FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 3974/07

Inquest into the Death of PATRICIA MARY COOK

Hearing Dates:	8 December 2009 and 21 June 2010
Representation:	Leading Senior Constable Greig McFarlane, SCAU, assisting the Coroner
	Ms Fiona Ellis of Counsel, on behalf of Dorset Lodge
Findings of:	AUDREY JAMIESON, Coroner
Delivered On:	28 August 2010
Delivered At:	Melbourne

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 3974/07

In the Coroners Court of Victoria at Melbourne

I, AUDREY JAMIESON, Coroner

having investigated the death of:

Details of deceased:

Surname: COOK
First name: PATRICIA
Address: Dorset Lodge Supported Residential Service
362 Dorset Road, Croydon 3136

AND having held an inquest in relation to this death on 8 December 2009 and 21 June 2010 at Melbourne Magistrate's Court

find that the identity of the deceased was PATRICIA MARY COOK

and death occurred on 5 October 2007

at the Royal Melbourne Hospital, Grattan Street, Parkville 3052

from:

1a. COMPLICATIONS OF SUBDURAL HAEMATOMA (EVACUATED)
1b. FALL
1c. WARFARIN THERAPY FOR ARTRIAL FIBRILLATION

in the following summary of circumstances:

Mrs Patricia Cook died from complications of a head injury she sustained in a fall at the supported residential facility where she had lived since 17 October 2006.

Mrs Cook's death constituted a *reportable death* as defined in section 3 *Coroners Act* 1985.[1]

[1] "Reportable Death" means a death -
(a) where the body is in Victoria; or
(b) that occurred in Victoria; or
(c) the cause of which occurred in Victoria; or
(d) of a person who ordinarily resided in Victoria at the time of death -
being a death -
(e) that appears to have been unexpected, unnatural or violent or to have **resulted, directly or indirectly, from accident or injury**; or ......

JURISDICTION & APPLICATION OF THE LAW

At the time of Mrs Cook's death, the *Coroners Act* 1985 (old Act) applied. From 1 November 2009 the *Coroners Act* 2008 (new Act) has applied to the finalisation of investigations into deaths which occurred prior to the new Act commencement.[2]

A coroner is required to find, if possible, the identity of the deceased, the cause of death and the circumstances in which the death occurred.[3] The 'cause of death' generally relates to the *medical cause of death* and the circumstances relates to the *context* in which the death occurred.

A coroner may also comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice.[4]

In particular settings, such as in the aged residential care setting where the elderly are dependant on the care of others, the conduct of the facility and/or its staff, may also be relevant to the circumstances surrounding a death. Questions relevant for a coroner are whether there was anything about the conduct that caused or contributed to the death and whether the death could have been prevented.[5]

A finding of contribution to the death by others is determined by reference to conduct and includes both positive acts and omissions. The relevant test is found in *Keown v Kahn*[6] where Callaway JA stated:

> *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 recognized duty*.

In considering whether an act or omission has departed from or is in breach of a recognized duty, such that it can be considered a causal or contributing factor in the death, the standard of care must be set at a realistic level. The fact finder can only make a finding of contribution to death if they have a comfortable degree of satisfaction that the death would not have occurred if the standard of care had been achieved.

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[2] Section 119 and Schedule 1 - *Coroners Act* 2008

[3] Section 67(1) - *Coroners Act* 2008

[4] Section 67(3)

[5] Section 1 - **Purposes**
The purposes of this Act are-

(a) to require the reporting of certain deaths; and
(b) to provide for coroners to investigate deaths and fires in specified circumstances; and
(c) **to contribute to the reduction of the number of preventable deaths** and fires through the findings of the investigation of deaths and fires, and the making of recommendations, by coroners; and.......

[6] [1999] 1 VR 69 .

The standard of proof in coronial matters is the balance of probabilities. The test to be applied is in accordance with *Briginshaw v Briginshaw*[7] where His Honour Dixon J stated:

> *The seriousness of the allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect references.*[8]

BACKGROUND CIRCUMSTANCES:

Mrs Patricia Cook was 85 years old at the time of her death. She was admitted to Dorset Lodge Supported Residential Service (SRS) at 362 Dorset Road, Croydon, on 17 October 2006, from Donvale Rehabilitation Hospital.

