IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 4408

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	Simon McGregor, Coroner
Deceased:	**Dorothy Lorraine Boyle**
Date of birth:	4 August 1926
Date of death:	3 September 2018
Cause of death:	Complications of a fractured left femur (operated), sustained in a fall
Place of death:	Epworth Hospital 89 Bridge Road, Richmond, Victoria

INTRODUCTION

1. Dorothy Lorraine Boyle was a 92-year-old woman who lived in an Aged Care Facility in South Morang at the time of her death.

2. Mrs Boyle was injured in a fall at her facility on 1 September 2018. Although she was treated in hospital, her condition deteriorated and she passed away on 3 September 2018.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mrs Boyle's death was reported to the Coroner. It appeared to be unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury 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, Detective Senior Constable Peter Anderson prepared a coronial brief of evidence in this matter. The brief includes statements from witnesses, including family, the forensic pathologist who reviewed the circumstances of Mrs Boyle's death, aged care staff and the investigating officer.

7. I have been assisted in this investigation by discussions with Professor Joseph Ibrahim of the Department of Forensic Medicine at Monash University. Following these discussions, I asked further questions of Estia Health who provided a considered response.

8. 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.

9. 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]

10. In considering the issues associated with this finding, I have been mindful of Mrs Boyle'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

11. When Mrs Boyle moved into her Aged Care Facility, Estia Health Plenty Valley, on 6 June 2016. She was initially placed in a double room on the first floor. On 22 August 2016, after being transferred from Respite Care to Permanent Care, she moved to Room 39, a single room with its own en-suite on the ground floor.[2]

12. On 20 June 2018 Robyn Boyle contacted Estia Health to inform them of concerns Mrs Boyle had raised. A co-resident had been wandering into Mrs Boyle's room which alarmed her and impacted on her privacy. Estia Health staff discussed the issue with Mrs Boyle and she requested that her door be kept locked.[3]

13. Staff discussed the possibility of adding a '*privacy chain*' to Mrs Boyle's door, but Mrs Boyle declined this option.[4]

14. Estia Health staff then put a sign on the door of Room 39 reading '*Please ensure to lock this room at all times*' and sent a memo to all staff reminding them of this request.[5]

15. Staff followed up with Mrs Boyle on 24 June and she told them that she was happy with the solution.[6]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

16. On the evening of 1 September 2018, Mrs Boyle was alone inside Room 39.[7]

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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 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 Valerie Boyle dated 28 January 2019, Coronial Brief; Floor Plan for Room 39, Exhibit 13 of Coronial Brief; Letter from Claire Thomas to the Court dated 1 September 2019.

3 Estia Health Feedback Form dated 20 June 2018.

4 Letter from Claire Thomas to the Court dated 1 September 2019.

5 Estia Health Feedback Form dated 20 June 2018; Photograph of Sign, Exhibit 9 of Coronial Brief.

6 Estia Health Feedback Form dated 20 June 2018.

7 Statement of Detective Senior Constable Peter Anderson dated 15 March 2019, Coronial Brief.

17. At 8.32pm, an Estia Health staff member, Sangetti Devi, entered Room 39 without needing to unlock the door. Ms Devi later left the room.[8]

18. Beginning at around 9.26pm, another resident, who suffered from dementia and was known to be a wanderer, was walking along the hallway near Room 39 and occasionally entering and leaving rooms.[9]

19. At 9.51pm the other resident entered Room 39 without needing to unlock it. Mrs Boyle was in the room's en-suite at this time.[10]

20. Mrs Boyle came out of the en-suite and saw the other resident in her room. She tried to push the other resident out of her room and, while she was doing so, lost her balance and fell.[11]

21. At 9.55pm the other resident walked out of Mrs Boyle's room and encountered staff member Sushila Suhang on her way out.[12]

22. Ms Suhang saw that Mrs Boyle had fallen. She immediately brought other staff including Registered Nurse Veerpal Malli. RN Malli assessed Mrs Boyle as having suffered a fracture at her hip and immediately contacted emergency services. She then contacted Mrs Boyle's family.[13]

23. At around the time Mrs Boyle's family arrived, RN Malli confirmed what Mrs Boyle's current medications were and provided her pain relief.[14]

