IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 0519

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**ANTHONY CHARLES DEBONO**
Date of birth:	11 January 1920
Date of death:	31 January 2017
Cause of death:	1(a) COMPLICATIONS OF A FRACTURED LEFT NECK OF FEMUR (OPERATED), SUSTAINED IN A FALL
Place of death:	Latrobe Regional Hospital, 10 Village Avenue, Traralgon, Victoria

HER HONOUR:

Background

1. Anthony Charles Debono was born on 11 January 1920. He was 97 years old when he died on 31 January 2017 from complications associated with a fractured neck of femur sustained in a fall.[1]

2. Mr Debono lived in a Bupa Aged Care (**BUPA Traralgon**) facility located at 96 Park Lane, Traralgon, Victoria.

3. Mr Debono's past medical history included vascular dementia,[2] cardiovascular accident (**CVA**),[3] postural hypotension,[4] depression, unstable angina,[5] blindness in his right eye with severe vision impairment to his left eye and generalised bilateral hearing impairment.

4. BUPA Traralgon classified Mr Debono as a high falls risk as a result of his cognitive impairment, impulsivity, gait instability and visual impairment.[6] He had a fall at the facility soon after his admission in March 2015 and was frequently reviewed by a physiotherapist. Mr Debono was considered unsafe to walk unsupervised due to his unstable gait, reliance on a four wheel frame, and impulsivity whereby he would attempt to walk unsupervised. In addition to the four wheel frame, Mr Debono required a person to help him balance, sensor alarms, and light to minimise his risk of falling.[7] Despite these strategies being in place, Mr Debono had further falls in September 2016, and 9 January 2017, which resulted in it being documented on his *Falls and Safety Risk Assessment* that he was an *extreme* falls risk,[8] and was 'not to be left on the toilet unattended at anytime'.[9]

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[1] Otherwise referred to as a fractured hip/thighbone.
[2] Cognitive impairment from impaired blood supply and small strokes.
[3] A cardiovascular accident is the sudden death of some brain cells due to a lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain. It is also commonly referred to as stroke.
[4] Postural hypotension occurs when a person's blood pressure falls when they suddenly stand up from a sitting or lying position. Severe drops in blood pressure can lead to fainiting, with a possibility of injury.
[5] Unstable angina is a condition in which a person's heart does not get enough blood flow and oxygen. It may lead to a heart attack. Angina I s a type of chest discomfort caused by poor blood flow through the blood vessels (coronary vessels) of the heart muscle (myocardium).
[6] A previous fall is a significant risk factor for older patients and a predictor of high risk of future falls. It may also suggest the presence of other risk factors. Individuals with multiple risk factors have an oincreased risk of falls than those with a single risk factor.
[7] The alarms alerted staff when Mr Debono attempted to walk unsupervised, and the the lighting was used to sense movement.
[8] BUPA Falls and Safety Risk Assessment dated 12 Janaury 2017. The category of 'extreme' is identified as the following: '*High falls risk and multiple adddtional safety risk factors. Implement falls prevention strategies and close*

The coronial investigation

5. Mr Debono's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

6. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[10]

7. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

8. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Debono's death. The Coroner's Investigator investigated the matter on my behalf and submitted a coronial brief of evidence. Further to this, I requested that the Coroners Prevention Unit (**CPU**) review Mr Debono's case in the context of the the care provided to him by BUPA Traralgon.[11]

10. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

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observation. Each falls domain and safety domain must be addressed separately, and interventions documented accordingly. Multidisciplinary team involvement is essential'.

[9] BUPA Falls Minimisation Plan of Care dated 12 January 2017.

[10] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

[11] The role of the CPU is to assist coroners investigating deaths, particularly deaths that occur in a healthcare setting. It is staffed by healthcare professionals, including practising physicians and nurses, who are independent of the health professionals and institutions under consideration.

11. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Identity of the deceased

12. Mr Debono was visually identified by his daughter, Ms Michaelina Vennix, on 1 February 2017. Identity was not in issue and required no further investigation.

Medical cause of death

13. On 3 February 2017, Dr Gregory Ross Young, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination upon the body of Mr Debono and reviewed a post mortem computed tomography (**CT**) scan.

14. The examination revealed that there were signs of medical and surgical intervention, and no unexpected signs of trauma.

15. The post mortem CT scan confirmed the presence of a left hip joint replacement. Calcification was seen in the coronary arteries in the heart,[12] and increased markings were seen in the lungs. There was no other significant pathology seen.

16. After reviewing the Victorian Police Report of Death (**Form 83**), the Coroners Court of Victoria e-Medical Deposition Form, and the post mortem CT scan, Dr Young completed a report, dated 6 February 2017, in which he formulated the cause of death as "*1(a) complications of a fractured left neck of femur (operated), sustained in a fall*".[13] I accept Dr Young's opinion as to the medical cause of death.

Circumstances in which the death occurred

17. On 24 January 2017, Mr Debono participated in a BUPA Traralgon 'Lifestyle' Activity, which was an escorted outing to Hog's Breath Café, Traralgon, for a co-resident's birthday. Mr Debono was transported to the venue in a BUPA bus along with four other residents; all were supervised by a recreational activity officer and a BUPA Red Cross volunteer.