Mrs Cook's principal diagnosis on discharge from Donvale Rehabilitation Hospital was congestive cardiac failure. Her medical history also included ischaemic heart disease, acute myocardial infarction, hypertension, atrial fibrillation, short term memory loss, back pain, deafness and falls. Her prescription medications included the anticoagulant, Warfarin.

The Facility:

Dorset Lodge Supported Residential Service is a 45-bed residential aged care facility in Croydon that promotes itself as being *designed to the specific needs of the aged, including grab rails, non-slip flooring and appropriate furnishings.*[9] The facility offers respite, short term and permanent residency.

Supported Residential Services (SRSs)[10] are privately run businesses that provide accommodation and basic assistance with activities of daily living to people with a range of care needs. They are not however, required to directly meet their resident's health needs. They do not get government funding and there is no service agreement between the SRS and the State government however, the Department of Health does play a supervisory and regulatory role

[7] (1938) 60 CLR 336

[8] *op cit* @ pp 361-362

[9] Dorset Lodge website describes itself as "an exclusive 45 Bed Aged Care Facility." It is not however, a "Residential Aged Care Facility" as defined and funded by the Commonwealth Government.

[10] s. 3 *Health Services Act 1988*

supported residential service means premises where-

(a) accommodation; and

(b) special or personal care-

are provided or offered for persons (other than members of the family of the proprietor of the premises) for fee or reward, whether or not the premises are registered as a health service establishment under this Act, but does not include a residential care service or a State funded residential care service;

residential care service means premises where accommodation and personal care or nursing care or both personal care and nursing care are provided to a person in respect of whom a residential care subsidy or a flexible care subsidy is payable under an Act of the Commonwealth.

under the *Health Services Act* 1988 and the Health Services (Supported Residential Services) Regulations 2001. An SRS is required to be registered with the Department and must maintain a number of documents including a Care Plan for each resident specifying the care needs required of the resident, the strategies and services to be employed in delivering that care and when the care plan was last reviewed (at least 6 monthly or when care needs change).[11]

At the time of Mrs Cook's admission to Dorset Lodge, a Care Plan assessment was performed. Mrs Cook required the use of a 4-wheel frame to assist with ambulation but was otherwise assessed as independent.

There is no requirement under the *Health Services Act* or the associated Regulations for a SRS to employ registered nurses. Dorset Lodge does not employ registered nurses. It is staffed by Personal Care Attendants (PCAs) with varying levels of training and experience. PCAs are not a registered or regulated profession.

Similarly, there is no legislated requirement of the proprietors of SRS's to implement any policies. The Department of Health provides guidance regarding the provision of quality care within SRS's through their publication "Meeting the Needs". This document includes a section on falls prevention strategies. The Department also has information about falls and falls prevention programs on their web site. Section 108E of the *Health Services Act* 1988[12] requires proprietors to take reasonable steps to provide any assistance that is required to facilitate mobility and sensory function of residents.

SURROUNDING CIRCUMSTANCES:

On Sunday, 30 September 2007, Mrs Cook suffered a fall in the ensuite of her room. She hit her head. She did not report the fall to staff at the facility.

At approximately 11:50am, PCAs, Sandra Johns and Margie Johansson, were informed by residents that Mrs Cook had suffered a fall earlier that day. Mrs Cook confirmed to PCAs Johns and Johansson the accuracy of the reports and demonstrated that she had hit the right side of her head. On examination by the PCA's no apparent injury could be identified. Mrs Cook could not recall what she had hit her head on. She stated that she was not experiencing any pain.

Mrs Cook completed her lunch. As she was leaving the table she was noted to stumble/slightly lose her balance. She was escorted back to her room without incident.

At approximately 2:30pm PCA Johns observed Mrs Cook making a cup of coffee.

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[11] As per correspondence received by the Court from Judith Abbott, Manager, Residential Services, Department of Health, dated 8 January 2010 - Exhibit 9

[12] s.108E **Mobility and sensory function of residents**

(1) The proprietor of a supported residential service must take reasonable steps to provide any assistance which is required to facilitate mobility and sensory function of residents.
Penalty: 120 penalty units.

(2) The proprietor of a supported residential service must take reasonable steps to ensure that any equipment used to facilitate mobility and sensory function of residents is maintained in good working order.
Penalty: 120 penalty units.

At approximately 3:45pm PCA Johns observed Mrs Cook sitting in her chair in her room. On both occasions Mrs Cook told PCA Johns that she was feeling fine.

