding on this issue due to the conflicting evidence. However, whatever position the bed was set in, it was insufficient to prevent Melissa moving up to the bed head and falling out.

48. It was conceded by the Hospital, even if the bed had been set up in a V shape, the padding on the bed was not a suitable response to the risks associated with the bed allocated to Melissa.

Was a proper assessment conducted including appropriate risk identification, assessment and management of Melissa's needs upon her transfer to an adult bed?

49. It was also conceded by the Hospital that staff did not conduct appropriate and adequate risk identification assessment and management in relation to transferring Melissa to the bed. There was no formal risk identification process designed or implemented by the Hospital. Mr Scott Hurren the then Director of Nursing at Allowah was responsible to oversee the risk assessment policies and ensure education took place.

50. Ms King's report stated:

"No risk assessment was completed when the facility decided to move her from a cot to a bed. An occupational therapist was not consulted regarding Melissa's safety in the bed and she was never identified as a falls risk. This was in spite of an incident when Melissa was found by staff with a side down on her cot and had the ability to roll."

The falls risk assessment in use was not appropriate to identify falls risks in children with a disability…. In completing the NSW Health Paediatric Fall Risk

Assessment based on information available regarding Melissa's status in the 6 months leading up to her death, she scored 12. A score equal to or greater than 12 indicates the patient is a "High falls risk".

51. I find Mr Hurren did not implement effective or appropriate policies or procedures regarding assessment at the Hospital. There was no effective system to ensure information recorded on the handover sheet was retained and transferred to the Master Copy and not deleted without appropriate oversight. Effectively the hospital relied on RNs to conduct and evaluate their own assessments. The reliance by the Hospital on the experience of its staff who had not been properly trained was coupled with inadequate admission forms. This resulted in a situation where no proper risk assessments were undertaken resulting in a lack of identification of risks to the most vulnerable of patients.

52. Relevant published guidance was available externally for Allowah before Melissa's death which identified a number of things that should be considered or done before putting a child with Melissa's disabilities in a new bed:

- Carry out a risk assessment
- Take account of the patient – their size, level of control, movement and communication
- Look at where the gaps are
- Take measures to address the risk
- Keep them under close observation
- Train staff

Allowah did not undertake any of these processes.

Were staff adequately trained to assess and adapt Melissa's bed?

53. The hospital conceded there was inadequate training of staff to assess and adapt Melissa's bed. Some of the nurses at the hospital work permanent nightshift. It became apparent throughout the course of the inquest night staff receive little or no training as opposed to staff on day or afternoon shifts. Mr Hurren who had the responsibility to provide education to staff failed to take into account the need for night shift nursing staff to receive the same level of education and training as other staff

54. No formal training took place in the hospital to instruct staff to appropriately adjust or adapt beds. This resulted in a mixture of very experienced and less experienced staff undertaking these procedures with little or no guidance.

Manner of death

55. Having considered all the evidence received at inquest I find the following factors contributed to Melissa falling from the bed and her subsequent death:

- Failure by the Hospital to develop and implement an appropriate risk assessment and admission procedure.

- Failure to implement a proper risk assessment to manage Melissa's change from a cot to a bed.

- The selection and use of a bed totally unsuited to the needs of Melissa

- Failure to properly adapt the bed selected to reduce risk given Melissa's special needs and the inappropriate use of bumpers as a fall prevention device.

- Failure to ensure important clinical information was retained regarding the adaption of the bed to ensure staff were fully informed of the specific needs of Melissa whilst a patient at the facility.

- Inadequate training of staff and the lack of a proper process to respond to concerns by staff.

- The lack of involvement by the Hospital of occupational therapists in the selection and use of appropriate beds for children with profound disabilities.

- Poor management practices relating to the development of internal policies and the training of staff regarding the admission and assessment of patients.

Standards and options for paediatric hospital beds in New South Wales

56. Mr Steven Winters the Clinical Product Co-ordinator for the Children's Hospital Westmead advised there are no formal standards applicable to paediatric beds in New South Wales. Standards exist for children's cots and adult sized beds only.

