FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 2379/08

Inquest into the Death of JOHN JAMES BYRON

Delivered On:	30th March 2010
Delivered At:	Coroners Court of Victoria at Melbourne Level 1, 436 Lonsdale Street, Melbourne, Victoria, 3000
Hearing Dates:	23rd February 2010
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	The family of Mr John James BYRON, in person Senior Constable Tania CRISTIANO, State Coroners Assistance Unit, to assist the Coroner.
Place of death:	Dandenong & District Hospital, Heatherton Road, Dandenong, 3175

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Court reference: 2379/08

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

Details of deceased:

Surname:	BYRON
First name:	JOHN
Address:	Berwick Private Nursing Home, 25 Parkhill Drive, Berwick, Victoria,

AND having held an inquest in relation to this death on 23rd February 2010

at Melbourne Magistrates Court

find that the identity of the deceased was JOHN JAMES BYRON born on the 25th October, 1912,

and that death occurred on the 4th June, 2008

at Dandenong & District Hospital, Heatherton Road, Dandenong 3175

from: 1(a) BRONCHOPNEUMONIA IN A MAN WHO HAS SUSTAINED EXTENSIVE HEAD INJURY

in the following circumstances:

1. Mr Byron was a ninety-five year old man who resided at the Berwick Private Nursing Home (operated by "Craigcare") from January 2008 when his care needs increased. Prior to this and since the death of his wife in 1979, he had been cared for by his daughter Ms Christine Gunther, and from time to time by his sons, Richard and Michael.

2. According to Dr Jacob Dessauer[1], his General Practitioner since 2002, Mr Byron's medical history included ischaemic heart disease, atrial fibrillation, chronic airways disease, right total hip replacement, gastric ulcer and cervical spondylosis. More recently, he had several strokes and had difficulty swallowing, leading to episodes of aspiration pneumonia. Mr Byron had been assessed by a speech pathologist and his regular intake included a number of food supplements to ensure adequate nutrition. He also developed dementia following the strokes.

3. Mr Horace Geale was another resident of the nursing home who suffered from dementia. He was ninety-three years of age, had been a resident since July 2007 and occupied room 29.[2]

4. At about 6:30pm on Saturday 31st May 2008, Mr George Rayner, a Registered Nurse Division 1[3], had just completed medication rounds and was returning the medication trolley when he looked down the hallway and saw Mr Byron using his walking frame, walking towards room 27a - his room. He then heard a loud voice yelling "If you don't get out of my room I will punch your lights out." just as he saw Mr Byron walk into his room. Mr Geale was standing opposite Mr Byron, no more than a metre and a half in front of him, and moving quickly towards him. Mr Rayner then saw Mr Geale lunge forward with a definite motion, using his right hand to either punch or push Mr Byron quite solidly to the "upper part of the body, heading towards the face"[4] causing him to fly through the air with both feet off the ground and to land heavily flat on his back. He was still holding the walking frame which came crashing down with him. His eye glasses went flying.

5. Mr Rayner went to Mr Byron's assistance immediately and other staff called for an ambulance. Mr Byron had a laceration to the back of his head which was bleeding and suffered a short period of unconsciousness. Ambulance officers arrived shortly thereafter to transport Mr Byron to Dandenong & District Hospital (DDH). Upon admission Mr Byron was assessed as having confusion, subdural and extradural haematoma, an undisplaced and unstable fracture at the base of the C2 vertebra which carried a risk of spinal cord compression and respiratory arrest. Mr Byron was not well enough to undergo surgery. After consultation with his family, he was

1 Dr Dessauer's statement dated 4 August 2008 was part of the brief.
2 Mr Geale's GP, Dr Jenshel's statement dated 4 August 2008 was also part of the brief.
3 Mr George Rayner's statement dated 3 June 2008 - Exhibit "B".
4 Ibid and transcript page 13 and follwoing where he describes the incident in similar terms to his statement.

treated conservatively but deteriorated with developing bronchopneumonia and died on 4 June 2008.[5]

4. An autopsy was performed by Senior Forensic Pathologist Dr David Ranson from the Victorian Institute of Forensic Medicine (VIFM) who provided a detailed report[6] of his findings and concluded that it would be reasonable to attribute death to "bronchopneumonia in a man who has sustained extensive head injury". Dr Ranson commented his findings of significant natural disease processes in the form of bronchopneumonia and other features suggestive of previous episodes of chest infections with extensive fibrous adhesions partly obliterating the pleural cavities; chronic venous congestion consistent with cardiac failure; and widespread ecchymoses with more focal areas of bruising around the tips of the elbows, beneath the point of the chin (consistent with the wearing of a cervical collar) and over the back of the head.

