IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 3130

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: ENA EDITH VICKERS

Delivered On:	25 February 2016
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Dates:	9 & 10 December 2015
Findings of:	PHILLIP BYRNE
Representation:	Mr Ross Ray QC for Embracia Aged Care Ms Sharon Keeling for Dr Alexander Terris Ms Roslyn Kaye for Dr Simon Pilbrow
Police Coronial Support Unit	Leading Senior Constable Joanne Allen

I, PHILLIP BYRNE, Coroner having investigated the death of ENA EDITH VICKERS

AND having held an inquest in relation to this death on 9 & 10 December 2015
at Melbourne
find that the identity of the deceased was ENA EDITH VICKERS
born on 31 December 1935
and the death occurred on 4 August 2012
at Frankston Hospital, Hastings Road, Frankston, Victoria 3199

from:

1 (a) COMPLICATIONS OF HEAD AND NECK INJURIES SUSTAINED IN A FALL

1 (b) PARKINSONS DISEASE, DEMENTIA, CHRONIC SUBDURAL HAEMATOMA

Pursuant to section 67(1) of the **Coroners Act 2008** there is a public interest to be served in making findings with respect to **the following circumstances**:

1. Mrs Ena Vickers, 76 years of age at the time of her death, resided at Embracia on the Peninsula Nursing Home, Rosebud.

2. Mrs Vickers had a past medical history of dementia, Parkinson's disease, anxiety, declining cognitive function and hearing impairment. Having regard to her condition Mrs Vickers required high level care.

3. At about midday on 30 July 2012 Mrs Vickers suffered an unwitnessed fall in her room in the Sullivan/Griffin household at the facility.

4. Mrs Vickers was attended by Personal Care Assistant (PCA) Ms Diane Jones and another PCA, and returned to her bed. As no registered or enrolled nurse was on duty in the Sullivan/Griffin household, Enrolled Nurse Ms Annie Guy, who was in charge in Shaw household, was requested to assess Mrs Vickers. After some initial assessment by Ms Guy, Ms Lisa Della Gatta, the Assistant Manager and Enrolled Nurse, attended Mrs Vickers' room and undertook a further assessment.

5. Following Ms Della Gatta's assessment, the decision was taken to convey to Mrs Vickers' general practitioner (LMO) the result of the assessment and seek direction as to the future course of action.

6. As a result of the report of the assessment to the "LMO", the decision taken was not to convey Mrs Vickers to hospital by ambulance for medical assessment, but to monitor her

condition at the nursing home. That decision will be the subject of attention later in this finding.

7. At approximately 4.00pm, members of Mrs Vickers' family, having been advised of the unwitnessed fall, attended Embracia. They found Mrs Vickers in distress and immediately sought a re-assessment. Ms Hayley Pettigrove, a Division 1 Registered Nurse, who had come on duty in Shaw household at 3.00pm, undertook a further assessment of Mrs Vickers and reported her findings to the LMO. As a result of that contact, an ambulance was summoned and Mrs Vickers was conveyed to hospital for investigation.

8. At Frankston Hospital it was established Mrs Vickers had suffered:

   - a fractured C7;
   - a fractured neck of femur;
   - an acute sub-dural haematoma; and
   - a subarachnoid haemorrhage.

9. Further assessments were undertaken and subsequently Mrs Vickers was, after consultation with family, palliated. On 4 August 2012 Mrs Vickers passed away.

10. The matter was reported to the coroner. The coroner who had carriage of the matter at the time ordered an external only post mortem examination be undertaken at the Victorian Institute of Forensic Medicine (VIFM).

11. Forensic Pathologist Dr Linda Iles, now Head of Pathology at VIFM, undertook the external post mortem examination and advised Mrs Vickers' death was due to:

    1 (a). Complications of head and neck injuries sustained in a fall.

    Contributing factors:

    Parkinson's Disease, dementia, chronic sub-dural haematoma.

12. The coroner who initially had carriage of the matter apparently indicated she proposed to finalise the matter without inquest. When advised of this, the family of Mrs Vickers, not surprisingly in my view, raised concerns about the post incident management of Mrs Vickers by Embracia on the Peninsula.

