IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 0586

FINDING INTO DEATH WITHOUT INQUEST

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

Amended pursuant to *section 76 of the Coroners Act 2008* on 13 January 2020

Findings of:	Simon McGregor, Coroner
Deceased:	**Annie Ruth Chettle**
Date of birth:	1 December 1944
Date of death:	31 January 2019
Cause of death:	Subdural haemorrhage following a fall in a woman with multiple medical comorbidities
Place of death:	Maroondah Hospital, 1-15 Davey Drive, Ringwood East Victoria 3135

INTRODUCTION

1. Annie Ruth Chettle was a 74-year-old woman who lived at Kirkbrae Presbyterian Homes (Kirkbrae) at the time of her death. Mrs Chettle's husband was also a resident at Kirkbrae and suffered dementia.[1] Mrs Chettle had no other immediate family and her affairs are managed by State Trustees.[2]

2. Mrs Chettle died following complications from a fall sustained at Kirkbrae on 31 January 2019.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mrs Chettle'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, Constable Jonathan Paul Woods prepared a coronial brief in this matter. The brief includes statements from witnesses, including Kirkbrae staff, treating clinicians and the forensic pathologist who examined Mrs Chettle.

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.

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[1] Coroners Court of Victoria, E-medical Deposition Form, Case Reference Number: 2019000586, Coronial Falls Brief.

[2] Statement of Kirkbrae Presbyterian Homes undated, Coronial Falls Brief.

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.[3]

9. In considering the issues associated with this finding, I have been mindful of Mrs Chettle'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. Mrs Chettle was an elderly woman with multiple comorbidities and a history of mental illness. She suffered from schizoaffective disorder, dementia, temporal lobe epilepsy, subdural haemorrhage, congestive cardiac failure, recurrent urinary tract infections and type 2 respiratory failure.[4]

11. Mrs Chettle had been a resident at Kirkbrae since December 2014. She was described by staff as pleasantly delusional but able to communicate her needs. She was also noted as having a tendency towards aggression, which she often directed towards her husband.[5]

12. Mrs Chettle required assistance with her daily activities. She was able to ambulate independently with the assistance of a walking frame. The Kirkbrae statement details that Mrs Chettle could be impulsive, delusional, agitated and demanding at times.[6]

13. Mrs Chettle had a history of falls, suffering a total of nine falls in the twelve months prior to her death.[7]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

14. On 31 January 2019 at approximately 7.15am, a Personal Care Assistant (PCA) entered Mrs Chettle's room. Mrs Chettle told the PCA that her eyes hurt and that she had barely slept throughout the night. Despite not feeling well, Mrs Chettle still wanted to shower. The PCA assisted Mrs Chettle into the shower chair.[8]

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

[4] Coroners Court of Victoria, E-medical Deposition Form, Case Reference Number: 2019000586, Coronial Falls Brief.

[5] Statement of Kirkbrae Presbyterian Homes undated, Coronial Falls Brief.

[6] Ibid.

[7] Ibid.

[8] Statement of Personal Care Assistant undated, Coronial Falls Brief.

15. After the water was turned off, the PCA dried Mrs Chettle. Mrs Chettle was not happy with the clothes the PCA had selected for her to wear and asked that another shirt be selected. The PCA states that prior to getting the new shirt, she ensured Mrs Chettle was sitting safely in the chair with the brake on. The PCA instructed Mrs Chettle to remain seated.[9]

16. In the brief period that the PCA left Mrs Chettle unattended, Mrs Chettle somehow fell from the shower chair and onto the floor, hitting her head. The PCA turned to face Mrs Chettle after hearing a shuffle and a scream.[10]

17. The incident was immediately reported to the Endorsed Enrolled Nurse (EEN), who conducted an initial assessment and commenced neurological observations according to the schedule set out in Kirkbrae's falls policy. An incident report was then commenced by the EEN.[11] Mrs Chettle complained of a headache and her head hurting.[12] Ongoing monitoring continued.[13]

18. Following her fall, Mrs Chettle appeared to be fine throughout the course of the day. She made no complaints of pain and displayed no signs of physical symptoms that would suggest serious injury. Neurological observations were unremarkable.[14]

19. At approximately 1.30pm, Mrs Chettle went on a Kirkbrae organised outing. The Lifestyle Supervisor was not aware that Mrs Chettle had suffered a fall earlier that day.[15] Staff reported no unusual behaviour on the outing. However, it was noted that Mrs Chettle fell asleep on the bus on the way back from the outing. When she was woken up, she requested that her doctor be notified because 'lately she had been feeling really sleepy and misses activities which makes her sad.'[16]

20. Upon returning at approximately 3.00pm, it was difficult to get Mrs Chettle off the bus.[17] Staff noted that she was having trouble mobilising. She was assisted by physiotherapy staff and a wheelchair was used to return her to her unit.[18] By the time she had been wheeled