[12] Calcification is the accumulation of calcium salts in a body tissue. It normally occurs in the formation of bone, but calcium can be deposited abnormally in soft tissue, causing it to harden.
[13] Complications of a fractured neck of femur (hip/thigh bone) may include chest infection (pneumonia), increased stress on the heart, multi organ system failure, wound infection, and development of deep vein thrombosis (commonly referred to as DVT; meaning a clot that occurs deep in a vein) and pulmonary thromboembolism (a "travelling clot" that is a complication of deep vein thrombosis).

18. After exiting the bus and walking towards the restaurant's entrance, Mr Debono had a fall. He was assisted back onto the bus and returned to BUPA Traralgon where he was examined by his general practitioner, before being transferred to the Latrobe Regional Hospital for further investigation. Radiological scans diagnosed Mr Debono as having a fractured left neck of femur. He was admitted with a plan for surgical intervention the following day.

19. On 25 January 2017, Mr Debono underwent a left hemiarthroplasty.[14] He was transferred to the ward after the surgery and was progressing well, however, on 28 January 2017, a MET call was made after it was recorded that Mr Debono's breathing had deteriorated.[15]

20. On 30 January 2017, Mr Debono's treating team consulted with his daughters regarding his progress. It was explained that there was a potential that Mr Debono's condition would not improve, however, they would continue to actively treat him.

21. On 31 January 2017, after Mr Debono's condition further deteriorated and it was determined that his prognosis was poor, Mr Debono's family were consulted and the decision was made that all active treatment would be ceased, and Mr Debono palliated. Mr Debono peacefully passed away later that day at 10.50pm.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008,* I find as follows:

(a) the identity of the deceased was Anthony Charles Debono, born 11 January 1920;

(b) Mr Debono died on 31 Janaury 2017 at Latrobe Regional Hospital, 10 Village Avenue, Traralgon, Victoria, from complications of a fractured neck of femur that was operated on after a fall; and

(c) the death occurred in the circumstances described above.

[14] An operation to replace the head of the femur (otherwise referred to as the thighbone).
[15] A MET call is a hospital based system, designed for nurses and other staff members to alert and call other staff for help when a patient's vital signs have fallen outside set criteria.

Comments

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

1. As part of my investigation, I requested that CPU review the care provided to Mr Debono in the context of his fall during the supervised recreational outing from the BUPA Traralgon aged care facility.

2. The CPU identified that despite BUPA Traralgon's falls risk and management strategies being of an acceptable standard within the residence, the care that was provided to Mr Debono whilst attending the outing to the Hog's Breath Café was not appropriate, as the outing represented an increased risk for which inadequate steps were taken to ensure Mr Debono's safety.

3. The CPU also noted that a root cause analysis (**RCA**)[16] was conducted in regard to the incident, however, it was delayed by one year in response to my coronial investigation. The CPU concluded that although the quality and recommendations generated from the RCA appeared to be appropriate, the timing of the review was inadequate. They agreed with Mr Debono's family and the findings from BUPA Traralgon's RCA that the outing was unsafe due to inadequate communication of the falls risk of participating residents; inadequate planning for appropriate use of wheelchairs; inadequate staffing numbers for the dependency of the residents; and unsafe venue access.

4. The CPU also agreed with Mr Debono's family that his fall may have been prevented if BUPA Traralgon's staff had used a wheelchair to transport Mr Debono from the bus to the restaurant door.

5. In July 2018, BUPA Traralgon underwent an unannounced review audit by the Australian Government in Aged Care Quality accreditation auditors. The CPU noted that BUPA Traralgon failed this accreditation, notably the internal and external complaints mechanisms, but passed all quality outcomes related to falls.

[16] A root cause analysis (RCA) is a framework for a systemic examination of a serious or critical event to find root causes that are amenable to sustainable improvements and prevention of further events.

Recommendations

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

1. Prior to the outing an assessment was undertaken regarding the the suitability of the venue and Mr Debono's functional ability and behaviour, with all information recorded on a BUPA form titled '*Daily Bus Outing Form*'. BUPA's RCA indicated that each resident's risks were assessed prior to the outing to the Hog's Breath Café on 24 January 2017, however the risks were not considered collectively as a group. If the cumulative risks of the group had been considered, the need for additional support staff would have been identified. I therefore recommend that BUPA residents are risk assessed both indivually and cumulatively for all future outings, with this information being recorded on the '*Daily Bus Outing Form*'.

2. Following the RCA, BUPA implemented changes to assessment forms completed prior to an outing. The forms specify how families are to be notified of planned outings. I recommend that BUPA undertake ongoing audits of these forms to ensure compliance.

I convey my sincere condolences to Mr Debono's family.

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

Ms Michaelina Vennix, Senior Next of Kin

Ms Alexandra Malon, Bupa Aged Care Australia Pty Ltd

Senior Constable Peter Ely, Coroner's Investigator, Victoria Police

Signature:

ROSEMARY CARLIN
CORONER
Date: 19 March 2019