13. In light of the impending retirement of the original coroner, the then State Coroner re-allocated the matter to me.

14. It was apparent to me that further investigation of the concerns was clearly warranted; to finalise the matter at that time was premature. My registrar advised the family I proposed to further investigate as on the face, having regard to the injuries sustained, the family concerns about the adequacy of the initial assessment required further investigation.

15. From the outset the disjointed "progress" of the investigation demonstrated the difficulties which can be encountered when one does not have carriage of a matter from the outset.

16. In any event, statements by Embracia staff were obtained and provided to the family to enable them to respond. The relevant Embracia progress notes were requested and provided to the Court, together with the facility's fall policy and falls assessment of Mrs Vickers. The investigation proceeded.

17. Finally I listed the matter for a Mention/Directions hearing on 28 August 2015 in an endeavour to progress the matter and try to determine its future course.

18. No firm conclusion was reached at that hearing as Mr Harnett for Embracia indicated he needed to take further instructions. I indicated that depending on what instruction he got, and whether any "concessions" were forthcoming, I would list the matter for full inquest. A tentative list of witnesses was settled.

19. Prior to turning to examine the circumstances leading to the death of Mrs Vickers, I propose to say something about the role of the coroner and the scope/parameters of his/her powers.

RELEVANT LAW – ROLE/FUNCTION OF THE CORONER

20. I turn to the scope/parameters of the investigation including the formal inquest. A coroner is a creature of statute; whatever Common Law powers existed were abrogated by the *Coroners Act 1985* which fundamentally changed the function of a coroner. It was truly a quantum leap from the 'old' quasi-criminal proceedings under the 1958 Act to the new fully inquisitorial role. It seems to me it took some time for those fundamental changes to be fully comprehended and applied.

21. I believe it is incumbent upon me, for several reasons, to include in my finding aspects of the law which impact upon the exercise of my powers under the *Coroners Act 2008* (the Act) because that finding forms the crucial conclusion to the coronial investigation. It is primarily directed to the parties directly impacted by the findings made; often families of the deceased person, lay persons, not their legal representatives. Furthermore, the finding constitutes the formal public record of the conclusions reached in the coronial proceeding. Very often parties leave with an unfulfilled expectation because those adversely affected by an act or omission alleged to have occurred look to the coroner to lay or apportion blame for the death being investigated. Often the implied attribution of fault is lost on the lay party who expected more direct strident denouncement of the party against whom the adverse finding is made.

22. When what is generally referred to as an "adverse finding" is made, it should as a matter of law, in my view, be couched in subtle terms.

23. Keown v Kahn,[1] a decision of the Victorian Court of Appeal, represents a landmark judgement which, in my opinion, provided much needed guidance to Victorian (and other) coroners. His Honour Mr Justice Callaway, adopting a statement contained in the report of the Brodrick Committee (UK) Report,[2] said:

> *"In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest required, without deducing from those facts any determination or blame."*[3]

24. Again quoting the Broderick Committee (UK) Report, His Honour noted:

> *"In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is a difference between a form of proceeding which affords to others the opportunity to judge an issue and one which appears to judge the issue itself."*[4]

25. So while not laying or apportioning blame, a coroner should endeavour to establish the CAUSE, or CAUSES, of a death; the distinction is fine but real. As Callaway JA described it in Keown v Kahn:

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[1] (1999) 1VR 69
[2] Report of the Committee on Death Certification And Coroners (1971) (UK) ("The Brodrick Report" Cmnd. 4810)
[3] (1999) 1 VR 69, 75
[4] (1999) 1VR 69, 75

"In determining whether an act or omission is a cause or merely one of the background circumstances, that is to say a non-causal condition, it will sometimes be necessary to consider whether the act departed from a norm or standard or the omission was in breach of a recognised duty, but that is the only sense in which para. (e) mandates an inquiry into culpability. Adopting the principal recommendation of the Norris Report, Parliament expressly prohibited any statement that a person is or may be guilty of an offence. The reasons for that prohibition apply, with even greater force, to a finding of moral responsibility or some other form of blame..."[5]