24. Paramedics arrived around twenty minutes after Mrs Boyle's family came. They took Mrs Boyle to the Emergency Department at Northpark Private Hospital, where she was reviewed by Dr Karim Al-Khafaji. Dr Al-Khafaji noted that by this time she was comfortable and not in distress.[15]

25. An x-ray scan showed a spiral fracture of her left-mid shaft of femur wish suspicious of a fractured right neck of femur. Dr Al-Khafaji determined that her condition required surgery and admission to intensive care following surgery. As this was not possible at Northpark

[8] Statement of Detective Senior Constable Peter Anderson dated 15 March 2019, Coronial Brief.
[9] Statement of Detective Senior Constable Peter Anderson dated 15 March 2019, Coronial Brief.
[10] Statement of Detective Senior Constable Peter Anderson dated 15 March 2019, Coronial Brief.
[11] Progress note dated 1 September 2018, Estia Health Coroner's Report, Exhibit 3 to Coronial Brief.
[12] Statement of Detective Senior Constable Peter Anderson dated 15 March 2019, Coronial Brief.
[13] Statement of RN Veerpal Malli dated 13 March 2019, Coronial Brief.
[14] Statement of RN Veerpal Malli dated 13 March 2019, Coronial Brief.
[15] Statement of Dr Karim Al-Khafaji dated 8 April 2019, Coronial Brief; Statement of Valerie Boyle dated 28 January 2019, Coronial Brief.

Private Hospital, he discussed the matter with Mrs Boyle's family and they requested a transfer to Epworth Hospital. She was transferred the following day.[16]

26. Mrs Boyle underwent surgery on the afternoon of 2 September 2018. However, after her surgery her condition deteriorated. She was moved to palliative care and passed away in hospital at around 1.10am the next morning.[17]

IDENTITY AND CAUSE OF DEATH

27. On 4 September 2018, Valerie Boyle visually identified Mrs Boyle's body. Identity is not in dispute and requires no further investigation.

28. On the same day, Dr Greg Young, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, reviewed an e-Medical Deposition regarding Mrs Boyle's death as well as medical notes from Epworth Hospital and Estia Health. Dr Young provided a written report, dated 6 September 2018, in which he formulated the cause of death as '*I(a) Complications of a fractured left femur (operated), sustained in a fall'*.

29. I accept Dr Young's opinion as to cause of death.

REVIEW OF CARE

30. There is no indication that there were any failures in the medical care provided to Mrs Boyle after her fall. RN Malli, Dr Al-Khafaji and staff at Northpark Private Hospital and Epworth Hospital all provided reasonable and appropriate treatment.

31. However, the circumstances leading up to Mrs Boyle's death pointed to possible issues with the regular operations of Estia Health Plenty Valley. In particular, the facility's management of problems posed by residents with dementia may have played a role in Mrs Boyle's death.

Resident-to-resident aggression

32. Mrs Boyle was fatally injured during a physical altercation with another resident who had intruded into her room. Considering the ambiguity of the situation, and the dementia suffered by the other resident, it is difficult to assign labels of 'victim' or 'perpetrator' to

[16] Statement of Dr Karim Al-Khafaji dated 8 April 2019, Coronial Brief.
[17] E-Medical Deposition of Mr Andrew Gong dated 3 September 2018.

either party. Further, considering the stigma attached to such labels, it is undesirable to do so.[18] Nonetheless, it was clearly a situation of 'resident-to-resident aggression'.

33. Professor Joseph Ibrahim has made a statement to the Royal Commission into Aged Care Quality and Safety which addresses this issue among others. In his statement, he gives the following definition of 'resident-to-resident aggression':

> '*Negative, aggressive and intrusive physical, sexual, verbal, and material interactions between long-term care residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm in the recipient.*'[19]

34. Resident-to-resident aggression has arisen in previous investigations by Victorian coroners. In particular, Coroner Carlin (as she then was) addressed it in her findings into the death of "BS", made 30 May 2019, and made several recommendations regarding reporting and capturing data regarding resident-to-resident aggression incidents. Coroner Jamieson has also addressed this issue in her findings into the death of Jane Nola Rolph made on 4 May 2020.

