IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 0591

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Simon McGregor, Coroner
Deceased:	**Antonios Vitou**
Date of birth:	17 June 1926
Date of death:	Between 31 January 2019 and 1 February 2019
Cause of death:	Ischaemic heart disease and cardiomegaly in the setting of a fall in a man with quadriplegia
Place of death:	22 Redholme Street, Moorabbin Victoria 3189

INTRODUCTION

1. Antonios Vitou was a 92-year-old man who lived on his own with the assistance of daily carers, at 22 Redholme Street, Moorabbin Victoria 3189 at the time of his death.

2. Mr Vitou was found deceased by ischaemic heart disease and cardiomegaly in the setting of a fall in a man with quadriplegia at his place of residence on 1 February 2019.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mr Vitou's death was reported to the Coroner as it appeared unexpected, unnatural or to have resulted, directly or indirectly, from an accident and so fell within the definition of a reportable death in the *Coroners Act 2008.*

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. 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.

6. The Coroner's Investigator, Senior Constable Michelle Mitchell prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist who examined Mr Vitou, treating clinicians and investigating officers.

7. 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. 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.

8. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

[1] This is 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

9. In considering the issues associated with this finding, I have been mindful of Mr Vitou's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

BACKGROUND

10. On 10 January 1993, Mr Vitou suffered an accident that left him a C4 quadriplegic. He had carers who attended his address[2] four times a day.[3] These sessions were paid for by the Transport Accident Commission[4] (TAC) and provided by AQA Victoria Ltd[5] (AQA).[6]

11. At the time of his death, Mr Vitou's support schedule covered daily support at the following times:

    (a) 8.00am- 11.00am;

    (b) 1.00pm- 2.00pm (12.30pm- 4.30pm: Tuesdays only);

    (c) 5.30pm- 6.30pm; and

    (d) 8.30pm- 10.30pm.[7]

12. Mr Vitou was able to walk a short distance using his walking frame but needed assistance with everyday living.[8]

13. In addition to several other comorbidities, Mr Vitou suffered from hypertension. The hypertension had caused an enlargement of his heart, for which he was prescribed Coversyl. His treating clinician, Dr Audrey De Jong states that Mr Vitou was very stubborn and would often refuse to take his medication. Amongst other medications, Mr Vitou was also prescribed Lipitor for his cholesterol and Bisoprolol for heart failure.[9]

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the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] Statement of Dr Audrey De Jong dated 15 May 2019, Coronial Brief.

[3] Statement of Senior Constable Michelle Mitchell dated 17 April 2019, Coronial Brief.

[4] Ibid.

[5] AQA is a member-based organisation providing support and services to people with spinal cord injuries and similar physical disabilities.

[6] Various statements, Coronial Brief.

[7] Statement of Annie Lillywhite (email) dated 17 April 2019, Coronial Brief.

[8] Statement of Dr Audrey De Jong dated 15 May 2019, Coronial Brief.

[9] Ibid.

14. In the year prior to his death, Mr Vitou was admitted to hospital on 6 June 2018 for pneumonia and congestive cardiac failure and again, on 12 December 2018 for a heart condition and heat stroke.[10]

15. On 31 January 2019, disability support worker, Ravishu Bawa attended Mr Vitou's residence from 8.00am through to 11.00am. Mr Bawa returned at 5.30pm for his afternoon shift. Mr Vitou's grandson was also present.[11]

16. Mr Bawa prepared dinner for Mr Vitou before placing him into his recliner. Mr Vitou always sat in his recliner after dinner. The recliner had a button to assist with the position of the recliner, which Mr Vitou would use to help him lean into his walker. Mr Bawa placed the walking frame in front of Mr Vitou.[12]

17. There was a correspondence book on the dining room table that carers wrote in. The purpose of the book was to facilitate disability support workers communicating between each other.[13] Mr Bawa filled this book out before leaving at approximately 6.30pm.[14]