57. There were guidelines and alerts available before Melissa's death in relation to bed safety or fall prevention that were not mandatory, including those published by the Cerebral Palsy Alliance and NSW Health.

58. Mr Winters referred to the ageing nature of a high percentage of paediatric beds in New South Wales and there is no paediatric bed on the NSW Government Contract. There is a lack of choice in the paediatric bed market and little public funding for upgrades. All paediatric beds are manufactured overseas.

What, if any, relevant changes have been introduced by Allowah since Melissa's death, particularly as to risk and bed allocations?

59. Ms Elizabeth McClean, Chief Executive Officer of Presbyterian Social Services gave evidence. In the course of her evidence Ms McClean offered a sincere apology to Melissa's family regarding failures by the Hospital that resulted in Melissa's death.

60. Ms McClean's evidence outlined the following changes that have occurred at the hospital subsequent to Melissa's death:

- The design and implementation of the Bed Allocation Screening Tool (BAST), first in 2015 and with version 4 in 24 July 2018. Underpinning the BAST is a Bed Allocation and Sleep Time Policy and Procedures and a quality improvement program in relation to bed safety. Audits have been conducted on use and compliance with the BAST and Ms King gave evidence that problems picked up in those reviews were appropriately addressed

- The PB2000 is no longer used. Allowah is implementing a replacement schedule and has purchased a number of new beds. It has undertaken assessment of those beds for risk and suitability for Allowah's particular patients. None of the new beds have gaps

- Bumpers are no longer used and more secure bolsters have been introduced

- Concerns by staff and incidents are recorded electronically via Tikit on Demand a computerised reporting system. This provides the opportunity for staff who have concerns about the nature, use or risk issues of any equipment or other matters to

report to senior management without the need to progress the complaint through their immediate supervisor if they wish

- The Wednesday Weekly newsletters, which staff in evidence indicated they read, are used to communicate happenings to staff. It communicates new policies and revisions. Other similar measures include quizzes on policies online and training by bed providers in use of new beds

- A risk management framework was introduced soon after Melissa's death and a quality improvement programme on risk management later in 2015

- The utilisation of the skills and knowledge of allied health staff (Occupational and Physiotherapists) in relation to bed use and safety has increased

- Notification to RN's on evening and night shift that beds were to be lowered as far as possible during evenings to minimise the risk of harm from falls

- The trialling of different beds and the involvement of bed suppliers to train and familiarise staff with new equipment

- Implementation of a bed replacement schedule to progressively replace older beds with safer alternatives

- Increased training of staff including one on one training of the BAST

- Review and implementation of an updated Falls Prevention Policy

61. During the inquest the Hospital undertook that the following issues, some only revealed during the course of the inquest, will be addressed as a matter of priority:

    - An external audit of all equipment not limited to beds to be conducted by an external occupational therapist or other specialist. This review to include compliance with TGA registration and ongoing notification to the TGA of any issues identified by the hospital regarding the use of specific beds.

- A review of the computerised handover record system, involving the computerised system and the processes utilised to ensure information cannot be removed or lost between admissions.

- A review of Child Care Management Plan procedures to ensure review dates are more easily captured and to include more detailed explanation of bed configurations and sleep systems.

- The immediate implementation as of 3 September 2018 in the admission process of the NSW Risk Assessment for Paediatric Fall Risk Assessment involving the Fall Risk Assessment Tool.

- Ensuring that nightshift staff are offered and can access the same training as staff on other shifts.

Should any recommendations pursuant to s 82 be made?

62. It is acknowledged that Allowah Hospital provides a service to families and carers of children with profound disabilities that is unique in NSW. It is a Hospital specifically established many years ago to provide respite to families and carers who dedicate their lives to the love and care of children with disabilities. During the course of this inquest the Court heard from nursing staff who have worked at Allowah caring for children for the majority of their working lives. However, the very nature of the children who attend Allowah demand the absolute best in care and treatment by the Hospital.