[9] Ibid.
[10] Ibid.
[11] Report from RN/ Clinical Supervisor AM Shift and statement of Kirkbrae Presbyterian Homes undated, Coronial Falls Brief.
[12] Statement of Personal Care Assistant undated, Coronial Falls Brief.
[13] Report from RN/ Clinical Supervisor AM Shift undated and statement of Kirkbrae Presbyterian Homes undated, Coronial Falls Brief.
[14] Ibid.
[15] Lifestyle Supervisor Report, undated, Coronial Falls Brief.
[16] Ibid.
[17] Ibid.
[18] Lifestyle Supervisor Report undated and Statement of Kirkbrae Presbyterian Homes undated, Coronial Falls Brief.

back, Mrs Chettle had fallen asleep again. Staff noted that she struggled to get out of the wheelchair and required assistance from two physiotherapists.[19]

21. The Lifestyle Supervisor thought that Mrs Chettle's medication was making her sleepy and affecting her mobility. They followed up Mrs Chettle's request that the doctor be notified. The Lifestyle Supervisor states that, had they known Mrs Chettle had suffered a fall, she would not have been aloud to go on the outing and they would have treated Mrs Chettle's mobility issue more seriously.[20]

22. An incident form created on 31 January 2019 at 3.44pm by the physiotherapist, details that Mrs Chettle suffered an unwitnessed fall in the shower. The report further details that Mrs Chettle was not able to recall the incident and denied any new pain. Mrs Chettle did state that she had been feeling very sleepy. The physiotherapist noted that Mrs Chettle appeared drowsy and was slouching in her chair, with a slight decrease in global strength.[21]

23. At approximately 4.00pm, the Registered Nurse (RN) completed a neurological observation. Afterwards, Mrs Chettle requested that she be taken to her bedroom so she could lie down. Visual checks were done.[22]

24. At approximately 5.30pm, the RN checked on Mrs Chettle and found her unresponsive. Emergency services were called and Mrs Chettle was transferred to Maroondah Hospital.[23]

25. A CT brain scan showed right subdural haemorrhage with mass effect. It was subsequently decided to take a palliative approach. Mrs Chettle died on 1 February 2019 at 2.29am.[24]

Kirkbrae's Serious Incident Analysis

26. Kirkbrae conducted an internal *Serious Incident Analysis* of Mrs Chettle's matter and identified several issues with the post-fall care processes, including nursing staff error in following falls management policies. I am satisfied that Kirkbrae's management have addressed the issues identified in the analysis, as far as they went. These include that:

    (a) the ENN did not report the incident to the RN in a timely manner;

[19] Lifestyle Supervisor Report undated, Coronial Falls Brief.
[20] Ibid.
[21] Incident Report dated 31 January 2019 and timed at 3.44pm, Coronial Falls Brief.
[22] Lifestyle Supervisor Report undated, Coronial Falls Brief.
[23] Ibid.
[24] Coroners Court of Victoria, E-medical Deposition Form, Case Reference Number: 2019000586, Coronial Falls Brief.

(b) the ENN did not provide sufficient information relating to the incident and subsequent injury in the incident report or in progress notes;

(c) the ENN completed neurological observations but did not complete vital observations satisfactorily;

(d) the RN did not complete a thorough assessment of Mrs Chettle and completed an evaluation without having all the required information;

(e) the RN completed the incident evaluation prior to the observation period being completed;

(f) the RN did not complete adequate documentation in progress notes; and

(g) the Lifestyle Supervisor took Mrs Chettle on a bus outing without first speaking to the nurse in charge.

27. I do however, raise further concern over the scope of the *Serious Incident Analysis* (the Analysis). Namely, that Kirkbrae did not include the 'work practice' of the PCA in its review. Kirkbrae's statement details that the 'work practice was discussed by the management team during the investigation and no changes were required as a result' without exposing the said work practice to actual scrutiny.[25]

28. In a subsequent statement obtained from Kirkbrae, the facility recognises and accepts that the Analysis should have referred to the PCA stepping away from Ms Chettle.[26] I am satisfied that this recognition will prevent future oversight.

29. After further investigation, Kirkbrae submitted that Mrs Chettle was not in the shower recess at the time of her fall. Specifically, a supplementary statement from the relevant PCA details that Mrs Chettle had been moved to a drier area of the bathroom near the vanity. The PCA states that she applied the brakes on the shower chair and assisted Mrs Chettle in drying herself. It was shortly after this that Mrs Chettle became distressed over the shirt. The statement details that Mrs Chettle was screaming and moving her arms around.[27]

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[25] Statement of Kirkbrae Presbyterian Homes undated, Coronial Falls Brief.
[26] Statement of Kelsey Mollison dated 6 August 2019, Coronial Falls Brief.
[27] Ibid.