26. I have found the dichotomy between finding cause of death on one hand and finding or apportioning fault, blame or culpability on the other difficult to articulate. Quite recently, in a judgement of the New Zealand Court of Appeal, I saw as good an explanation of the conundrum as I have seen. In the Coroners Court v Susan Newton & Fairfax New Zealand Ltd[6] reference is made to *Laws NZ*, Coroners. At paragraph 28 under the heading of "blame", the following statement appears:

"It is no part of the coroner's function to apportion blame for the death. The coroner must however be able to go beyond the mere cause of death if the coroner is to serve a useful social function, and must establish so far as is possible, the circumstances of the death. The implicit attribution of blame may be unavoidable in order for the coroner to ascertain or explain how the death occurred in the wider events that were the real cause." (emphasis added)[7]

27. In his judgement in Keown v Kahn, Callaway JA referred to the Norris Report, upon which the 1985 Coroners Act was largely founded, and observed:

"A coroner is not concerned with questions of law of that kind. Instead the coroner is to find the facts from which others may, if necessary, draw legal conclusions."[8]

28. In the same case His Honour Justice Ormiston observed:

"The findings of coroners ought to eschew use of language which connotes legal conclusions as opposed to factual findings."[9]

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[5] (1999) 1VR 69, 76
[6] [2006] NZAR 312
[7] [2006] NZAR 312, 320
[8] (1999) 1VR 69, 75
[9] (1999) 1VR 69, 70

29. Once the facts are elucidated the parties (and others) can do with them what they will. I have heard it contended that if there is no determination of criminal or civil liability what is the point of the exercise? That contention is, in my view, not only cynical, but ill founded.

30. Causation goes to the heart of the matter. It has been the subject of considerable judicial attention and discussion in the coronial context.

31. In Chief Commissioner of Police v Hallenstein, Justice Hedigan observed:

> *"The issues of causation and contribution have bedevilled philosophers for centuries and have attracted consideration by superior courts in all jurisdictions and places for more than a century. The inclination to expound, in an authoritative way, the connection between human behaviour and consequences has proved seductive. The estimation of the nature and extent of this connection may be described as the evaluation of "contribution". The law has also espoused minimalism in attempting definition of the causative or contributing effect of conduct. Nearly 50 years ago, a powerful High Court (Dixon CJ, Fullagar and Kitto JJ) described causation as "all ultimately a matter of common sense" adding for good measure that "in truth the conception in question is not susceptible of reduction to a satisfactory formula." Fitzgerald v Penn (1954) 91 CLR 268, 278.*
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> *In E and MH March v Stramare, (1991) 171 CLR 506 the High Court of Australia considered the fundamentals of causation in the negligence context. The statements of principle in relation to causation are, in my view, applicable to the concept of contribution within the Act, is concerned with the causes of death and who contributed to it."* [10]

32. In March v Stramare (supra) Chief Justice Mason observed:

> *"What was the cause of a particular occurrence is a question of fact "which must be determined by applying common sense to the facts of each particular case."* [11]

INQUEST

33. The matter proceeded to formal inquest on 9-10 December 2015. Family members were present, but not legally represented. Mr Roger Vickers represented the family's interests

[10] (1996) 2 VR 1

[11] (1991) 171 CLR 506, paragraph 17

and was invited to join my assistant, Ms Joanne Allen of the Police Coronial Support Unit (PCSU) and counsel at the bar table. Mr Ross Ray QC represented Embracia Aged Care, Ms Sharon Keeling represented Dr Alexander Terris and Ms Roslyn Kaye represented Dr Simon Pilbrow.

34. I heard evidence from the following witnesses:

- Mrs Carol Vickers;
- Ms Sandra Pacillo – Residential Care Manager;
- Ms Annie Guy – Enrolled Nurse;
- Ms Diane Jones (now Mrs Fenney) – Personal Care Assistant (PCA);
- Ms Lisa Della Gatta – Enrolled Nurse and Assistant Manager;
- Ms Hayley Pettigrove – Registered Nurse (Division 1);
- Dr Alex Terris – General Practitioner; and
- Dr Simon Pilbrow – General Practitioner.

