IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 007017

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Deceased:	Catherine Mary REID
Delivered on:	30 November 2023
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing date:	27 November 2023
Findings of:	Coroner Sarah Gebert
Coroner's Assistant:	Emily Southwell Coroner's Court of Victoria
Counsel for Yooralla:	Ben House instructed by Minter Ellison
Keywords:	*Death in care; Disability care; Fall; Mechanical hoist*

INTRODUCTION

1. On 26 December 2020, Catherine Mary Reid[1] was 80 years old when she died in hospital from injuries sustained in a fall on 11 December 2020.

2. At the time of her passing, Mary lived in Thornbury at the Ventilator Accommodation Support Service (**VASS**) residence operated by Yooralla.

3. Due to her age, Mary was not eligible for assistance under the National Disability Insurance Scheme (**NDIS**) and therefore received financial assistance for her support through the Commonwealth Continuity of Supports Programme, as facilitated by the National Disability Insurance Agency (**NDIA**).

4. Mary is survived by her sister Margaret, who had cared for her at home up until the time she came to reside at VASS on a full-time basis, as well as her extended family. Mary's family described her as someone with an unwavering commitment to improving the lives of people with disabilities. She loved to go out, travel, and actively participate in the community. She had a love of cooking, wine, and conversation, and enjoyed watching sport and attending the opera.

5. Mary's carers reported that throughout her life, she was a strong advocate for community-based support for people requiring mechanical ventilation and was part of the push to establish community-based services at VASS. She was passionate about being as independent as possible and maintaining agency in the decisions made about her care and support.

THE CORONIAL INVESTIGATION

The purpose of a coronial investigation

6. Mary's death was reported to the coroner as it fell within the definition of a reportable death under section 4(2)(a) of the *Coroners Act 2008* (**the Act**) because her death appeared to

[1] I have referred to the deceased as 'Mary' throughout my finding in accordance with the family's wishes unless more formality is required.

have been unexpected, unnatural or violent, or to have resulted directly or indirectly from accident or injury.

7. Coroners independently investigate reportable deaths to find, if possible, the identity, medical cause of death, and surrounding circumstances of the death. Cause of death in this context is accepted to mean the medical cause or mechanism of death. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death.

8. Under the Act, coroners have an additional role to reduce the number of preventable deaths and promote public health and safety by their findings, and by making comments and/or recommendations about any matter connected to the death they are investigating.

9. When a coroner examines the circumstances in which a person died, it is to determine causal factors and identify any systemic failures with a view to preventing, if possible, deaths from occurring in similar circumstances in the future. It is not the role of the coroner to lay or apportion blame, but to establish facts.[2]

Discretionary inquest

10. Pursuant to section 52(2)(b) of the Act, a coroner must hold an inquest into a death if the deceased was, immediately before death, a person placed in custody or care, and their death was not due to natural causes.[3]

11. The definition of a person placed in custody or care in section 3(1) of the Act includes 'a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health'. However, funding for disability services shifted from the Department of Families Fairness and Housing (**DFFH**) to the NDIS in 2019. This meant that deaths such as Mary's which occurred in residential

[2] See section 89(4) of the Act.
[3] Section 52(3A) of the Act states that an inquest into the death of a person who was, immediately before death, a person placed in custody or care is not mandatory if the coroner considers that the death was due to natural causes.

disability care facilities after 2019 were no longer captured by the Act as 'in care' deaths for coronial purposes.

12. More recently, on 11 October 2022, this lacuna in the legislation was rectified when amendments to the *Coroners Regulations 2019* came into effect. Sub-regulation 7(1)(d) provides that a person placed in custody or care now includes 'a person in Victoria who is an SDA resident residing in an SDA enrolled dwelling.[4] Mary would now likely meet the new definition of a person placed in custody or care.

13. For this reason, and to advance the legislative intention of section 52(2)(b) of the Act, I considered it appropriate that an inquest be held into Mary's death. A summary inquest was held on 27 November 2023 and no witnesses were called to give evidence.

Sources of evidence

14. The Victorian WorkCover Authority (**WorkSafe**) conducted an investigation into Mary's passing and provided me with a complete copy of the WorkSafe Investigation Brief (**WorkSafe Brief**). The NDIS Commission also reviewed Mary's passing and were satisfied that Yooralla acted quickly following the incident to implement appropriate changes at its facilities and therefore did not take any enforcement action against Yooralla in relation to this case.

