IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 002142

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Darren J. Bracken
Deceased:	Gwenyth Evelyn Miles
Date of birth:	30 October 1930
Date of death:	28 April 2019
Cause of death:	1(a) Multisystem organ failure in the context of exposure, humeral fracture, and clinical dehydration. Contributing factors: Dementia
Place of death:	Alfred Health, Caulfield Hospital, 260 Kooyong Road, Caulfield, Victoria, 3162

INTRODUCTION

1. On 28 April 2019, Ms Gwenyth Evelyn Miles (**Ms Miles**) was 88 years old when she died at the Caulfield Hospital. Nearly two months prior, on 1 March 2019, Ms Miles was found collapsed in Asling Street, Brighton, some 800 – 900 metres from the Arcare Residential Aged Care facility in which she lived (**RACF**).[1]

THE CORONIAL INVESTIGATION

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

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, cause of death, and surrounding circumstances. Surrounding circumstances are limited to events that 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.

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

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Miles' death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as Ms Miles' family, staff of the RACF, treating clinicians and investigating police. The Coronial Investigator compiled and submitted a Coronial Brief.

6. This finding draws on the totality of the coronial investigation into the death of Ms Miles including evidence contained in the Coronial Brief. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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[1] I note that some statements in the Coronial Brief refer to the relevant date, the date on which Ms Miles left the RACF as 12 April 2019. This is erroneous as explained by the Coronial Investigator at page 7, paragraph 9 of the Summary that forms a part of the Coronial Brief.

[2] 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.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

7. On 28 April 2019, Ms Sandra Miles identified the deceased as her mother, Evelyn Miles, born 30 October 1930.

8. Identity is not in dispute.

Medical cause of death

9. On 1 May 2019 Dr M. Dodd, senior forensic pathologist practising at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination of Ms Miles' body and provided a written report dated 6 May 2019 setting out his findings.

10. Dr Dodd's report refers to areas of healing thermal injury. Dr Dodd referred to a CT scan showing mild to moderate dilation of the left ventricles, mild cerebral atrophy, patchy bilateral lung changes, calcification of the aorta extending to and beyond the iliac arteries as well as evidence of cardiac enlargement with patchy coronary calcification. The report also referred to a right surgical neck of humerus fracture and evidence of a remote left femoral fracture repair.

11. Toxicological analysis of ante-mortem samples identified no alcohol, common drugs or poisons not connected with Ms Miles' treatment.

12. Dr Dodd provided an opinion that the medical cause of Ms Miles' death was "*1(a) Multisystem Organ Failure in the Context of Exposure, Humeral Fracture and Clinical dehydration"*and that dementia was a contributing factor .

13. I accept Dr Dodd's opinion.

Circumstances in which the death occurred

14. Arcare Brighton is a RACF over two floors. Residents may walk around the facility and indeed are free to leave at their will.

15. The investigation revealed that Ms Miles left the RACF at about 1.10pm on 1 March 2019 and was found collapsed on the street approximately 800 – 900 metres away at about 1.30pm. That day it was very hot. Ms Miles was taken to the Alfred Hospital and then to the Caulfield Hospital where, on 28 April 2019, she died.

16. As at 1 March 2019 Ms Miles had lived in a ground floor room at the RACF for a little more than 12 months. Ms Miles suffered from Alzheimer's dementia and had a knee replacement and a broken neck of femur repaired. Ms Miles moved to the RACF after her dementia made it difficult for her to look after herself.

17. Despite her knee replacement and healed broken neck of femur Ms Miles was mobile with the aid of a framed walker. Ms Miles walked '*…a circuit along the ground floor corridor, through the lounge and back past the front door.*'[3] In her statement to the Coronial Investigator dated September 2009 Ms Civarella, the then General Services Manager at the RACF, described Ms Miles as:

> "*…having a history of absconding from the residence. She walked around the reception area and adjoining lounge which was close to the front door and looked for opportunities to leave……Prior to the incident on 12 April 2019* [sic] *I recall I was involved once when she absconded from the residence and I followed her down to Bay Street, Brighton. I could not get her to return, but I supervised her walking until a family member was called and arrived and she was taken back to the residence.*"[4]

18. In her written statement Ms S. Miles said:

> *"She didn't like the idea of being locked in and yearned for the freedom she used to have to walk to the shops or just to sit outside. There were meant to be outside areas that the residents could freely access but often we would arrive to find the doors to these areas locked and Mum frustrated.*"[5]

19. In her statement, Ms Civarella, described the front doors of the RACF as being electronically secured from the inside by a system requiring a numerical code to open them. Ms Civarella described the door opening automatically when a person approached them from outside.

