IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 5980

FINDING INTO DEATH WITH INQUEST

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

Findings of:	**SIMON McGREGOR, CORONER**
Deceased:	**NIKOLAOS MARGELIS**
Delivered on:	29 November 2018
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing date:	23 November 2018
Counsel Assisting:	Rebecca Johnston-Ryan, State Coroner's Legal Officer

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HIS HONOUR:

BACKGROUND

1. Nikolaos Margelis was an 82-year-old man who lived at the Northside Public Sector Residential Aged Care Service (**Northside PSRACS**), at the Peter James Centre, Burwood East, Victoria, at the time of his death. Mr Margelis had lived at the Northside PSRACS since October 2013.

2. Northside PSRACS is a secure, transitional care facility for people over 65 years of age who require nursing home care but cannot access mainstream Residential Aged Care Facilities (**RACFs**) due to their identified behavioural disturbances associated with mental health needs.

3. Mr Margelis had a significant medical history including Alzheimer's dementia, branch bundle blockage and cardiomyopathy. Mr Margelis was unable to access mainstream RACFs due to his dementia and worsening behavioural and psychological dementia symptoms. Mr Margelis had both short and long term memory loss. He suffered from increasing agitation and confusion, wandering and verbal and physical aggression when frustrated. Mr Margelis' first language was Greek and his language difficulties sometimes resulted in increased aggression.

4. Mr Margelis' son, Mr Steven Margelis (**Steven**) noted that Mr Margelis had experienced a previous fall with head strike and head trauma, and his care following the fall was managed in consultation with his psychiatrist. Steven sought to have a reduction of the psychotropic medications at this time due to their adverse effects on Mr Margelis' movement and walking.

5. Mr Margelis was known to be intrusive with other residents. The intrusive behaviour had increased in the period leading up to his death following a reduction in his psychotropic medications on 24 October 2014, due to a recent delirium and aspiration pneumonia episode. Mr Margelis reportedly always wanted nursing staff and residents to walk and talk with him. He would push furniture around and would often take hold of a person's hand and try to pull them along while he spoke to them in Greek. Nursing staff were aware of Mr Margelis' intrusive behaviour and routinely monitored it.

6. From 14 November 2014, Mr Margelis was recommenced on Seroquel at 12.5mg, which was administered by staff twice daily. On 20 November 2014, the dosage was increased to 25mg twice daily because Mr Margelis' increasingly intrusive and agitated behaviour could not be sufficiently inhibited by other methods.

THE PURPOSE OF A CORONIAL INVESTIGATION

7. Mr Margelis' death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria, and was not from natural causes and resulted from an injury.[1]

8. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3]

9. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[4] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[5] or to determine disciplinary matters.

10. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

11. For coronial purposes, the phrase "*circumstances in which death occurred*,"[6] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

12. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

13. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[7]

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1 Section 4, definition of 'Reportable death', *Coroners Act 2008*
2 Section 89(4) *Coroners Act 2008*
3 See Preamble and s 67, *Coroners Act 2008*
4 *Keown v Khan* (1999) 1 VR 69
5 Section 69 (1)
6 Section 67(1)(c)
7 Section 72(1)

(b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[8] and

(c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[9] These powers are the vehicles by which the prevention role may be advanced.

14. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[10] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[11] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

15. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was as a result of homicide (and no person or persons have been charged with an indictable offence in respect of the death), or the deceased was immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

16. While Mr Margelis' identity was not in dispute and he was not a person placed in "*custody or care*" as defined by section 3 of the Act, his death is considered to be a homicide. Therefore, it is mandatory to conduct an inquest into the circumstances of his death as no person or persons have been charged with an indictable offence in respect of the death.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the Act

17. On 24 November 2014, Mr Margelis' son, Steven Margelis, visually identified the deceased as his father, Nikolaos Margelis, born 10 September 1932.

18. Identity is not in dispute and requires no further investigation.

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8 Section 67(3)
9 Section 72(2)
10 *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152
11 (1938) 60 CLR 336

Medical cause of death pursuant to section 67(1)(b) of the Act

19. On 25 November 2014, Dr Yeliena Baber (**Dr Baber**), a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr Margelis' body and provided a written report, dated 25 March 2016. In that report, Dr Baber concluded that a reasonable cause of death was traumatic head injury.