35. The first significant finding I make is that I am entirely satisfied that there is a nexus, a causal connection, between Mrs Vickers' unwitnessed fall at about midday on 30 July 2012 and her subsequent death on 4 August 2012; it has not been contended otherwise.

36. My focus has been on the period of time of the fall, about midday on 30 July 2012 and about 5.00pm when Mrs Vickers was conveyed to hospital by ambulance. More precisely, the issues I have primarily concentrated on are:

- The efficacy of the initial assessment of Mrs Vickers by Embracia staff after the fall, who undertook the assessment, and what conclusions were reached as to Mrs Vickers' condition;
- What clinical observations were made and what level of monitoring was undertaken between 12.00 midday and shortly prior to 4.00pm when Mrs Vickers was seen by family members;
- Whether the results of the assessment were conveyed to the doctor referred to in the progress notes as LMO;
- If the results were conveyed, precisely what information was conveyed and to whom;

- If the call was made, what directions were given by the doctor contacted;
- Whether the second assessment undertaken shortly after 4.00pm was as a result of concerns raised by family members as to Mrs Vickers condition;
- Who undertook the second assessment and what conclusions were reached by the assessor; and
- Which doctor was advised of the further assessment that resulted in an ambulance being called and Mrs Vickers being conveyed to Frankston Hospital for further assessment and treatment.

37. The crux of the family's concerns was confirmed by the first witness, Mrs Carol Vickers. The family firmly maintains Mrs Vickers' condition straight after the fall warranted her immediate transfer to hospital by ambulance.

38. After her assessment, Enrolled Nurse Ms Annie Guy formed a view that an ambulance should be summoned to convey Mrs Vickers to hospital. She noted a head strike and noted Mrs Vickers' pupils were pinpointed. Ms Guy maintained that Ms Diane Jones concurred with this view. However, in evidence Ms Jones said she had no recollection of Mrs Vickers' pupils being pinpointed and denied there was any discussion about an ambulance being called.

39. In evidence, Ms Guy maintained her original notes "went missing", but as she had kept her own notes she was able to make retrospective notes when she was asked to go into the facility the following day. No real explanation was forthcoming as to the "missing notes", so I take that matter no further, save to say it may well have been an issue examined in a post incident review, had one occurred.

40. I had been advised by my assistant, Ms Allen of PCSU, that Ms Jones was reluctant to give evidence, however at her request Ms Jones gave evidence by video-link, which in my view is not the preferred way to receive evidence. I must say I got the distinct impression Ms Jones sought to minimise her involvement in the matter, even though she was the person principally involved in the care of Mrs Vickers throughout the afternoon.

41. After Ms Guy's initial assessment, Enrolled Nurse/Assistant Manager Ms Lisa Della Gatta attended Mrs Vickers' room and undertook a further assessment.

42. Ms Della Gatta, experienced in aged care, maintained, and other witnesses confirmed, that when being assessed Mrs Vickers did not exhibit pain or distress and was smiling.

43. Ms Guy advised Ms Della Gatta that she thought Mrs Vickers' pupils were pinpointed. Ms Della Gatta re-examined Mrs Vickers' pupils after the curtains were drawn and concluded they were "equal and reacting". Ms Della Gatta conceded she was aware Mrs Vickers had suffered a head strike. Ms Della Gatta said she checked leg and arm range of movement and observed Mrs Vickers "smiling and nodding" with no indication of pain or distress. She did however note there was slight "resistance" as that examination was undertaken. Apparently she was advised Mrs Vickers was normally "quite stiff". I note that Ms Della Gatta was not aware that Mrs Vickers was on aspirin. Considering the potential consequence of the head strike on a person on blood thinning medication, I suggest it would have been advisable to enquire as to that issue.

44. In answer to a question from me, Ms Della Gatta accepted that until Ms Pettigrove came on duty at 3.00pm, no Division 1 nurse was on duty at the facility. She further said that if one had been available at the facility that he/she would have "attended to review the client."

45. In answer to a question put to her by Ms Keeling for Dr Terris, Ms Della Gatta conceded she made no contemporaneous note in the Progress Notes of her examination/assessment of Mrs Vickers or her discussion with the LMO, but made a "late" retrospective note the following day.