30. The PCA is said to have again moved Mrs Chettle and the shower chair to the bathroom door. The PCA applied the brakes and instructed Mrs Chettle not to move while she turned to get a different shirt.[28]

31. The PCA details that while she could have called for assistance through the call button in the bathroom or by mobile phone, she decided not to because it would have taken too long for someone to assist at that point in the morning.[29]

> *Annie was in the midst of a "meltdown" and was screaming and visibly upset and I thought it might take too long for someone to arrive and I wanted her to calm down.*[30]

32. On the issue of staffing, Kirkbrae state that they have high staffing levels for the industry. They further state that mornings are busy periods for the facility, with staff members being kept busy as they prepare residents for the day. Kirkbrae submit that the level of attendance of the PCA was akin to her attending to a task within the bathroom, as may occur when helping someone to shower or attend to other personal activities of daily living.[31] Mrs Chettle was 'classed as a one-person assist with showering', meaning she only required one PCA.[32] On that view and given the geography of the room and Mrs Chettle's placement, Kirkbrae state that Mrs Chettle was not strictly left unattended.

33. The PCA estimates that the cupboard was 1-1.5 metres away from where Mrs Chettle was seated and virtually within arm's reach. The PCA further estimates that she had her back turned for ten seconds. During this brief period, the cupboard door blocked the PCA's view of Mrs Chettle. It was during this brief period that Mrs Chettle fell.[33] Kirkbrae have confirmed that that the flooring within the Mrs Chettle's bathroom is aged care quality standard and suitable for a wet area with slip resistance qualities.[34]

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[28] Ibid.
[29] Ibid.
[30] Ibid.
[31] Statement of Ingrid Nunnink dated 7 August 2019, Coronial Falls Brief.
[32] Statement of Kelsey Mollison dated 6 August 2019, Coronial Falls Brief.
[33] Statement of Kelsey Mollison dated 6 August 2019 and Ingrid Nunnink dated 7 August 2019, Coronial Falls Brief.
[34] Statement of Ingrid Nunnink dated 7 August 2019, Coronial Falls Brief.

IDENTITY AND CAUSE OF DEATH

34. On 1 February 2019, Lynette Kleehammer visually identified the body of Annie Ruth Chettle, born 1 December 1944. Identity is not in dispute and requires no further investigation.

35. On 4 February 2019, Dr Victoria Christabel Mary Francis, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination of Mrs Chettle's body and reviewed a post mortem computed tomography (CT scan), the medical deposition and the Police Report of Death for the Coroner. Dr Francis provided a written report, dated 6 February 2019, in which she formulated the cause of death as '*I(a) Subdural haemorrhage following a fall in a woman with multiple medical comorbidities*'.

36. I accept Dr Francis' opinion as to cause of death.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT[35]

37. I note that initial statements obtained from Kirkbrae detail a suspected wet bathroom floor and Mrs Chettle's unpredictable and spontaneous behaviour to be external factors in her fall. Specifically, that she experienced regular delusions and had non-compliant tendencies.[36] I also note that Mrs Chettle had informed the PCA that her eyes hurt and she had not slept well during the night.

38. I appreciate the difficulty faced by PCAs having to make instantaneous assessments in situations where a resident has become agitated, resistive or aggressive. Especially, when those decisions may place greater demand on already strained resources. I also note that the PCA involved did not act in a manner inconsistent with Kirkbrae policy.

39. It is apparent from the evidence before me that Mrs Chettle was known to be unpredictable and spontaneous. In addition to certain behavioural propensities, Mrs Chettle had a sizeable falls history which should have been considered. Upon being informed that she had not slept well and that her eyes hurt, it would have been appropriate to forfeit showering Mrs Chettle until such a time that demands on staff were not as great and two PCAs could attend.

40. Finally, I make note of the flawed Analysis and poor quality of initial information submitted to the Coroner's Court of Victoria, resulting in delays and the realisation upon a significant amount of information not initially considered by Kirkbrae in their Analysis. It is imperative

[35] Reformatted under a new sub-heading. Inclusive of paragraphs 37-40.
[36] Statement of Kirkbrae Presbyterian Homes undated, Coronial Falls Brief.

that aged care facilities risk assess their policies, procedures and operations with a thorough investigative approach. Failure to recognise and correct this shortcoming poses a systemic risk to all residents at Kirkbrae.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT[37]

41. I recommend that Kirkbrae update their relevant policies and procedures to reflect the need and/ or allow PCAs to make instantaneous risk assessments and defer undertaking high risk activities with vulnerable residents when insufficient staff are available.

FINDINGS AND CONCLUSION

42. Pursuant to section 73(1B) of the Act, I direct that this finding be published on the Internet.[38]

43. 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 Annie Ruth Chettle, born 1 December 1944;

    (b) The death occurred on 12 February 2019 at Maroondah Hospital, 1-15 Davey Drive, Ringwood East from a subdural haemorrhage following a fall in a woman with multiple medical comorbidities;

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

[37] Reformatted under a new sub-heading. Inclusive of paragraph 41.
[38] Insertion of publication clause as per section 73(1B) of the Act.

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

(a) Ms Miriam Bako, State Trustees, senior next of kin

(b) Director of Nursing, Kirkbrae Presbyterian Homes, interested party

(c) Mr Andy Price, Aged Care Quality and Safety Commission, interested party

(d) Dr Yvette Kozielski, Medico-Legal Officer, Eastern Health, interested party

(e) Constable Jonathan Paul Woods, Victoria Police, Coroner's Investigator

Signature:

SIMON McGREGOR
CORONER
Date: 13 January 2020