IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 003913

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Ms F[1]
Date of birth:	[redacted] 1941
Date of death:	21 July 2020
Cause of death:	*Combined Effects of Neck Compression and Haemothorax in the Setting of a Fractured Thoracic Vertebra*
Place of death:	[redacted] Box Hill North, Victoria, 3129
Keywords:	*Bed Poles*

[1] This finding has been de-identified by order of Coroner Sarah Gebert to replace the names of the deceased, her family members and select individuals with pseudonyms to protect their identity and redact identifying information

INTRODUCTION

1. Ms F, born [redacted] 1941, was 79 years old at the time of her death. She is survived by her son, Mr F.

2. Ms F had lived at her home in Box Hill North since 2000, following her mother's passing. She had initially lived with one of her brothers and with her son, but her brother went into an aged care facility in January 2020.

3. Ms F had an extensive medical history and received bi-weekly visitations from nurses.

4. On 21 July 2020, Ms F passed away suddenly in her home.

THE CORONIAL INVESTIGATION

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

6. 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.

7. 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.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms F's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into Ms F's death 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]

Background

10. According to Ms F's treating doctor, Dr Geoffrey Gidley, she had a *number of complex medical problems*, including ischaemic heart disease, chronic airways disease, seizures, bipolar affective disorder, depression, and generalised osteoarthritis.

11. She was also *significantly overweight* and had deteriorating mobility, requiring a walking frame or wheelchair at times.

12. Since October 2018, Ms F received visits from Mecwacare nurses, which, according to Dr Gidley, helped in the support and monitoring of her depression and skin integrity.[3] Ms F had developed a sacral pressure wound on her right buttock during the last 6 weeks of her life, which the nurses also provided care for.

13. Ms F would apparently not allow the nurses into her bed room and would receive the nurses in other areas of the house.

14. On 14 April 2020, Ms F had a fall at home whilst in the bathroom and was unable to get up. When her son returned from running errands, he phoned Triple Zero and she was hospitalised for 4 days.

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

Circumstances in which the death occurred

15. At approximately 10.00pm on 20 July 2020, Ms F and her son ate their dinner in their Box Hill North home. Ms F retired to bed at approximately 11.00pm. At approximately 11.30pm, her son checked on her and noted that she was lying on her left side. This was not unusual given her buttock wound, so he retired to bed to watch television.

16. At approximately 3.05am on 21 July 2020, Ms F's son heard a *muffled scream* and *thud* from his mother's room. He ran to her room and observed that Ms F's head was wedged

[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.

[3] Mecwacare is a not-for-profit charitable organisation that specialises in, among other things, home nursing, care, and support services for the elderly.

between the side of her mattress and the support bed pole that was weighted down by her mattress rather than fixed.

17. Her son attempted to move her, but he found it too difficult, so he phoned Triple Zero. Ms F was still conscious at this time. An Ambulance Victoria paramedic arrived at the house at 3.31am and observe Ms F to be *firmly wedged between a disability rail and the mattress*.

18. The paramedic found that Ms F was not breathing at this time, and initial cardiac monitor readings suggested that she was pulseless. With the assistance of her son, the paramedic managed to extricate Ms F and transferred her to the hallway. Upon assessment, she appeared to have regained a cardiac rhythm, so the paramedic began resuscitation attempts at approximately 3.44am.

19. These resuscitation attempts were unfortunately unsuccessful, and Ms F was declared deceased at 4.15am on 21 July 2020.

20. Police commenced an investigation and collected photographic evidence which formed part of the coronial brief.

21. Following their investigation, police found no evidence of suspicious circumstances.

Identity of the deceased

22. On 21 July 2020, Ms F born [redacted] 1941, was visually identified by her son, Mr F.

23. Identity is not in dispute and requires no further investigation.

Medical cause of death

24. Senior Forensic Pathologist, Dr Sarah Parsons from the Victorian Institute of Forensic Medicine, conducted an autopsy on 22 July 2020 and provided a written report of his findings dated 13 October 2020.

25. The autopsy revealed evidence of injury to Ms F's neck, including fractures and haemorrhages, which are consistent with the circumstances in which Ms F became wedged.

26. Toxicological analysis of post-mortem samples identified the presence

i. Amitriptyline (Blood) - ~0.6 mg/L;[4]

ii. Nortriptyline (Blood) - ~0.3 mg/L;[5]

iii. Metoprolol (Blood) - ~0.03 mg/L;[6] and

iv. Paracetamol (Blood) - Trace Detected[7].

27. Dr Parsons provided an opinion that the medical cause of death was *Combined Effects of Neck Compression and Haemothorax in the Setting of a Fractured Thoracic Vertebra*.

28. I accept Dr Parson's opinion.

CPU REVIEW

29. I requested that the Coroners Prevention Unit (**CPU**) conduct a review into the number of deaths that have occurred as a result of a person having become wedged between bedding and moveable bed poles, as featured in Ms F's death.[8]

30. The CPU identified 7 cases similar to Ms F's occurring in the last 22 years, with none occurring in the previous 10 years. However, 3 of those 7 cases involved the KA524 model of bed pole, which is the same as that used by Ms F at the time of her death. The CPU considered that the use of bed poles, particularly the KA524 model, in a private home with limited access to professional nursing care, may pose a serious risk of harm (albeit rare in occurrence).

31. I note that in 2012 a NSW coroner recommended that aged care facilities not use KA524 bed poles due to "unacceptable risk" and in 2016 a Tasmania coroner also recommended that aged care services and approved providers immediately cease the use of bed poles of the model KA524 or similar styes in aged care facilities.

[4] Amitriptyline is an antidepressant medication that is used to treat major depression, panic disorder, neuropathic pain and enuresis.

[5] Nortriptyline is a metabolite of amitriptyline. A metabolite is a substance that is produced when its parent molecule (in this case, amitriptyline) is broken down by the body's biochemical processes.

[6] Metoprolol is a medication used in the treatment of hypertension/high blood pressure.

[7] Paracetamol is a common painkiller.

[8] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

32. Relevantly, Occupational Therapy Australia, in a September 2020 statement, found that bed poles in general *should be considered a last line intervention, and all other avenues should be exhausted prior to their recommendation.*

33. It is unknown how the bed pole came into Ms F's possession, but she appears to have purchased it privately and it was not provided to her by Mecwacare. The KA524 model is sold online by several Australian mobility websites, although it is no longer manufactured and is apparently no longer being used in the aged care sector.

34. The CPU considered in those circumstances, that the only available prevention opportunity is to advise private individuals that the use of bed poles should be as a last line intervention, and their use is not without risk.

FINDINGS AND CONCLUSION

35. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Ms F, born [redacted] 1941;

    b) the death occurred on 21 July 2020 at [redacted] Box Hill North, Victoria, 3129, from *Combined Effects of Neck Compression and Haemothorax in the Setting of a Fractured Thoracic Vertebra*; and

    c) the death occurred in the circumstances described above.

RECOMMENDATION

36. Pursuant to section 72(2) of the Act, I make the following recommendation:

    Victorian Department of Health

    The Victorian Department of Health, as part of their responsibility to support independent living for the State's older people, provide clear public advice to Victorians about the potential risk to life of the KA524 bed pole or similar style, and of the risks posed by improperly used bed poles in particular.

37. I convey my sincere condolences to Ms F's family for their loss.

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

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

Mr F, Senior Next of Kin

Victorian Department of Health

Detective Senior Constable Mel Leeds, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date : 06 October 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.