IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2018 5078

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**JANE NOLA ROLPH**
Date of birth:	**15 December 1927**
Date of death:	**7 October 2918**
Cause of death:	**Complications of a right fractured neck of femur (Operated) sustained in a fall in a woman with dementia.**
Place of death:	**Eventide Homes, 111 Patrick Street, Stawell, Victoria 3380**

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Jane Nola Rolph was 90 years old at the time of her death. She had lived at Eventide Homes in Stawell since January 2018 and was cared for in Warne House, a dedicated area for dementia sufferers.

2. On 23 August 2018, Ms Rolph was located by staff on the floor in the hallway with skin tears to her upper right arm and right hand. She otherwise appeared unharmed.

3. Staff at the facility viewed CCTV footage to ascertain how Ms Rolph came to be on the floor in the hall and discovered that another resident had made physical contact with her which resulted in her fall.

4. Later that day, Ms Rolph appeared hesitant to weight bear on her right leg. She was transferred to Stawell Hospital where Ms Rolph was diagnosed with a fractured right neck of femur.

5. On 24 August 2018, Ms Rolph was transferred to Ballarat Hospital and underwent surgery to repair the fracture on 25 August 2018. Her post-operative recovery was uneventful, and she was transferred back to Eventide Homes on 28 August 2018. However, her good recovery was short lived, and her health began to deteriorate.

6. On 5 October 2018 Ms Rolph was placed in palliative care and she was declared deceased on 7 October 2018.

INVESTIGATIONS

Forensic pathology investigation

7. Dr Linda Iles, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination upon the body of Jane Nola Rolph, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83.

8. Dr Iles reported that the post mortem CT scan demonstrated no acute intracranial changes, a right hip hemiarthroplasty and there were increased lung markings in the left lower lobe. The external examination identified signs of medical intervention and signs

of injury to the extent that there were patchy areas of senile purpuric bruising noted about the forearms.

9. Based on the external examination and the materials available to her in the absence of a full post mortem examination, Dr Iles ascribed the cause of Joan Nola Rolph's death to complications of a fractured right neck of femur (operated) sustained in a fall in a woman with dementia.

Police investigation

10. Senior Constable (SC) Sarah Bartorelli was the nominated Coroner's investigator.[1] At my direction, SC Barorelli investigated the circumstances surrounding Jane Nola Rolph's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Ms Rolph's son, Henry Rolph, General Practitioner (GP) Dr Andrew Cunningham and Lifestyle and Care Manager, Eventide Homes Stawell, Katherine Potter.

11. During the investigation, police learned that Ms Rolph was born in Goroke, Victoria and grew up and lived in western Victoria her whole life. She married in the 1950's had had five children with her husband.

12. Ms Rolph had a medical history of hypertension, hypokalaemia, hyperlipidaemia, right cataract removal and implant in 2006 and transient ischaemic attack (TIA) in 2016. Henry Rolph said that it was approximately five years before his mother's death that her health began to deteriorate. Approximately three years prior to her death, Ms Rolph was diagnosed with dementia. At this time, she was living alone but had '*great neighbours who kept an eye on her*'.

13. In early 2018, Ms Rolph's neighbour contacted Henry Rolph to inform him that he had seen Ms Rolph returning home from a walk at 2.30am. Concerned for his mother's welfare, Henry Rolph subsequently arranged for his mother to move into an aged care facility.

[1] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

14. Ms Rolph was admitted to Eventide Homes on 31 January 2018. Henry Rolph states that this was a huge upheaval for his mother, and she developed aggression issues. Over the following months, these issues settled but did not completely resolve and Henry Rolph said that these behaviours were often affected by who was caring for her. However, he said that overall his mother appeared happy.

15. Henry Rolph also said that his mother had experienced a few falls at Eventide Homes. On two occasions she suffered head injuries requiring stitches. In about July 2018, Ms Rolph commenced wearing hip protectors to minimise the risk of sustaining hip fractures in a fall.

16. On 23 August 2018, Ms Rolph was located by staff lying down on the floor in the hallway. There were no witnesses to her fall. Ms Rolph was wearing her hip protectors and on examination did not demonstrate any signs indicative that she had sustained a fracture and she did not appear to be in pain. She did have a large skin tear to her upper right arm and right hand. According to Catherine Potter Lifestyle and Care Manager, Eventide Homes Stawell, staff responded to Ms Rolph's fall in accordance with the facility's falls policy with two staff members utilising the lifting machine to get Ms Rolph off the floor and into a chair. Her arm injuries were treated, a referral to an Occupational Therapist was made and Henry Rolph was contacted and made aware of his mother's fall.

17. Henry Rolph attended at Eventide Homes in response to the call about his mother's fall mid-afternoon on 23 August 2018. He found her sitting in a wheelchair at the nurse's station, eating pavlova; she appeared happy, content and not in pain.