At approximately 4:40pm, PCA Pamela David observed Mrs Cook coming out of her room and collapse to the floor. She did not lose consciousness but did not appear to understand what was being said to her by the staff members who came to her aid - PCA David and Johns. The PCAs assisted Mrs Cook back to the chair in her room. An ambulance was requested.

At approximately 4:55pm, Mrs Cook was transported to Knox Private Hospital by ambulance. She underwent a CT scan of the brain which demonstrated a large left subdural haemorrhage.

Mrs Cook was transferred to the Royal Melbourne Hospital and underwent a craniectomy and drainage of the subdural haemorrhage. Post operatively Mrs Cook was transferred to the Intensive Care Unit.

On 4 October 2007, Mrs Cook was extubated but she remained comatosed with poor neurological recovery. Following consultation between the health care providers and Mrs Cook's family, active medical support was withdrawn.

Mrs Cook died on 5 October 2007.

INVESTIGATIONS

The identity of Patricia Mary Cook and the date and place of her death were without dispute and required no additional formal coronial investigation.

The medical investigation:

The family lodged an Objection to Autopsy under section 29 *Coroners Act* 1985.

Dr Michael Burke, Forensic Pathologist, at the Victorian Institute of Forensic Medicine performed an external examination and reviewed Mrs Cook's medical records. Dr Burke reported that in the absence of a full post mortem examination, and in the circumstances, a reasonable cause of death would appear to be from complications of a subdural haematoma consequent of a fall, contributed to by the treatment Mrs Cook was receiving (Warfarin) for the condition atrial fibrillation.

The Objection to Autopsy was accepted.

The Police Investigation:

Constable Peter Zorzi prepared the Inquest Brief for the Court.

Constable Zorzi's investigation into the circumstances surrounding Mrs Cook's fall on 30 September 2007, retrieved copies of record entries by the PCAs and a copy of Dorset Lodge Supported Residential Service Falls Policy which set out in a flow-chart, the course of action to be adopted when a resident falls over. The initial steps in the Falls Policy appeared to have been followed by the PCAs after they became aware of Mrs Cook's fall however, it was not apparent from the statements obtained by Constable Zorzi, why the PCAs had not followed through with

the policy directions and advised Mrs Cook's doctor, Locum doctor or contacted the manager of the facility or the Director of Nursing.

The investigation identified issues with the management of Mrs Cook, which required further exploration. These issues included the development of the Falls Policy, training of staff in the application of the policy and the apparent failure to implement the Falls Policy in respect of Mrs Cook's fall.

An Inquest was held pursuant to section 52(1) *Coroners Act* 2008[13].

THE INQUEST:

Viva voce evidence was received from the following witnesses:

- Ms Sandra Johns, PCA
- Ms Margie Johansson, PCA
- Ms Rena Buchanan, PCA, Manager / Personal Care Coordinator
- Mr Liborio Fisicaro, Business Manager, Dorset Lodge

FINDINGS, COMMENTS[14] & RECOMMENDATIONS[15]

Development of the Falls Policy

In approximately mid-2006, PCA Rena Buchanan, Manager / Personal Care Coordinator initiated the need for a falls policy.[16]

In collaboration with PCA Buchanan, Mr Fisicaro, Business Manager, developed the Falls Policy for Dorset Lodge. He has no medical background and experienced difficulty with the process. He stated:

> *It was done on line and I had quite a bit of difficulty finding information about falls policies and trying to get the right information ... I had a lot of information on about how to minimise falls, and more so about what to do on - when the fall occurred, so it was kind of an amalgamation of any kind of relevant information....and I also added in the flow chart...*[17]

Mr Fisicaro did not intend the policy to be prescriptive in its entirety. In particular it was not intended to mandate the calling of a doctor if the resident appeared fine after a fall. The rationale for allowing this discretion on behalf of the staff was that it was also the policy of the facility that the treating doctor would be advised of the fall the next time the doctor came to visit the

[13] s. 52(1) A coroner may hold an inquest into any death that the coroner is investigating.

[14] Pursuant to section 67 of the *Coroners Act* 2008

[15] Pursuant to section 72(2)

[16] Exhibit 3 - Statement of Rena Buchanan @ p.3

[17] Transcript of Proceedings - pp 78-79

resident.[18] Although the policy flow chart did not indicate that a discretion was open to the staff, this was done through the training of the staff by PCA Buchanan.