18. AQA rostered disability support worker, Xiaoping Zhang on permanent rostered hours to attend Mr Vitou's residence for several shifts throughout the week. None of these shifts were on Thursdays. Ms Zhang states that when she reviewed her timesheet covering the fortnight of Mr Vitou's death, she had been rostered on to cover the 1.00pm- 2.00pm shift on Thursday, 31 January 2019. Ms Zhang states that she did not attend this shift because she had not been made aware of it.[15] AQA SMS records show that Ms Zhang was sent a text message on Wednesday, 30 January 2019 at 10.41am[16], notifying her of the available shift. This text message was sent out to several staff members. Later the same day, Ms Zhang spoke to a member of the AQA rostering team and accepted the shift. Ms Zhang's acceptance of the shift was confirmed via another text message sent the same day at 1.15pm.[17]

19. Ms Zhang's failure to attend the confirmed shift on 31 January 2019 resulted in no one attending to Mr Vitou between Mr Bawa's first and second visit that day.

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[10] Ibid.
[11] Statement of Ravishu Bawa dated 9 April 2014, Coronial Brief.
[12] Ibid.
[13] Ibid.
[14] Ibid.
[15] Statement of Xiaoping Zhang dated 9 April 2019, Coronial Brief.
[16] Email from Christine Morfis to Michelle Mitchell dated 9 April 2019, Coronial Brief.
[17] Statement of Annie Lillywhite dated 19 September 2019, Coronial Brief.

20. Mr Vitou's 8.30pm-10.30pm shift involved the disability care worker helping him to bed. Mr Vitou has been described as quite stubborn, insisting that he go to bed every night at 10.00pm on the dot. On the night of 31 January 2019, no one attended for the 8.30pm shift.[18]

21. Disability support worker, Tuy Le, was permanently rostered on to tend to Mr Vitou on Tuesdays between the hours of 12.30pm- 4.30pm. She had been asked to cover the 8.30pm shift with Mr Vitou on 31 January 2019. Ms Le states that she forgot. She also notes that she received many text messages from AQA regarding upcoming shifts that needed to be filled and that finding specific messages could be difficult.[19] AQA have provided evidence that a confirmation text message was sent to Ms Le for the 31 January 2019 8.30pm shift. This message was sent on 29 January 2019 at 10.48am.[20]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

22. On 1 February 2019, disability support worker, Anna Kats, attended her scheduled shift at Mr Vitou's residence at 7.59am. Ms Kats states that as she got to the door, she heard the television on inside the property. This was unusual because Mr Vitou was usually in bed and asleep at this time of the day.[21]

23. Ms Kats entered the property and found Mr Vitou on the floor to her left. She approached Mr Vitou and sighted, what she believed to be blood coming from his mouth. Ms Kats called emergency services.[22]

24. Ms Kats states that upon entering Mr Vitou's residence, she noted that his walking frame was not directly in front of his chair. It was to the left of him near the fireplace. She states that he still would have been able to reach it, but that it would have been a stretch. Normally, the walking frame would have been directly in front of him because his duress button was tied to the middle of the frame.[23] Mr Vitou refused to wear his duress button around his neck, 'as he said "He wasn't a priest to wear something that big around his neck"'.[24]

25. Mr Bawa was the last disability support worker to attend to Mr Vitou. He states that he sat Mr Vitou in the recliner and placed the walking frame in front of him. It is likely that, after a disability support worker failed to attend, at some point during the evening or early morning,

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[18] Statement of Ravishu Bawa dated 9 April 2014, Coronial Brief.
[19] Ibid.
[20] Statement of Annie Lillywhite dated 19 September 2019, Coronial Brief.
[21] Statement of Anna Kats dated 22 April 2019.
[22] Ibid.
[23] Ibid.
[24] Statement of Antony Vitos dated 17 March 2019, Coronial Brief.

Mr Vitou attempted to get out of the recliner. I note that Mr Vitou was said to have been very stubborn about making it into bed by 10.00pm.

IDENTITY AND CAUSE OF DEATH

26. On 1 February 2019, Audrey De Jong visually identified the body of her patient, Antonios Vitou, born 17 June 1926. Identity is not in dispute and requires no further investigation.