20. Ms Civarella described Ms Miles being required to wear a bracelet that set off an alarm (**Alarm Bracelet**) if she left the RACF through the front doors and when she did an alarm would ring on:

> "*... DECT phones that carers and nurses carry as well as DECT phone kept at reception... Ms Miles also had a bracelet* [and Alarm Bracelet] *fixed to her walker*

[3] Statement of Michelle Civarella p.1.
[4] Id.
[5] Statement of Ms Sandra Miles dated 30 October 2019 p.4.

> ...[she] *was aware of the purpose of the bracelet…On one occasion…*[she] *left the premises by leaving her walker* inside."[6].

There seems to be no controversy that this alarm did not sound or was not heard when Ms Miles left the RACF on 1 March 2019.

21. Ms Civarella explained that on 1 March 2019 she was working at the reception desk of the RACF and that she left the desk for lunch at about 1.00pm. When she returned, she describes attending to another task and then going to the reception area. Ms Civarella found her lunch time relief, Ms Gomo, taking a telephone call from a woman who had found Ms Miles lying in the street.[7] Ms Civarella's statement recounts Ms Gomo telling her that she had contacted Mr Singh, an employee registered nurse then on duty, about Ms Miles. Ms Civarella contemplated going to assist Ms Miles herself because she knew Ms Miles but decided in the end that a medically trained person such as Mr Singh would be more appropriate. Ms Civarella recalls the woman who first telephoned the RACF and reported having found Ms Miles called back and complained that it was taking too long for someone from the RACF to get down to where Ms Miles lay in the street. Sometime there-after Ms Civarella and Mr Singh left the RACF and went to help Ms Miles. When Ms Civarella and Mr Singh arrived, they saw that Ms Miles had her walker with her and that an ambulance paramedic who had apparently arrived on a motor-cycle was treating her. They stayed with Ms Miles until an ambulance arrived and took her to hospital.
22. Ms Civarella later checked video footage of the reception area and saw that it had recorded Ms Miles leaving the RACF "…*around 3 minutes after I left for lunch...* [when] *a nurse form Cabrini Hospital came in the front door*.".[8] Ms Civarella was unable to say anything about why the alarm had not sounded.

23. In her statement Ms Gomo described starting work at the reception desk between 12.30pm and about 1.00pm.[9] Ms Gomo explained that she did not see Ms Miles leave the premises and that the alarm at the reception desk did not sound while she was there. Ms Gomo recounts receiving a telephone call reporting that Ms Miles had been found in the street and that she had been injured. Ms Gomo telephoned Mr Singh.

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[6] Id.
[7] On the basis of the content of Ms S. Miles statement and the notes attached to Senior Constable Sheehan's statement this caller is likely to have been Ms Anne Lomax whose mother was then also a resident of theRACF.

[8] Ibid. p2.
[9] Statement of Lisa GOMO dated 30 September 2019, p.1

24. Mr Singh also provided a statement in which he described Ms Gomo telephoning him at about 1.30pm and telling him about Ms Miles having been found collapsed and injured in the street. His statement refers to him carefully considering whether he ought to go to Ms Miles' aid and considering that he was the only registered nurse then working at the RACF; he was reluctant to leave the facility without a nurse. In any case Mr Singh recounts gathering dressings, "*…about 3 minutes after being told of the incident…*", a first aid kit, his car keys and he and Ms Civarella going to where Ms Miles' had been found.[10] Mr Singh describes arriving and seeing Ms Miles being attended to by an ambulance paramedic. Ms Miles told Mr Singh that she had lost her balance and fallen. Mr Singh describes seeing:

    a) Ms Miles lying on the footpath and her legs on the grass and seeing some blood through her trousers on her knee.

    b) People holding umbrellas keeping her in shade.

    c) That she was not in visible pain, and she was talking normally. She was not crying or visibly distressed or short of breath.

25. Mr Singh recounted staying with Ms Miles until an ambulance arrived, about 10 minutes after he and Ms Civarella arrived, and of the ambulance taking Ms Miles to the Alfred Hospital.[11] Mr Singh estimates that he and Ms Civarella arrived at where Ms Miles lay in the street between seven and 10 minutes after he hung-up the telephone from Ms Gomo's call to him.