Training

PCA Rena Buchanan, Manager / Personal Care Coordinator has a number of responsibilities attached to her role including *hiring, firing, rostering, training, evaluating, disciplining and supervising of the staff at Dorset Lodge*[19]. As part of the implementation of the Falls Policy she stated:

...the policy was presented to all current staff and they were asked to make themselves familiar with the policy and the procedures required in the event of a fall.

Staff are required to use their experience, training and qualifications when following the procedure to determine what steps of the policy they need to follow and when to perform each step of the procedure.[20]

PCA Buchanan never took the position that the Falls Policy mandated the calling of the resident's doctor or a locum doctor. It was her interpretation of the policy that it was a discretion of the staff member observing the resident, that if there was no change to the resident's condition and there was no apparent injury, observing and assessing could continue and a doctor need not be called.[21]

The understanding by staff of the practical application of the Falls Policy reflects the position of their manager, PCA Buchanan. The implementation of the policy involved no more training than requiring the staff to familiarise themselves with it and it was not enforced or complemented by any additional training such as about the potential risks associated with head injuries.

The implementation of the Falls Policy in this manner, permitting the application of discretion, implies there was a level of experience and understanding of injuries *per se* and a level of knowledge about head injuries and the associated risks to residents receiving anticoagulation therapy. I am not satisfied that there was an acceptable standard of knowledge and understanding existed at the time of Mrs Cook's fall. The evidence of PCA Johns indicated only a basic understanding of the effects of Warfarin and not a level of understanding that prompted any additional action.

Access to medical treatment

I accept the evidence of PCAs Johns and Johansson that they responded to the notification of Mrs Cook's fall by enquiring with her and examining her for apparent injury. I accept that they were satisfied to a level consistent with their knowledge, that there were no signs or symptoms of head injury. I accept that they continued to informally observe Mrs Cook and only observed seemingly normal behaviour. The evidence from PCA Johns about the episode of "losing balance" , "being

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18 Transcript of Proceedings @ pp 79-80

19 Exhibit 3 - Statement of Rena Buchanan @ p.2

20 *op cit* @ p.3

21 Transcript of Proceedings @ p.55-56

unsteady" or "stumbling"[22] at lunch was confusing and not consistent, however, I am unable to find at a level consistent with the requisite degree that this was indicative of a symptom of neurological compromise rather than a simple, unrelated stumble at the dining room table.

In the absence of an observable injury or change in condition, the staff have not notified a doctor or requested the attendance of a doctor for an assessment. Their deviation from the Falls Policy is consistent with the standard of training they received from their employer.

Whether a strict application of the Falls Policy would have made a difference to the outcome requires consideration of the availability of a medical practitioner to attend the facility. Mrs Cook fell at Dorset Lodge on a weekend. Attendance by a medical practitioner after hours or on a weekend is dependant on a locum service. The facility has experienced long delays between the time of the request for a locum and the doctor's actual attendance. Both PCA Johns[23] and PCA Buchanan[24] described delays ranging from a couple of hours up to several hours and on occasion, no attendance at all.

Dr Burke, Forensic Pathologist, was requested to provide a supplementary report[25] addressing the relationship between the chances of surviving a subdural haemorrhage and the timing of medical intervention. Dr Burke opined:

> *In any case of subdural haemorrhage the earlier the diagnosis is made and, if surgical intervention is indicated and surgery proceeds, then the prognosis is much better.*

It follows from Dr Burke's opinion that in the event that the PCAs had requested a doctor to attend on Mrs Cook, at the first opportunity - that is, at approximately 11:50am, when they became aware of the fall involving striking her head; her prognosis would have been much better. However, in the absence of a definitive answer to the question, when would a locum doctor have actually arrived or indeed attended at all if it was reported that Mrs Cook was "stable"; it is not possible to state with any degree of certainty whether an examination of Mrs Cook by a doctor at the facility at a time proximate to report of the fall, would have made any difference to the outcome.

Approximately 4 hours elapsed from the time that PCAs Johns and Johansson became aware of Mrs Cook's fall and her subsequent collapse. In the absence of actual medical evaluation, Mrs Cook was denied the opportunity for earlier intervention however, I accept that the facility has experienced difficulties in obtaining a locum after hours and at the weekends, which leads me to conclude that the only certainty about Mrs Cook receiving an effective medical assessment would have occurred if she had been immediately transferred to a hospital. At the time, the Falls Policy did not provide such a direction.