46. In the evidence Ms Della Gatta agreed that Ms Guy had indicated she, Ms Guy, considered an ambulance should be called. However, after her further assessment Ms Della Gatta made the decision, after discussing the result of her assessment with the "LMO", not to transfer Mrs Vickers but to monitor her at the facility.

47. Ms Della Gatta, experienced in aged care, and other witnesses confirmed that when being assessed Mrs Vickers did not exhibit pain or distress. The evidence suggests Mrs Vickers was apparently comfortable when observed by staff in the "princess chair" in the dining/main communal area during the afternoon.

48. <u>I have searched for reasons to explain Mrs Vickers' parlous state when observed by family members at about 4.00pm and her apparent relaxed demeanour, lack of pain and distress when assessed by Ms Della Gatta and her apparent comfort during the afternoon</u>. There is absolutely no evidence of any further incident during the intervening period. A significant conundrum arises endeavouring to reconcile the two situations.

49. Ms Annie Guy, as an Enrolled Nurse, was designated to undertake formal clinical observations. Observations were documented by Ms Guy at 12:05pm, 12:15pm, 12:30pm and 1:30pm. There was no further formal neurological or other clinical observation documented, although it is claimed. Mrs Vickers was monitored throughout the afternoon. Ms Guy stated she maintained contact with PCA Ms Diane Jones through to the end of her shift at 3.00pm, even though she was extremely busy in her own household. In evidence, Ms Della Gatta conceded she did not give a direction or indication to Ms Guy or Ms Jones as to how long formal clinical observations should be continued. It seems to me that the arrangement in relation to monitoring Mrs Vickers to ensure no deterioration in her condition warranting hospitalisation was somewhat uncoordinated/disjointed. To put it another way, there was, in my opinion, an absence of continuity in the management of Mrs Vickers, amply demonstrated by the fact that when Ms Guy did a hand over to Ms Hayley Pettigrove, the circumstances of Mrs Vickers' fall and subsequent assessment were not conveyed to Ms Pettigrove.

50. I have considered whether Mrs Vickers' medical conditions – dementia, Parkinson's disease, the fact that for all intents and purposes she was at that time non-verbal, may have masked symptoms of the injuries. To some extent that may have been the case; for example, apparently due to Parkinson's disease Mrs Vickers had a level of rigidity in her legs. However, I accept that at around 4.00pm, signs of discomfort, distress and indeed pain were present. In the final analysis I am still unable to reconcile this issue with any degree of comfort.

51. I am satisfied that after Ms Della Gatta's initial examination and assessment of Mrs Vickers a telephonic report was made to a doctor. I am further satisfied information was conveyed to a doctor by Ms Della Gatta. The issue then is which general practitioner, Dr Simon Pilbrow or Dr Alex Terris, received the report. One would have thought the question should have been easy to resolve, but for several reasons a satisfactory answer has proved to be elusive.

52. I heard from both Dr Pilbrow and Dr Terris. Each gave evidence that if a call from a nursing home was received when they were at their medical clinical it is their invariable practice to make a note in the relevant medical record of what information was conveyed and what direction for management they conveyed back to the nursing home.

53. Neither Dr Pilbrow nor Dr Terris made any such entry in Mrs Vickers' medical records. Both doctors maintained they had no recollection of a call being received. However, when pressed by counsel in examination each, somewhat reluctantly it seemed to me, concede it was possible a report was made, but not noted in the medical record. My dilemma was compounded by the fact that the relevant Embracia Progress Notes merely stated "LMO notified", without naming the doctor to whom the report was made. None of the staff could categorically recall which general practitioner was spoken to, but most thought it was Dr Pilbrow.

54. There was a further complication in that although Dr Terris was, and for some time had been, Mrs Vickers' general practitioner, her file suggested her general practitioner was Dr Pilbrow. The file had not been updated. I am not comfortably satisfied in naming either Dr Pilbrow or Dr Terris as the person to whom the first call was made.

55. In the final analysis my dilemma in relation to whom the initial report was made was allayed as Ms Keeling, supported on this issue by Ms Kaye, submitted in the final analysis it is not imperative to make a formal finding in this issue because whichever doctor took the call, the advice given as to the management of Mrs Vickers, ON THE BASIS OF THE INFORMATION CONVEYED, was reasonable. I accept that to be the case.