35. A recent systematic review of research in this area has found that resident-to-resident aggression is '*ubiquitous with serious consequences for residents*' and that '*[a]lthough physical injuries were rarely reported, each study described the negative social and psychological effects of aggression on the quality of life of nursing home residents*'.[20]

36. Although there is a limited amount of research about the issue, it is clear that residents who are suffering dementia, such as the other resident who intruded into Mrs Boyle's room, are at increased risk of being involved in these events. In particular, the systematic review identified residents who '*are cognitively impaired yet have sufficient mobility "to put themselves in harm's way"*' as a group particularly in danger.[21]

37. The circumstances leading up to Mrs Boyle's altercation are also not uncommon. A 2011 study of the major types of resident-to-resident aggression events in New York City nursing

[18] See the statement of Professor Joseph Ibrahim dated 23 April 2019, Royal Commission into Aged Care Quality and Safety Exhibit 3-70, para 134.
[19] Ibid para 131.
[20] Ferrah et al, 'Resident-to-resident physical aggression leading to injury in nursing homes: a systematic review' (2015) *Age and Ageing* 44 356, 362.
[21] Ferrah et al, 'Resident-to-resident physical aggression leading to injury in nursing homes: a systematic review' (2015) *Age and Ageing* 44 356, 362.

homes found that the second most common category was events occurring after '*invasion of room privacy*'.[22]

Privacy and dementia care at Estia Health Plenty Valley

38. Following a discussion with Professor Ibrahim, I requested that Estia Health Plenty Valley provide details on the care they provide for residents with dementia, and any ways in which their facility is structured to respond to the particular needs of residents with dementia.

39. Estia Health Plenty Valley have advised that they are not a dementia-specific facility, but are a 'dementia sensitive facility' which does not discriminate against residents with dementia. As such, they are aware that they will have residents with and without dementia living within the same areas. Although Estia Health has other facilities with dementia-specific units, Estia Health Pleasant Valley does not.

40. They note that the area around Room 39 was '*not known to be an area where Residents living with dementia were more or less likely to wander within the facility*', but that all residents are free to walk within all areas.

41. Estia Health's strategies to address individual residents' needs can include '*behavioural charting including monitoring of wandering behaviours, sighting charts, pain charting, Wanderer's bracelets, medication review, leisure and lifestyle engagement and sundown management*'. All staff are trained to provide this care, and have access to external resources such as Dementia Australia, which provides in-house education sessions.

42. Based on the information provided, I am satisfied that Estia Health Plenty Valley treats its residents who live with dementia appropriately, and do not place their other residents at heightened levels of danger. It is impossible to completely eliminate the danger of resident-to-resident aggression, as these events show, but it appears that Estia Health Plenty Valley have taken reasonable measures to reduce all possible harm to their patients.

Reporting of incident

43. Estia Health Plenty Valley have informed the Court that the incident leading to Mrs Boyle's death was not reported to the Commonwealth Department of Health, or to any other public bodies, apart from providing a statement to the Court at our request.

[22] Pillemer et al, 'Resident-to-resident aggression in nursing homes: results from a qualitative event reconstruction study' (2011) *The Gerontologist* 52 24.

44. They state that they were not required to provide any such report to any body.

45. As of September 2018, section 63-1AA of the *Aged Care Act 1997* required providers of residential aged care to report an allegation or suspicion of a 'reportable assault' to a police officer and to the Department of Health.[23] However, section 53 of the *Accountability Principles 2014* made under section 96-1 of the *Aged Care Act 1997* (Cth) specifically states that no such reporting is required if the assault '*was committed by a care recipient*' who had been assessed as suffering from a cognitive or mental impairment.[24]

46. It is unclear if the interaction between Mrs Boyle and the other resident who had intruded into her room would have been classifiable as a 'reportable assault' in the first place, and the fact that the other resident was known to suffer from dementia puts the issue even further in doubt.

47. I accept Estia Health Plenty Valley's position that they were not required to report this incident to the Department of Health.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

48. The solution of having staff systematically keep Mrs Boyle's door locked appeared reasonable, and most importantly was accepted by Mrs Boyle as sufficient. However, it appears that this solution was not executed properly on the day of Mrs Boyle's death.