Accordingly, I make no adverse finding against PCAs Johns and Johansson. I do not have a comfortable degree of satisfaction that Mrs Cook's death would not have occurred even in the event that the PCAs had implemented the Falls Policy prescriptively.

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[22] Transcript of Proceedings @ pp 66-68

[23] Transcript of Proceedings @ p. 24

[24] Transcript of Proceedings @ p. 57

[25] Dated 11 December 2009 - Exhibit 7

I accept and adopt the medical cause of death as identified by Dr Burke and **I find** that Patricia Mary Cook died from the complications of a subdural haematoma. The antecedent causes were a fall in which she sustained a head injury and Warfarin treatment for atrial fibrillation.

Changes subsequent to Mrs Cook's death

There was an immediate change to the interpretation of the policy, mandating staff to call an ambulance for any fall where it is suspected a head injury had been sustained. PCA Buchanan stated:

> *I went round to each staff member individually and explained very clearly to each one what they had to do if someone fell and hit their head however small the fall might have been, that an ambulance had to be sent for immediately and sent off to be examined.*[26]

The evidence of the PCAs Buchanan and Johns about the level of training provided at Dorset Lodge after Mrs Cook's death was misleading. PCA Buchanan intially gave evidence that external training had been provided to staff, about the management of head injuries. PCA Johns gave similar evidence.[27] PCA Buchanan subsequently clarified her evidence[28] when she was recalled by Ms Ellis of Counsel. PCA Buchanan's slight embellishment of the facts can best be explained by her nervousness about appearing in Court[29] rather than a deliberate intention to mislead.

I accept that the immediate response by the facility to Mrs Cook's death was one of instruction about the implementation of the policy. Subsequently, approximately one month[30] prior to Mr Fiscaro giving his *viva voce* evidence, a revised Falls Policy was drafted. Again, Mr Fiscaro experienced some difficulty in crafting the flow chart and wording of the policy[31]. The revised policy adds additional instruction on the course of action to adopt where a head injury is sustained or suspected. Other means of improving on staff training were also being explored by Mr Fiscaro[32].

The current Falls Policy

The draft policy was amended further, settled and implemented in January 2010. A warning has been added to treat residents on Warfarin with extra caution. The new policy mandates the request for an ambulance for all head injuries and suspected head injuries regardless of whether there are neurological symptoms.

The Falls Policy has been reviewed by Dr Peter Sharp, general medical practitioner. In a letter to Dorset Lodge dated 20 January 2010, Dr Sharp endorsed the Policy in the following terms:

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[26] Transcript of Proceedings @ p.74

[27] Transcript of Proceedings @p.68

[28] Transcript of Proceceings @ pp 74-75

[29] Transcript of Proceedings @ p. 73

[30] Transcript of Proceedings @ p.84

[31] *op cit*

[32] Transcript of Proceedings @ p. 85

It is comprehensive and should provide good clear guidance to staff faced with a resident who has fallen to facilitate the best possible outcome in your supported residential service.[33]

Training of all staff, as was anticipted by PCA Buchanan[34], has occurred and conducted by an external trainer, Mr Laurie Benham. Training has been in relation to falls, head injuries and the Falls Policy. Mr Benham also endorsed the Falls Policy as adequate and *if followed correctly will result in the patient receiving the appropriate treatment.*[35]

Staff at Dorset Lodge are now also required to complete a 'Staff Training Questionnaire' - to test the staff member's knowledge on the Falls Policy and with the purpose of ensuring training has effectively occurred.

I am satsified that Dorset Lodge SRS has now taken appropriate measures to respond to systemic shortcomings in their management and implementation of a Falls Policy. I accept that there was an immediate response to Mrs Cook's death to the extent that PCA Buchanan provided additional instruction to the other staff particularly in relation to head injuries however, the revising of a new policy and its associated training was not of itself immediate. Ms Maree Cook's observations about the facility's delay in implementing these changes were valid and acknowledged however, I find that the changes are thorough and reflect a committment to improve the health and safety of its residents and intended to prevent like deaths.