20. Dr Baber commented that:

    (a) in her opinion, the death was "*due to traumatic head injury as a result of the head striking the floor ... Some natural disease is also present, however this has had no bearing on the cause of death*"; and

    (b) toxicological analysis of the post mortem samples taken from Mr Margelis reflected medical intervention.

21. I accept the cause of death proposed by Dr Baber.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the Act

22. At approximately 8.10pm on 22 November 2014, a psychiatric services officer witnessed Mr Margelis walking down the corridor at the same time as co-resident Ronald Taylor. Mr Margelis either pulled or held onto Mr Taylor's left arm and, in response, Mr Taylor (who also suffered from Alzheimer's dementia) pushed Mr Margelis. Mr Margelis fell backwards as a result of the push and struck his head on the floor.

23. Staff responded immediately and, finding Mr Margelis to be unconscious and unresponsive, initiated a Medical Emergency Team (**MET**) call and telephoned for an ambulance.

24. Mr Margelis regained consciousness approximately 10-15 minutes after the fall. At 8.25pm, when Ambulance Victoria paramedics arrived, Mr Margelis had a Glasgow Coma Score (**GCS**) of 13.

25. Mr Margelis was transported by ambulance to the Box Hill Hospital. On arrival at the Box Hill Hospital Emergency Department, Mr Margelis' GCS was 10. A Computed Tomography (**CT**) scan revealed that Mr Margelis had extensive head injuries. Mr Margelis had a large left subdural haemorrhage with midline shift, extensive cortical contusions in both cerebral hemispheres, subarachnoid haemorrhage, severe mass effect with subfalcine and descending transtentorial herniation, as well as an occipital bone fracture.

26. Following the CT scan, Mr Margelis' GCS deteriorated to six. The Emergency Department resident, Dr Ramesh Ranjan, noted that Mr Margelis' pupils had become unequal, the left one being unresponsive to light.

27. Due to the severity of Mr Margelis' intracranial injuries and in light of his comorbidities, treating doctors and family determined not to intervene surgically. Mr Margelis was palliated and died at 12.09pm on 24 November 2014.

COMMENTS PURSUANT TO SECTION 67(3) OF THE *CORONERS ACT 2008*

28. Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:

    (a) Ronald Taylor died on 4 April 2015 and was not charged with an offence in relation to Mr Margelis' death. I note simply that Mr Taylor's actions directly caused Mr Margelis' injuries, resulting in Mr Margelis' death;

    (b) my investigation into Mr Margelis' death was directed to public health and safety matters and focused on the issue of resident-to-resident aggression in RACFs;

    (c) I considered a recent Australian systematic review of research into this issue (**the review**),[12] which identified that the frequency of resident-to-resident aggression varied markedly, with insufficient information across the studies to calculate prevalence. However, the review found that resident-to-resident aggression most commonly took place in communal settings and was often triggered by communication issues and invasion of space. This appeared to be the case in Mr Margelis' interaction with Mr Taylor in the hallway;

    (d) Mr Taylor, who had a five-year history of Alzheimer's dementia, was admitted to Northside PSRACS on 20 November 2014, two days before the incident with Mr Margelis. Mr Taylor, who had previously been in the South Ward of the Peter James Centre, had significant cognitive impairment and was known to be unpredictably aggressive, agitate and violent, although staff described him as cooperative, sociable and '*pleasant*'. He had previously threatened co-residents in another ward and was intrusive into co-residents' rooms. Mr Taylor was a former Olympic boxer and

[12] Ferrah, Murphy, Ibrahim, Bugeja, Winbolt, Logjuidice, Flicker and Ranson, (2015) *'Resident-to-resident physical aggression leading to injury in nursing homes: a systematic review'*, Age and Ageing, 0:1-9

Victorian Football League player and former police officer. He was known to be protective of residents and staff, especially females;

(e) in response to the incident with Mr Margelis, Northside PSRACS sought to arrange a single bed room for Mr Taylor and arranged for him to be more closely supervised by staff when he was in the communal areas and around other residents. At approximately 3.00pm on 23 November 2014, staff observed Mr Taylor punch another resident in the face, unprovoked. In light of his increasing agitation and aggression, staff arranged a locum doctor to attend to review Mr Taylor's medications. On 24 November 2014, Mr Taylor's olanzapine dose was increased and he was transferred back to the South Ward;