49. It is possible that fitting Mrs Boyle's door with a self-locking mechanism might have been able to prevent the intrusion which led to Mrs Boyle's death. However, this would likely have caused difficulties of its own. As Mrs Boyle accepted the solution reached by Estia Health, I consider that Estia Health acted reasonably in forming this plan, despite the flaws in its later execution.

50. This incident appears to be isolated, and does not indicate that there is any larger pattern of failures of care at Estia Health Plenty Valley. I am confident that their approach to their residents' security and well-being is appropriate.

Reporting of incidents

51. Coroner Carlin wrote in her 2019 findings into the death of 'BS' that:

[23] *Aged Care Act 1997* (Cth) s 63-1AA(2).
[24] *Accountability Principles 2014,* Compilation no 7 (28 July 2018).

'*[I]t seems to me that the starting point for any prevention opportunities is to have an accurate record of incidents of aggression so that a clearer picture can be gained, not only of the number of such incidents, but also the circumstances in which they occur.*'[25]

52. She made recommendations to the Commonwealth Department of Health regarding the expansion of existing reporting frameworks, the development of a national database on incidents of physical aggression in residential aged care services, and public reporting.

53. Acting Assistant Secretary Ingrid Leonard has written to the Court and advised that the Department of Health has current initiatives underway which will address Coroner Carlin's recommendations.

54. Ms Leonard states that the Department of Health is '*undertaking preparatory work for the implementation of the Serious Incident Response Scheme (**SIRS**)*', which will replace current compulsory reporting requirements. She states that the SIRS is '*expected to mandate reporting of a broader range (than at present) of serious incidents in residential aged care to the Aged Care Quality and Safety Commission*'.

55. According to Ms Leonard, the range of incidents reported would include '*incidents of abuse and aggression between aged care consumers where the alleged perpetrator has an assessed cognitive or mental impairment that are currently exempt from reporting*'.

56. It appears that, if the scope of this scheme remains sufficiently broad and if it is implemented effectively, it should go some distance toward providing the '*clearer picture*' Coroner Carlin referred to.

Royal Commission into Aged Care Quality and Safety

57. Issues surrounding the implementation of the SIRS are likely to be best addressed by the Royal Commission into Aged Care Quality and Safety, which is receiving public submissions until 31 July 2020.

58. As such, I will direct that a copy of this finding be provided to the Royal Commission as a submission, so that they might consider the circumstances of Mrs Boyle's death and how they might be captured, or not captured, by specific proposals for the SIRS.

[25] Finding into the death of BS dated 30 May 2019 (COR 2013 4853), available on the Coroners Court of Victoria website.

59. I note that Professor Ibrahim was the lead author of the *Recommendations for Prevention of Injury-Related Deaths in Residential Aged Care Services* published by the Health Law and Ageing Research Unit at the Monash University Department of Forensic Medicine, and that Chapter 7 of this report sets out ten recommendations directed to reducing deaths related to resident-to-resident aggression.

60. Coroner Audrey Jamieson has expressed her support for these recommendations in her recent findings into the death of Jane Nola Rolph,[26] and I wish to express my support as well.

61. I submit to the Royal Commission that implementing these recommendations would be an effective step towards preventing deaths such as Mrs Boyle's.

FINDINGS AND CONCLUSION

62. I express my sincere condolences to Mrs Boyle's family for their loss.

63. 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 Dorothy Lorraine Boyle, born 4 August 1926;

    (b) The death occurred on 3 September 2018 at the Epworth Hospital, 89 Bridge Road, Richmond, Victoria, from complications of a fractured left femur (operated), sustained in a fall; and

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

64. Pursuant to section 73(1A) of the *Coroners Act 2008*, I direct that a copy of this finding be published on the internet.

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

    (a) Ms Valerie Boyle, senior next of kin;

    (b) Estia Health Plenty Valley;

    (c) Royal Commission into Aged Care Quality and Safety;

[26] Finding into the death of BS dated 4 May 2020 (COR 2018 5078), available on the Coroners Court of Victoria website.

(d) Ms Helen Gray, Epworth Healthcare Richmond; and

(e) Detective Senior Constable Peter Anderson, Coroner's Investigator.

Signature:

SIMON McGREGOR

CORONER

Date: 22 July 2020