Dorset Lodge has accepted that the Falls Policy should be prescriptive in relation to head injuries and suspected head injuries. They have endeavoured to make uniform the interpretation and understanding of their policy by providing education and a method of testing the education by implementing a staff questionnaire. The Falls Policy has highlighted the need for heightened caution if the resident who has fallen is also on Warfarin - an additional safeguard in an environment where care is being provided to the elderly in the absence of any medically trained staff.

Having completed the staff training in January 2010, it is now incumbent on Dorset Lodge to ensure periodic updates of training are provided to the staff in order to ensure the maintenance of acceptable standards of knowledge and delivery of care to its residents.

I recommend pursuant to section 72(2) *Coroners Act* 2008 that Dorset Lodge Supported Residential Service develop and implement a professional development educational program for staff providing periodic sessions on all aspects of the management of falls including prevention of risks, assessment and management of injury, and implementation of the Falls Policy.

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33 Attached to the revised Dorset Lodge Falls Policy - handed to the Court on 21 June 2010 - dated January 2010.

34 Transcript of Proceedings - pp74-75

35 Letter from Mr Laurie Benham dated 16 December 2009, attached to the revised Dorset Lodge Falls Policy - handed to the Court on 21 June 2010 - dated January 2010.

ADDITIONAL COMMENTS[36] & RECOMMENDATION

In the absence of any legislative requirements on Supported Residential Services to develop any policies, a SRS is given a wide bearth on the delivery of care to its residents. An interpretation of section 108E *Health Services Act* 1988 does not equate to, or mandate the development of a Falls Policy. The Department of Health provides a comprehensive guide to proprietors about prevention strategies and meeting resident care needs but it is not able to set or enforce minimum standards across services. The lack of minimum enforceable standards, specifically in relation to Falls Policies, is difficult to reconcile with the large number of deaths associated with falls in the elderly that are reported to the Coroner each year. Falls account for the largest proportion of external cause reportable deaths. Many of these falls occur in a residential aged care setting, however, due to the complexity and variability in coding for residential services, it is not possible to specifically identify falls which have occurred in the SRS setting.

There is currently a process of legislative change underway that will produce a series of outcome-based standards for SRS. The *Supported Residential Services (Private Proprietors) Act* 2010 received assent by the Victorian Parliament on 24 August 2010. The Act will create the framework for the subsequent development and implementation (through regulations) of Accommodation and Support Standards which will provide the prescriptive detail of requirements. It is not known whether falls prevention will feature in these Standards. It is expected that the associated regulations will be developed during 2010-2011.

The need for a comprehensive approach to falls prevention in SRSs is clear when considering the vulnerabilities and needs of their residents. The Coroners Prevention Unit (CPU) has identified that the major risk factors for falls include advanced age, physical and/or cogitative impairment and functional dependency[37]. According to the Department of Health website, there were 176 registered SRSs in Victoria as of 1 August 2010[38]. The latest Supported Residential Services Census in 2008 identified a total of 4,356 residents living in an SRS, with an average age of 70 years and the most common age group of 80-89 years (28%).[39] Most residents lived at an SRS on a permanent basis (92%), and 89% had at least one disability. Types of disability ranged from age related frailty (38%), psychiatric (17%), dementia, physical or intellectual disability (14% respectively).

I recommend that the Victorian Department of Health include the requirement to have a falls prevention policy in the Accommodation and Support Standards of the *Supported Residential Services (Private Proprietors) Act*. This requirement should extend to all SRSs, and be appropriate for the characteristics and needs of residents at each facility. The Department should provide ongoing assistance to SRS operators to develop their falls prevention plans through training courses, guidance material and planning frameworks.

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[36] Section 67(3) *Coroners Act* 2008

[37] Hill K, Vrantsidis F, Haralambous B et al. An Analysis of Research on Preventing Falls and Falls Injury in Older People: Community, Residential Care and Hospital Settings (2004 update). Australian Government Department of Health and Ageing, 2004

[38] http://health.vic.gov.au/srs/ - accessed 2 August 2010

[39] The Social Research Centre. 2008 Supported Residential Services Census. Prepared for the Department of Human Services, SRS & Accomodation Support Unit, March 2009.

Signature:

AUDREY JAMIESON
CORONER
Date: 27 August 2010

DISTRIBUTION OF FINDING:

Ms Maree Cook

Mr Peter Cook

Dorset Lodge Supported Residential Service

Judith Abbott, Manager, Residential Services, Department of Health

The Hon. Daniel Andrews, Minister for Health