27. On 7 February 2019, Dr Melanie Archer, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine (VIFM), conducted an autopsy upon Mr Vitou's body and reviewed a post mortem computed tomography (CT scan), preliminary examination report, VIFM contact log and the Police Report of Death for the Coroner. Dr Archer provided a written report, dated 7 June 2019, in which she formulated the cause of death as '*I(a) Ischaemic heart disease and cardiomegaly in the setting of a fall in a man with quadriplegia*'.

28. Toxicological analysis of post mortem samples taken from Mr Vitou identified the presence of bisoprolol[25].

29. Dr Archer commented that the cause of death was a combination of an enlarged heart (most likely due to hypertension or 'high blood pressure') and blocked coronary arteries (ischaemic heart disease). However, this occurred in the setting of a fall in a man with quadriplegia. It is not known whether the cardiac event or the fall came first.

30. Mr Vitou's heart was enlarged (cardiomegaly) and he had congestive cardiac failure. Cardiomegaly is associated with increased oxygen demand by the heart muscle. Whereas, ischaemic heart disease is associated with reduced oxygen supply to the heart muscle. Both conditions can therefore, interact. They are also both associated with sudden cardiac death due to lethal arrhythmia. The risk of a cardiac event ('heart attack') is increased at times of higher cardiac workload. Unassisted mobilisation in a man with quadriplegia and/ or a fall potentially places a high demand on the heart.

31. There was no evidence of significant trauma from the fall at autopsy, including no fresh damage to the spinal cord and no fracture of the neck.

32. I accept Dr Archer's opinion as to cause of death.

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[25] Bisoprolol is a synthetic beta-adrenergic blocking agent for the treatment of hypertension. It is prescribed for the treatment of stable chronic moderate to severe heart failure.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

33. AQA have stated that, where they can, they 'schedule regular staff into the schedules to provide consistency' to clients. Where a shift is vacant, AQA backfill the shift. They state that in the first instance, they attempt to backfill with a known staff member to the client. Where this fails, they rely on their 'entire casual workforce'. If this fails, AQA have contingency protocols that may involve utilising alternative agencies, contacting next of kin and informal supports to provide assistance or other options as identified by the individual.[26]

34. AQA further state that in Mr Vitou's case, they would ensure care by either engaging with Mr Vitou's grandson or utilising an alternative agency.[27] I note that neither of these contingency protocols were actioned and likely could not have been, given that AQA were not aware that staff had failed to attend their confirmed shifts.

35. AQA stated that they offer an 'After Hours Service which allows staff and clients to contact AQA 24 hours a day, 365 days a year.' Mr Vitou's coordinator, Christine Morfis, advised that Mr Vitou was unable to make or accept phone calls because of his hearing impairment. This in turn, prevented him from utilising this service. This had been raised with TAC and Mr Vitou's grandson, with Ms Morfis suggesting a device to amplify sound.[28] There is no evidence to suggest that this recommendation had been actioned at the time of Mr Vitou's death.

36. I am satisfied that, in circumstances where a client is not hearing or mobility impaired, this service is a satisfactory measure to circumvent situations were staff fail to attend rostered shifts. Such measures should not however, deflect from, nor prevent the correction of systemic communication issues.

37. Various statements have identified that there are many issues with AQA's rostering practices. Namely, that people are either not covered when unavailable to fulfil their hours or conversely, several people are rostered on to cover one shift. Such errors are blatant communication failures.

38. It was also noted in several statements that AQA employ the practice of sending employees text messages or emails about covering shifts. There have allegedly been instances where AQA have sent a text message and assumed that the shift has been accounted for, even in

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[26] Statement of Annie Lillywhite (email) dated 17 April 2019, Coronial Brief.
[27] Ibid.
[28] Statement of Annie Lillywhite dated 19 September 2019, Coronial Brief.

the absence of a reply from the disability support worker.[29] AQA refute this, detailing that it is not their practice to use text messages to allocate shifts but rather, they utilise text messages to:

(a) advertise shift vacancies and invite responses from staff regarding their availability; and

(b) to provide confirmation of a shift to a staff member once that shift has been accepted by the staff member.[30]

39. There are conflicting accounts as to the causal factors behind the failed attendances on 31 January 2019 by Ms Zhang and Ms Le. AQA records seemingly confirm that both employees accepted the shifts, for which follow-up confirmation text messages were sent.

