



CORONER'S REPORT
INTO THE DEATH OF

MOONEY

SURNAME

ELDON

GIVEN NAMES

OF

NORTH VANCOUVER
MUNICIPALITY OF RESIDENCE

I, Kate Corcoran, a Coroner in the Province of British Columbia, have investigated the death of the above named, which was reported to me on the 30th day of January, 2011, and as a result of such investigation have determined the following facts and circumstances:

Gender: MALE FEMALE

Age: 88 YEARS

Death Premise: CARE FACILITY

Place/Municipality of Death: NORTH VANCOUVER

Date of Death: JANUARY 29, 2011

Municipality of Illness/Injury: NORTH VANCOUVER

Time of Death: 0855 HOURS

MEDICAL CAUSE OF DEATH

(1) Immediate Cause of Death: a) Aspiration of Food

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any: b)

DUE TO OR AS A CONSEQUENCE OF

Giving rise to the immediate cause (a) above, stating underlying cause last. c)

(2) Other Significant Conditions Contributing to Death: Poor dentition; Dementia

BY WHAT MEANS Choked while being fed

CLASSIFICATION OF DEATH ACCIDENTAL HOMICIDE NATURAL SUICIDE UNDETERMINED

Date Signed: JULY 16, 2011

Kate Corcoran, Coroner
Province of British Columbia





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INVESTIGATIVE FINDINGS

On January 29, 2011, at 0855 hours, Mr. Eldon Mooney was pronounced deceased at his care facility in North Vancouver. A family member reported his death to the BC Coroners Service (BCCS) the following day and an investigation commenced.

During the AM hours of January 29, 2011, Mr. Mooney was fed breakfast in his bed by a staff member at Sunrise of Lynn Valley (SLV). He died shortly thereafter. According to the family member, Mr. Mooney's death was an accidental death, as she alleged he choked on food while being fed by staff. As well, she alleged staff had not reacted to the choking in a proper manner. Her allegations were based on video obtained from a "nanny cam" surreptitiously set up in Mr. Mooney's room.

Initial statements from facility management indicated there were no problems or concerns at the time of Mr. Mooney's morning meal. BCCS was told Mr. Mooney was comfortable prior to staff exiting his room; that staff returned shortly after to find the 88 year old unresponsive and that when assistance arrived, given an existing DNR (Do Not Resuscitate) order, no actions to resuscitate were initiated. Following Mr. Mooney's death and as per protocol, staff notified one of its physicians and upon hearing the details, the physician discerned the death natural and likely due to a cardiac event.

Mr. Mooney's documented medical history at the time of admission included dementia, a remote subdural hematoma (etiology unknown), deafness and bowel incontinence. During initial conversations with management, BCCS was told the facility did not have what it believed was a thorough account of Mr. Mooney's medical history, given it had hurried its admission process one month earlier to assist what it perceived to be a family in need. In the weeks that followed Mr. Mooney's admission, staff had become aware of his acute dementia and behavioral issues, along with the need to supervise him while eating, owing to the risk of choking.

Given the differing stories between family and management, the BCCS ordered Mr. Mooney's body transported to Vancouver General Hospital for a forensic autopsy. Medical charting from the facility was seized, as was video from the nanny cam and Vancouver Coastal Health (Community Care Facilities Licensing/CCFL) was immediately notified. CCFL commenced an independent investigation and in conjunction with the video, a more thorough understanding of Mr. Mooney's death surfaced. Mr. Mooney's death was the result of a choking incident during breakfast; an incident not responded to in a safe, efficient and effective manner. The video confirms that some of SLV's staff members were less than forthcoming with the facts surrounding Mr. Mooney's final minutes, leaving management unaware of the correct circumstances.

As a result of its investigation, CCFL found numerous contraventions to the Community Care and Assisted Living Act. A summary of the contraventions *specifically of interest* to the BCCS involves areas of patient monitoring; employee monitoring; actions of staff prior to, during and after death; food preparation and delivery; admission screening; reportable incidents and the implementation of existing policies/procedures. Among the key findings of interest to the BCCS:





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- Appropriate monitoring of the patient was not in place, nor was there sufficient staff understanding and/or protocol of what monitoring entailed, including the lack of an adequate signaling system for the patient to use in case of emergency
- When the resident choked, appropriate emergency action was not taken
- In accordance with the individual nutrition plan, safe feeding techniques, sufficient assistance and supervision were not followed to feed this patient
- Staff present at the death of the resident were not truthful with regards to the final moments of death
- Staff assigned to care for the patient were lacking the knowledge or skill to feed a resident at risk for choking
- Supervisory staff were unable to respond appropriately to a choking emergency
- There was a lack of recent staff training with regards to patients requiring assisted feeding
- Patient was admitted to facility prior to receiving a thorough medical history, resulting in less than safe and adequate care
- There was no documentation regarding an oral health care plan and proper denture fit
- Care and supervision required for the patient was not consistent with what was written on care plan, and the care plan itself was neither monitored nor reviewed for updated changes

Since the release of the CCFL report, Sunrise of Lynn Valley (SLN) has initiated numerous and timely improvements. Written plans addressing stated concerns have been provided to the licensing body, along with a timeline of implementation. Primary changes involve the introduction of 24 hour on-site nursing (RN) care; amendments to its intake procedures with regards to high risk patients and improvements to training protocols with respect to delirium; feeding techniques and choking situations, and group discussions regarding ethics and the importance of full and honest incident reporting.

At the time of this report, CCFL was accepting of the progress made and monitoring the facility on a continued and heightened basis.

POST MORTEM/TOXICOLOGY EXAMINATION

The forensic pathologist was provided with the video camera footage. His opinion was that it revealed a patient going into distress, apparently trying to cough shortly before becoming unconscious while being fed by a staff member.

Post mortem examination found a massive amount of partially chewed food in the airways, extending into the smaller bronchi of the lungs. Microscopic examination of the lungs showed both acute and chronic areas of aspiration; findings consistent with a massive acute aspiration of food, as well as recurrent aspiration of smaller amounts of food in the past. The decedent was noted to be edentulous (lacking in teeth).

Other findings included moderate to severe coronary artery atherosclerosis, with some ischemic changes in the heart; evidence of a remote subdural hematoma bilaterally; several small infarcts in the brain, and severe nephrosclerosis in the kidneys. These are chronic conditions and not unusual for his age. The presence of multiple remote cortical infarcts is consistent with the clinical history of dementia, and suggests that multi-infarct dementia is a likely cause. There was no acute brain injury found, and toxicology results were unremarkable.





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CONCLUSION

Mr. Mooney was a challenging patient to care for, and staff was ill prepared and incapable of dealing with his issues— issues known to exist in the elderly and vulnerable population that facilities such as Sunrise of Lynn Valley cater to. If not for the video brought forward by the family, Mr. Mooney's accidental death would not have surfaced.

Accordingly, I find Mr. Eldon Mooney died in North Vancouver on January 29, 2011, from aspiration of food. Contributing factors include poor dentition and dementia. I classify this death accidental. Given the improvements that have been implemented at the care facility, and the heightened monitoring being carried out by Vancouver Coastal Health's Community Care Facilities Licensing, I make no recommendations.

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Kate Corcoran, Coroner
Province of British Columbia