26. Mr Kaur, an Arcare Regional Support Manager, also provided a statement for the Coronial Brief explaining that he was at RACF on 1 March 2019. In his statement Mr Kaur refers to Ms Miles having been given an alarm bracelet which she wouldn't wear all the time and so on 5 April 2018 one was fitted to her walking frame. Mr Kaur refers to RACF records detailing Ms Miles having left the RACF on 4, 23 and 25 April 2018 without telling anyone and on one other occasion, 5 August 2018, refusing to return after an escorted walk.[12]

27. Mr Kaur refers to a meeting between RACF staff and members of Ms Miles' family in August 2018 at which Ms Miles' leaving the RACF without telling anyone was discussed. Mr Kaur refers to the RACF suggesting that Ms Miles be transferred to a room on the first floor which would require her to use a lift to get to the ground floor – that lift requiring input of a security code for operation. According to the content of his statement Ms Miles' family decided

[10] Statement of Harshdeep Singh dated 19 September 2019. p.1.
[11] Id.
[12] Statement of Prabhjit Kaur dated 23 September 2019. p.2.

against this alternative. I note that Ms S. Miles recollection of the discussion at that meeting as set out in her statement is different from Mr Kaur's recollection. Mr Kaur recalls that by early 2019 Ms Miles had been stopped from leaving the RACF on a number of occasions and on one occasion, in February 2019, Ms Miles left the RACF leaving her walker behind knowing that an alarm bracelet had been attached to it. Mr Kaur described two alarm bracelets being hidden on Ms Miles' walker. Mr Kaur also refers to having the alarm system utilising the alarm bracelets checked after 1 March 2019 and of it apparently operating properly. He speculates that Ms Miles may have covered the bracelet or bracelets in her walker compromising their effectiveness.

28. I note that Ms S. Miles' statement refers to her taking her mother out of the RACF several weeks before 1 March 2019 and when no alarm sounded of checking her mother's walker and finding that there was no alarm bracelet attached to it. She recounts reporting this to staff and of the bracelet being in place when she next visited her mother.

29. There is an obvious tension between Ms Miles being free to come and go from the RACF whenever she pleased and the dangers that her ill health posed should she leave. Whilst the RACF ought not arbitrarily to prevent Ms Miles' coming and going as she pleased it should seek to ensure that residents don't wander off and injure themselves as occurred on this occasion. The RACF is faced with something of dilemma.

30. I note the references in Ms S. Miles' statements to a change in Ms Miles' medication being canvassed by staff of the RACF with the view of reducing Ms Miles' activity and of her, Ms S. Miles', opposition.

Time Line Analysis

31. Video footage from the RACF shows Ms Miles leaving at 1.04pm.

32. Ms Civarella's statement refers to her having checked the recorded video and to Ms Miles leaving the RACF "… *about 3 minutes after I left for lunch.*" In her statement Ms Civarella recalls leaving reception for her lunch break at about 1.00pm.

33. Ms Gomo's statement refers to her being at the reception desk for approximately an hour from 12.30pm – 1.00pm and of her taking one or two calls about Ms Miles from a person who found Ms Miles in the street; Ms Gomo does not identify this caller.

34. Ms Civarella's statement also refers to Ms Gomo being on the phone to the woman reporting Ms Miles having fallen in the street (Ms Lomax) when she returned from lunch. Ms Gomo's statement refers to Ms Civarella speaking to Ms Lomax on the telephone and to her, Ms Gomo contacting Mr Singh with the view to him going to Ms Miles' aid.

35. Mr Singh's statement records him being contacted by Ms Gomo "…*at approximately 1.30pm*."

36. Ms Civarella refers to the woman hanging up and calling back because "…*it was taking too long"* and of Mr Singh and her "…*then…"* leaving to go to Ms Miles.[13]

37. Neither Ms Civarella nor Mr Singh nominate a time that they left the RACF to go to where Ms Miles had fallen but it couldn't have been long before they arrived because they drove the 800 – 900 metres to where Ms Miles was found.

38. The first '000' call for assistance for Ms Miles was at 2.12pm. Ms Civarella's and Mr Singh's statements refer to a "…*paramedic…"* being present when they arrived at Ms Miles' location. Ms Civarella's statement refers to the paramedic having arrived on a "…*bike"*. That Ms Civarella and Mr Singh arrived after the paramedic on the motorcycle is also referred to in Senior Constable Sheen's notes of his conversation with Ms Anne Lomax 30 October 2019.

39. According to the notes attached to Ms S Miles statement of a conversation between Ms S. Miles' sister, Ms K Miles, and Ms Lomax, RACF staff took 20 minutes to arrive at where Ms Miles had fallen. This is consistent with Ms Civarella's and Mr Singh's statements but inconsistent with the first '000' summoned the paramedic on the motorcycle.

FAMILY CONCERNS

40. Ms S. Miles drew an email to the Coronial Admissions and Enquiries department of the Victorian Institute of Forensic Medicine on 30 April 2019 raising concerns about:

    a) Ms Miles' care at the RACF.

    b) Ms Miles being able to leave the RACF without the staff being aware including concerns about the functioning of the 'buzzer' said to have been attached to Ms Miles' walking frame that was meant to alert staff to her leaving the RACF.