40. Despite AQA communication protocol being followed, there were two failed attendances in the one day, highlighting inadequacies in the communication strategy employed by AQA. It was further noted that AQA do not send an updated roster when these ad-hoc staffing changes are made. AQA confirm this in their statement, detailing that staff must request a copy of their monthly rosters if needed. They also state that, where staff pick up additional shifts, they can request an updated schedule.[31] This statement implies that the provision of up to date documentation is not automatic.

41. When this issue was put to AQA, they responded with a statement detailing that they are currently undertaking a project involving system review and digital transformation across the organisation. 'This includes AQA's Customer Relationship Management System and Rostering System. Through this, AQA's aim is to have a system where staff and clients can access live rosters and where changes will be visible in real time.[32]

42. AQA further noted that they are hopeful this system will also notify them when a staff member has failed to attend a shift, signal a response and follow-up to determine if contingencies are required. [33]

43. In Mr Vitou's case, I am unable to ascertain whether the fall caused the cardiac event or vice versa. While determining the circumstantial cause of the death is not possible, I am satisfied

[29] Statement of Xiaoping Zhang dated 9 April 2019, Coronial Brief.
[30] Statement of Annie Lillywhite dated 19 September 2019, Coronial Brief.
[31] Statement of Annie Lillywhite (email) dated 17 April 2019, Coronial Brief.
[32] Statement of Annie Lillywhite dated 19 September 2019, Coronial Brief.
[33] Ibid.

that failings in administrative processes facilitated human error, which likely contributed to Mr Vitou's death.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

44. While I am not satisfied to the requisite standard that AQA systemic failings caused Mr Vitou's death, I do take this opportunity to recommend that AQA continue the re-evaluation of their communication strategies. Namely, their processes for backfilling shifts and ensuring attendance. Once implemented, I request an outline on the new system detailed at paragraph 41 for my consideration.

45. I further note that in Mr Vitou's case, there was a 'correspondence book', in which disability support workers could log entries for the following disability support worker to review. While not implying there is blame to be placed on Mr Bawa, I do consider it a missed opportunity for potential intervention, that Mr Bawa did not identify in this book that no one had attended the 1.00pm shift. Perhaps if this had been communicated back to AQA, steps would have been taken to follow-up why there had been no attendance and confirmation sought for the backfill of the 8.30pm shift.

46. I recommend that 'correspondence books' and mandatory entries by disability support workers after every shift be implemented for all high-level care patients. Training should be provided to all disability care workers to identify in these books when a shift has not been attended. This should then be communicated back to AQA for follow-up.

47. I have reviewed Mr Vitou's support plan and note that the failure of attendance at his 1.00pm and 8.30pm shifts resulted in him not receiving vital care. This included food and personal hygiene requirements, that would have undoubtedly adversely affected his health. Such failings run contrary to the very purpose of AQA as an organisation.

48. When this was put to AQA, they responded by saying that they have reviewed their support documentation to ensure that each client has a shift backfill protocol negotiated as part of the planning and service agreements with AQA. 'This includes a protocol for unplanned events or instances where preferred methods of shift coverage are not available.'[34] I have requested a copy of this protocol to retain on this investigation file.

[34] Statement of Annie Lillywhite dated 19 September 2019, Coronial Brief.

FINDINGS AND CONCLUSION

49. Pursuant to section 73(1B) of the Act, I direct that this finding be published on the Internet.

50. I express my sincere condolences to Mr Vitou's family for their loss.

51. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was Antonios Vitou, born 17 June 1926;

    (b) The death occurred between 31 January 2019 and 1 February 2019 at 22 Redholme Street, Moorabbin Victoria 3189 from ischaemic heart disease and cardiomegaly in the setting of a fall in a man with quadriplegia; and

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

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

    (a) Mr Efftratils Vitou, senior next of kin

    (b) Michelle O'Sullivan, Board of Directors, AQA Victoria Ltd, interested party

    (c) Clare Rowan, Transport Accident Commission, interested party

    (d) Senior Constable Michelle Mitchell, Coroner's Investigator

Signature:

SIMON McGREGOR
CORONER
Date: 2 October 2019