(f) I received copies of Northside PSRACS' standards, policies and practice guidelines pertaining to resident-to-resident aggression, which I referred to the Coroners' Prevention Unit (**CPU**) for review. The CPU's role is to assist coroners investigating reportable deaths. The CPU has a specialist team, staffed by healthcare professionals including practising physicians and nurses, which assists with investigation of medical-related reportable deaths. These healthcare professionals are independent of the health professionals and institutions under consideration;

(g) the CPU provided a report, which confirmed that Mr Taylor's management was appropriate and was in line with the standards, policies and practice guidelines. The CPU concluded that all appropriate medical, social and allied health initiatives were undertaken for both Mr Margelis and Mr Taylor. They did not identify any prevention opportunities arising out of the circumstances of this case;

(h) at the Summary Inquest hearing held on 23 November 2018, Steven was afforded an opportunity to provide his thoughts on the medical management of his father on behalf of himself and his family. He spoke eloquently and with great insight into the challenges of management of a much-loved family member experiencing significant cognitive decline.

(i) On reflection of the care received by Mr Margelis, Steven noted the following:

    (i) it may be appropriate to consider protective headwear for patients at risk of falls, such as Mr Margelis;

(ii) in facilities where high care and difficult patients are cared for, a '*more sympathetic floor treatment*' may be of benefit;

(iii) under and over-medication of patients in such a setting is always a risk, and close monitoring of the use of psychotropic medications is required;

(iv) it is challenging for staff to physically manage patients, particularly those of a larger and more imposing stature;

(v) it may be appropriate for the facility to consider CCTV and monitoring, noting that Mr Margelis once escaped into an unmonitored yard at the facility on at least one occasion; and

(vi) Steven was somewhat perturbed by a Peter James Centre nursing staff member's perceived pre-determination of Mr Margelis' prognosis following his fall on 22 November 2014, while also noting that this commentary may have been provided in the context of the experience of the relevant staff member.

(j) There are clearly a number of challenges in administering care to patients experiencing cognitive decline in a RACF setting. While the subject matter of Steven's commentary referred to above may be of benefit when considered in a general RACF setting, I must turn my mind to considering the causal and contributing factors of Mr Margelis' death and implementation of measures which may prevent these factors from having such an impact again.

(k) I note that while a more rubberised floor covering may, in hindsight, have assisted in reducing the severity of injuries sustained by Mr Margelis, it cannot be said with any level of certainty that it would have limited Mr Margelis' injuries to the extent where his death may not have occurred. Mr Margelis had been assessed for falls risk, and the wearing of a helmet was not recommended as a part of a falls risk mitigation plan. Further, Mr Margelis' wandering was an issue, but his previous access of an outdoor courtyard area with no CCTV coverage is not, in my view, a causal or contributing factor in his death.

(l) On the basis of the evidence before me, I am of the view that the implementation of the measures suggested by Steven prior to Mr Margelis' fall was not warranted in the circumstances, and would likely not have altered the final tragic outcome.

(m) I am satisfied that Mr Margelis' death was not preventable because Mr Taylor's actions on 22 November 2014 were unpredictable and unexpected.

(n) I note Steven took the opportunity during the Summary Inquest to thank Coronial Services staff for the level of professionalism, care and consideration shown to his father while he was in the care of the Court and the Victorian Institute of Forensic Medicine. His kind words to Coronial Services staff are greatly appreciated.

FINDINGS AND CONCLUSION

29. Having investigated the death of Mr Margelis, I make the following findings, pursuant to section 67(1) of the Act:

    (a) that the identity of the deceased was Nikolaos Margelis, born 10 September 1932; and

    (b) that Mr Margelis died on 24 November 2014, at Box Hill Hospital, Box Hill, Victoria from traumatic head injuries, in the circumstances described above.

30. I convey my sincerest sympathy to Mr Margelis' family and friends.

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

    (a) Steven Margelis, senior next of kin;

    (b) Voula Christodoulou, Eastern Health;

    (c) Dr Yvette Kozielski, Eastern Health;

    (d) Sue Allen, Chief Counsel, Eastern Health; and

    (e) Sergeant Brendon Pollock, Victoria Police, Coroner's Investigator.

Signature:

SIMON McGREGOR
CORONER

Date: 29-11-2018

Coroners Court of Victoria