63. I am satisfied the evidence heard at this inquest reveals the Hospital has made real efforts to identify and implement procedures to address system failures, lack of staff training and culture following Melissa's death. It is the clear wish of Melissa's family that lessons be learnt and changes occur to ensure another child is not placed at risk in similar circumstances.

64. I have carefully considered the recommendations suggested by Melissa's family in light of the changes that have occurred at the Hospital. Some suggestions are outside the scope of this inquest. I am of the view on the basis of the evidence received at inquest from the Hospital that no recommendations relating to Allowah are necessary or desirable.

65. However, the inquest heard of the changing nature of the challenges faced by facilities such as Allowah.

66. There are and will continue to be large systemic changes following the introduction of the NDIS. It was not within the scope of this inquest to determine the extent to which the service providers of medical or integrated healthcare for children with profound disabilities, or respite care, are evolving.

67. There is a changing cohort of patients, with children suffering significant medical difficulties living longer than they may have previously.

68. Available beds appropriate for patients such as those at Allowah have changed in the last 5/6 years although the market remains contracted and choice is limited. All beds are manufactured overseas and costs are significant.

69. Allowah itself has seen changes as the range of children for whom it cares has widened significantly. Further, each child presents with his or her own set of unique characteristics and special need for particular care.

70. Mr Winters, Ms King, and Ms McClean all indicated that guidelines or standards in relation to the safety of hospital beds for children who suffer profound disabilities is necessary. Variation in the special needs of patients with disabilities and the varying circumstances surrounding their treatment are substantial. Attendance at various facilities coupled with the changing nature of equipment and ongoing advances in equipment, therapies and treatment require clear guidelines to staff.

71. It was not within the scope of this inquest to undertake a full review of all of these issues. It is more desirable in the circumstances that broader expertise from persons with relevant experience and knowledge in these specialised areas are utilised in the formulation of any guidelines. It is in the interests of the community, patients with profound disabilities and their families and carers that appropriate standards, guidelines or other publications be developed in this regard.

Recommendation pursuant to s 82 of the Coroners Act 2009

To the Minister for Health, it is recommended that a group of appropriately qualified experts, in consultation with organisations that represent or care for children with physical and neurological disabilities develop a standard, guideline or

other type of publication, which is directed to improving the safety of beds used by children with physical and/or neurological disabilities including:

1. How to conduct a thorough assessment, taking into account characteristics such as any movement disorder and bed mobility to determine the risk of entrapment, entanglement, fall or injury to a child. That such assessment occur prior to a child with a physical and/or neurological disability being placed in any bed. The assessment of bed accessories or equipment, and strategies to eliminate or appropriately minimise risks.
2. Recommended appropriate training in relation to the matters listed in (1) above.
3. Recommended proper review procedures or re-evaluation of the matters listed in (1) above.
4. Any other matter that the group considers appropriate to ensure bed safety.

Conclusion

72. Whilst at Allowah, Melissa was completely dependent on the care provided by the Hospital. Melissa's family relied on the Hospital to keep her safe. Due to failures in systems in place at the Hospital Melissa fell from her bed. I find that Melissa's death was preventable.

73. The care, love, dedication and devotion to Melissa was overwhelmingly demonstrated by her family throughout this inquest. Melissa's loved ones will remember her enriching their lives with her contagious smiles and laughter that coupled with her crying was her only way of communicating with them. Melissa's family loved her, will treasure her memory and miss her terribly.

74. I offer my sincere condolences to Melissa's family

75. I wish to acknowledge the assistance of Counsel Assisting Ms Bonnor and Ms Geddes from the Crown Solicitors Office for their assistance in this matter.

Findings Pursuant to s 81 of the *Coroners Act* 2009

Identity

Melissa Standen

Date of death

14 January 2015

Place of death

Westmead Children's Hospital

Cause of death

Hanging

Manner of death

Fall from a bed at Allowah Hospital due to failures to implement proper systems for risk assessment, bed selection and the training of staff for a child patient with profound disabilities.

Les Mabbutt
State Coroner
25 September 2018