CONCLUSION

56. In relation to the failure to identify at an early stage the significant injuries sustained by Mrs Vickers there is one glaring inference open to be drawn and no other compelling reason was proffered. The initial assessment was made by Ms Della Gatta, an Enrolled Nurse, albeit one with significant experience in aged care. No Division 1 Registered Nurse was on site on the day in question until Ms Pettigrove came on for the evening shift at 3.00pm. The evidence establishes that while no Division 1 nurse was on site until then, apparently one was on call if her/his attendance had been requested. No such request was made.

57. The various conditions suffered by Mrs Vickers, particularly her inability to verbally communicate and her dementia, made an efficacious assessment of Mrs Vickers problematic. That, together with the obvious head strike, should have resulted in a thorough examination and assessment being undertaken by, at least a Division 1 Registered Nurse, or even more appropriately by a medical practitioner. If neither of

these alternatives were readily available, I conclude an ambulance should have been summoned to convey Mrs Vickers to hospital for further investigation. In light of Mrs Vickers' inability to verbalise, a conservative approach would have been appropriate.

58. In short I conclude the initial assessment was inadequate/deficient. However, having formed that view, I accept that even if the injuries had been identified at that time, and either a doctor summoned or an ambulance called to convey Mrs Vickers to hospital, the outcome may have been the same. I am not comfortably satisfied admission to hospital some 4-5 hours earlier would necessarily have altered the outcome, but hopefully Mrs Vickers' distress/pain experienced later in the afternoon may have been avoided.

COMMENTS

1. It would appear no formal post incident review was conducted. Having regard to the outcome and the death of Mrs Vickers several days after the incident, I must say I am surprised that a comprehensive internal review was not undertaken. It would have been most helpful if the observations/recollections of the staff involved had been sought and documented shortly after the incident, while the circumstances were fresh in their minds. In light of the fact that the matter would be reported to the coroner, I would have thought management would have been keen to assess the performance of staff and examine whether the facility's Practices and Protocols were complied with. I am of the firm view that mere subsequent "discussions" were an inadequate response to the circumstances leading to Mrs Vickers' untimely death.

2. If a formal post incident review had been undertaken, I am confident that the issue of the adequacy, or more importantly the inadequacy, of documentation in the Progress Notes would have been front and centre.

3. I do not believe I can reasonably make any adverse finding or comment in relation to the performance of either Dr Pilbrow or Dr Terris. As stated earlier in this finding, the direction given (no matter by whom) was, on the basis of the information conveyed, reasonable and appropriate.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. If they have not done so already, I recommend Embracia Aged Care formalise and implement a comprehensive, robust internal review process.

I direct that a copy of this finding be provided to the following:

Mr Roger Vickers;

L/S/C Joanne Allen;

Ms Mia Janssen;

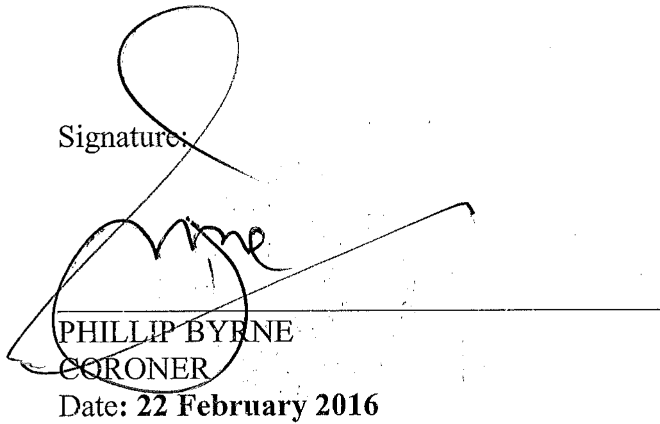
Mr Anthony Palmieri;

Dr Simon Pillbrow;

Dr Alexander Terry; and

Embracia on the Peninsula.

Signature:



PHILLIP BYRNE
CORONER
Date: **22 February 2016**