[13] This account of the content of the call or calls is consistent with Ms Gomo's and Ms Civarella's statements.

c) The time RACF staff took to respond to Ms Miles having been found in the street.

41. Ms Miles also provided a statement for the Coronial Brief in which she eloquently lamented her mother's passing and expressed concern about the level of care her mother received at the RACF specifically canvassing what she saw as problems with the front doors including:

a) There not being a vestibule.

b) The doors remaining open for some time after someone entered or left the RACF.

c) The apparent failure of the 'alarm' fitted to Ms Miles' walker to warn staff of her leaving the RACF.

ADDRESSING FAMILY CONCERNS

42. I take into account that the role and function of Coroner eschews consideration of criminal or civil liability but rather is a fact-finding exercise which may underpin comments and recommendations made in order to reduce the number of preventable deaths. The role of the Coroner includes dealing with matters of public health and safety and serving the administration of justice. Coroners are legislatively bound to find the identity of a those whose death is a reportable death, the cause of that death and the circumstances (proximate) surrounding the death. With this foundation I will consider the issues raised by the coronial brief and the Ms S. Miles' concerns with the operation of the RACF.

CONCLUSIONS

43. Residential aged care facilities generally and the RACF in this matter face the dilemma of balancing their clear obligation not to interfere with the liberties of their residents and at the same time to protect their residents from the dangers that ill-health including conditions such as dementia pose.

44. This balance can be difficult to strike, all the more so when residents show some unwillingness and perhaps some determination to be bound by RACF rules as Ms Miles did.

45. Ms Miles was entitled to come and go from the RACF as she pleased and the RACF ought not be expected to immediately accommodate residents' every whim to leave the premises at any time by, for example, having a staff member accompany them.

46. The alarm bracelet system that the RACF put in place represents a thoughtful attempt to minimise interference with residents' rights and at the same time protect residents from the

perils posed by their health conditions. That it didn't work on 1 March 2019 when Ms Miles left the RACF does not seem to be controversial albeit why the alarm didn't sound is unknown.

47. The evidence at least suggests that Ms Miles was somewhat adept at avoiding RACF staff when she wanted to leave the premises. It seems that she took advantage of the temporary change-over of the reception desk staff on 1 March 2019 and of Ms Gomo being required to undertake duties away from the reception desk. Staff working at the reception desk were best placed to physically monitor traffic through the front doors of the RACF. Such monitoring was essential given that a person coming in the front doors opened them for Ms Miles to leave and staff knew that this may occur.

48. But what was the RACF to do? They could not and should not stop Ms Miles walking around the facility, or even to stop her lingering by the front doors if she wanted to. RACF staff knew that the bracelet alarm system had not been a complete answer to alert staff to Ms Miles leaving the premises and a dedicated staff member to follow Ms Miles around and make sure that she didn't leave the premises would be impractical, unreasonable and probably offensive to Ms Miles and her family.

49. The plan to move Ms Miles to the first floor so that she would have to overcome a security coded lift if she wanted to leave has some merit although faced with Ms Miles focus and determination, I am far from sure it would have been a panacea.

50. I am driven to the conclusion that the only practical alternative would be for reception staff to directly monitor the front door: someone always being behind the reception desk and monitoring people entering and leaving the premises is the key. This must be considered in the context that there is no evidence that residents leaving the RACF through the front door undetected is a common and ongoing issue. That said, it is clear that the effect of that occurring has been and could easily again be grave.

FINDINGS

51. Pursuant to section 67(1) of the *Coroners Act 2008* I find:

    a) The identity of the deceased is Gwenyth Evelyn Miles, born 30 October 1930.

    b) Ms Miles died on 28 April 2019 at the Caulfield Hospital form Multisystem Organ Failure in the context of Exposure, Humeral Fracture and clinical dehydration with a contributing factor of dementia; and

c) Ms Miles' death occurred in the circumstances described above.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I recommend that

1. Arcare Brighton consider reviewing staffing and infrastructure arrangements at the front door of their premises with a view to having doors which open automatically to allow people to enter the facility and there-by allow residents to leave, directly monitored by staff.
2. Arcare Pty. Ltd. consider such a review at other of their facilities with the view to maximising residents' liberty and at the same time optimising their safety.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

1. Ms. Sandra Miles, Senior Next of Kin
2. Arcare Pty Ltd
3. Alfred Health
4. Senior Constable Sheen - Coroner's Investigator

Signature:

Coroner Darren Bracken

Date: 11 May 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.