5. In his report, Dr Ranson noted that specialist neuropathological examination[7] identified areas of intracranial haemorrhage with cortical contusions together with a partial fracture of the odontoid peg of the second cervical vertebra, as well as features of Alzheimer's disease. He also referred to the phenomenon of contrecoup cerebral injury as accounting for the injuries to the front of the brain, and expanded on this in his evidence at inquest.[8]

6. He also explained the significance of his comments regarding widespread ecchymoses which, potentially, masked the presence of self-defence type injuries and injuries suggestive of offensive action by Mr Byron, but the effect of his evidence, consistent with the comments in his report was that "there were no injuries necessarily attributable to self-defence injuries or injuries that might have occurred as a result of an offensive act", that is on the part of Mr Byron.[9]

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5 Medical deposition from Dandenong Hospital @ 4 June 2008.

6 Dr Ranson's autopsy report dated 19 January 2009, including his formal qualifications and experience was Exhibit "A".

7 Associate Professor Penny McKelvie provided a detailed report dated 4 July 2008 containing her findings following examination of the brain - in summary these were "Recent head injury with acute subdural haemorrhage, subarachnoid haemorrhage and intracerebral haemorrhage associated with contusions in the right inferior frontal an she .

8 Transcript pages 6-7.

9 This is of course entirely consistent with the only eye-witness account. Mr Rayner described an unprovoked one blow incident with no aggression on the part of Mr Byron, and no real opportunity to defend himself.

7. Police investigated the incident in which Mr Byron sustained the injuries which resulted in his death.[10] In the course of their investigation, Mr Geale was assessed by a Clinical Forensic Physician who concluded that he was unfit to be interviewed on the basis of his advanced dementia. It follows that no criminal proceedings have been instituted.

8. The main focus of the inquest was on the level of supervision of residents. This related to the concern expressed by Mr Byron's family that the level of supervision/staffing was inadequate and/or that Mr Byron and Mr Geale should not have been accommodated in the same part of the facility. When Detective Senior Constable Stanton testified, he reiterated his concerns about patient/staff ratio being inadequate given what he saw as the demanding nature of the job. He conceded that these concerns were 'intuitive' rather than based on any appreciation of the relevant legislative requirements.[11]

9. Ultimately, Mr Steven Richard Wood, from the Commonwealth Department of Health and Ageing, Melbourne,[12] attended the inquest and provided very helpful evidence about the legislative regime around aged care facilities and their own investigation of the incident.

10. He explained that there were no patient/staff ratio as such prescribed for aged care facilities. Rather there are Quality of Care Principles prescribed under the Aged Care Act which speak in terms of "appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care services philosophy and objectives". He also explained that there is a Charter of Residents' Rights and Responsibilities under the Aged Care Act of 1997 which, among other things recognises a right "To live in a safe, secure and home-like environment. To move freely both within and outside the residential care service without undue restriction."[13]

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10 The brief was compiled by Detective Senior Constable Justin Stanton from the Casey Criminal Investigation Unit. There is no suggestion in the brief of any animosity between Mr Byron and Mr Geale, or anything than an apparent mistake on the part of Mr Geale that Mr Byron was advancing into his (ie Mr Geale's) room uninvited.

11 Transcript pages 27-28.

12 His full title is Manager, Quality Risk Management Team, Quality & Compliance Section, Aged & Community Care Branch, Department of Health & Ageing, and he is based at 595 Collins Street, Melbourne.

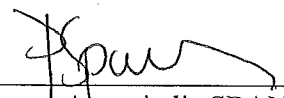
13 Transcript pages 33 and following. Exhibits "D" and "E" Quality of Care Principles 1997 and Schedule 1, Charter of Residents' Rights and Responsibilities, User Rights Principles 1997, respectively.

11. Mr Wood was involved in an investigation of the incident in which Mr Byron was injured, the focus of which was to investigate whether the approved provider/Craigcare had discharged its responsibilities under the Aged Care Act 1997 and whether they had acted appropriately. He noted that Craigcare had reported the incident in a timely way, in circumstances where they had a discretion not to report at all.[14]

12. The investigation included a site visit within a few days of the incident and a thorough audit of records including care plans, progress notes, observations charts and incident reports and the like by a Commonwealth Nursing Officer.[15] They found nothing amiss and in particular, ascertained that staffing on the particular day was adequate, that Mr Geale was a "wanderer" and was on 30 minute observations on the day which had been complied with, and that this was the first incident of this type involving Mr Geale. That is, that there had been no prior display or exhibition of violence or aggression on his part to any other person.[16] In my view, it is this latter fact which is most telling and colours any assessment of the appropriateness of Mr Geale's placement and supervision.

13. I find that Mr Byron died from the sequelae of injuries he sustained in an unprovoked attack by a co-resident at Berwick Private Nursing Home who was cognitively impaired by dementia at the time and in circumstances where the attack could not have been reasonably foreseen or prevented by management. It needs to be stressed that Mr Byron did nothing at all to provoke the attack. His death in these tragic circumstances serves to highlight the need for vigilance in managing elderly residents with dementia or with otherwise impaired and diminishing cognitive function.

Signature:



Paresa Antoniadis SPANOS
Coroner
Date: 30th March 2010

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14 The discretion not to report arose from the fact that both parties had prior cognitive problems. However, it was reported when it became apparent that Mr Byron's condition was so serious.

15 It also included discussions with the police and staff members. Transcript page 39.

16 Transcript pages 39-40.