18. Later in the afternoon of 23 August 2018, Ms Rolph was reviewed by an Occupational Therapist who identified that Ms Rolph could not weight bear on her right leg. Transfer to Stawell Hospital by Ambulance occurred on the same day. Henry Rolph confirms that he was made aware of these developments and he again went to Eventide Homes and followed the Ambulance to Stawell Hospital.

19. On admission to Stawell Hospital, Ms Rolph was diagnosed with a right fractured neck of femur. She was transferred to Ballarat Hospital the following day and underwent a

right hemiarthroplasty[2] on 25 August 2018 without complication. Ms Rolph was returned to Eventide Homes on 28 August 2018.

Eventide Homes' investigation

20. Ms Potter said that she conducted a thorough investigation of Ms Rolph's fall. She reviewed the CCTV footage because there were no witnesses. The CCTV footage revealed that Ms Rolph was walking down the hallway when another resident nudged Ms Rolph with her elbow as she was walking past. The nudge caused Ms Rolph to lose her balance and fall over. The other resident already had a diagnosis of dementia-mixed type and had been identified as exhibiting aggressive behaviours and territorial.

21. Ms Potter stated that she reported the incident to WorkSafe and that a WorkSafe Inspector attended Eventide on 28 August 2018, the same day Ms Rolph had returned to the facility. The Inspector viewed the CCTV footage, spoke to the resident identified in the CCTV footage, discussed with the facility what could be done to prevent a similar situation occurring again and completed a WorkSafe Entry Report.

22. Ms Potter also said that the other resident had been reviewed by her doctor and Dementia Support Australia following the incident and that strategies had been put in place to manage the resident's problematic behaviour. Ms Potter also stated that both families had been notified as '*Eventide Homes has an open disclosure to all incidents which occur within our facility*'.

23. Henry Rolph said that he was informed of the involvement of the other resident approximately one week after his mother's death.

[2] A hemiarthroplasty is a surgical procedure that involves replacing half of the hip joint. Hemi means "half" and arthroplasty refers to "joint replacement." Replacing the entire hip joint is called total hip replacement (THR).

COMMENTS

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

1. Professor Joseph Ibrahim is the lead researcher/author of the publication *Recommendations for Prevention of Injury-Related Deaths in Residential Aged Care Services* undertaken by the Health Law & Ageing Research Unit, Department of Forensic Medicine at Monash University. Chapter seven of the publication deals with resident-to resident aggression (RRA) in residential aged care services (RACS) and says that it is defined as:

   > *negative, aggressive and intrusive verbal, physical, sexual, and material interactions between long-term care residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress of harm to the recipient.*

2. RRA is stated to be an emergent public health concern and commonly occurs between one or more residents with dementia. Due to an ageing population, the prevalence of dementia has also risen and approximately 50% of RACS residents in Australia have a diagnosis of dementia. Professor Ibrahim states that '*RRA is expected to increase as the population continues to age and the needs of older people become increasingly complex'.* Ten recommendations were developed by the researchers for the prevention of RRA among RACS residents in Australia following consultation with key experts and stakeholders.

3. I support each of the Recommendations outlined in pages 176 – 177 of the publication noting that they are focussed on improving public health and safety and preventing deaths from RRA in RACS.

4. The circumstances of the death of Jane Nola Rolph highlights that the issue of RRA in RACS needs to be addressed proactively not reactively.

FINDINGS

1. I find that Jane Nola Rolph, born 15 December 1927 died on 7 October 2018 at Eventide Homes, 111 Patrick Street, Stawell, Victoria 3380.

2. I find that Eventide Homes responded appropriately and in accordance with its own policies and ensured that Jane Nola Rolph received timely medical attention to injuries sustained in a fall on 23 August 2018.

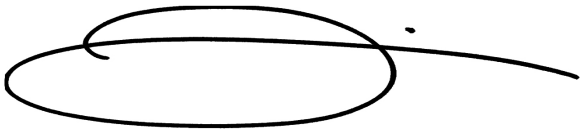
3. AND I further find that Eventide Homes appropriately investigated the circumstances of the presumed unwitnessed fall of Jane Nola Rolph and took appropriate steps when they identified the involvement of another resident to notify WorkSafe and implement strategies with the aim of preventing like incidents.

4. I accept and adopt the cause of death ascribed by Dr Linda Iles and I find that Jane Nola Rolph, a woman with dementia died from complications of a fractured right neck of femur sustained in a fall, in circumstances where I find that resident-to-resident aggression was responsible for the fall.

Pursuant to section 73(1A) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

I direct that a copy of this finding be provided to the following:
Henry Rolph
Eventide Homes Stawell
Worksafe
Royal Commission into Aged Care
SC Sarah Bartorelli

Signature:



AUDREY JAMIESON
CORONER
Date**: 4 May 2020**