15. Victoria Police assigned Senior Constable Michele De Felice (**SC De Felice**) to be the Coroner's Investigator for the investigation of Mary's death. SC De Felice conducted inquiries on my behalf and assisted me to obtain investigation materials from Yooralla and WorkSafe, as well as the forensic pathologist.

16. This finding draws on the totality of the coronial investigation and inquest into the death of Catherine Mary Reid. Whilst I have reviewed all the material, I will only refer to that

[4] 'SDA resident' has the same meaning as in the *Residential Tenancies Act 1997* (Vic) and captures a person who is an SDA recipient. 'SDA enrolled dwelling' also has the same meaning as in the *Residential Tenancies Act 1997* (Vic).

which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, the standard of proof applicable to findings is the balance of probabilities.[5]

BACKGROUND

17. Mary was diagnosed with post-polio syndrome following a severe poliomyelitis infection as a child. As a result, she suffered profound muscle weakness, had limited use of her arms and legs, and required assistance for mobilisation.

18. Mary lived a full life and worked tirelessly to improve the services and supports provided to people with disabilities. She was an instrumental advocate for the introduction of the *Disability Services Act 1986* (Cth), which sought to grant others like her greater agency and opportunities. Her work at the Australian Quadriplegics Association led to the launch of the QualCare Program which launched a state-wide respite care program for people with disabilities and their carers.

19. In 2006, Mary was awarded the Order of Australia Medal in recognition of her contributions to improving the health and wellbeing of people with disabilities.

20. Mary had been a respite user of VASS since it was first established in 2008. In 2019, she was diagnosed with Alzheimer's disease and began to experience increasing confusion, short-term memory loss and distress associated with dementia. The diagnosis of dementia meant that Mary required more support, and she became a permanent resident of VASS when funding was approved in 2019.

21. At the time of her death, Mary was receiving 1:1 supports during the day and up to 1:4 supports at night, requiring 24/7 supervision.

[5] 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

Circumstances in which the death occurred

22. On 11 December 2020, two Disability Support Workers (**DSW**) attended Mary's room at approximately 7.30 pm to assist with her bedtime routine. Mary was fitted with a four-point sling while in her wheelchair, which was affixed to a T-Bar ceiling hoist.

23. Mary was hoisted above her wheelchair over a bedpan for toileting, and then lowered onto the bedpan with the sling remaining in situ. Mary was then hoisted to remove the bedpan and undertake cleaning, before being lowered again into her wheelchair.

24. Once in her wheelchair, the sling and thoracic brace were removed in order to dress Mary in her nightgown. The DSWs then replaced the sling on Mary with a crossover between her legs, using the white loops for top and blue loops for legs in accordance with safe operating procedure.

25. One DSW was on Mary's left side, the other was on her right, between the wheelchair and bed to guide her transfer to bed. As the hoist began to raise, a DSW noticed that the leg section of the sling appeared to be caught on the wheelchair. The wheelchair was moved away from the sling and the lift was recommenced.

26. When Mary was approximately 30cm above the arm rest of the wheelchair, a DSW was guiding her towards the bed with one hand on her back and one hand on her leg at the sling crossover. Almost immediately, Mary's entire body weight was on worker, who fell down with Mary on top of her. She protected Mary's head during the fall, managing to land with Mary's head over her chest.

27. The DSWs activated the emergency response calling for Registered Nurse (**RN**) assistance. Two RNs attended immediately and arranged for an ambulance to be called. Mary remained coherent and was conversing with staff who continued to support her on the floor until Ambulance Victoria paramedics arrived.

28. At 7.45pm, Mary was transported to the Austin Hospital and admitted on the same day. Following assessment and imaging, she was diagnosed with the following injuries:

a) minimally displaced and impacted left neck of humerus fracture;

b) minimally displaced and impacted left femoral neck fracture;

c) likely un-displaced transcervical proximal right femoral neck fracture; and

d) bilateral sacral insufficiency fractures.

29. While in hospital, Mary's health began to gradually decline. She had a reduced ability to sit upright due to pain which required analgesia. Her oral intake slowly reduced throughout her admission, and she was unable to consistently achieve good intake. She became less engaged and interactive with attending clinicians and began to demonstrate a degree of agitation and delirium.

30. Mary slowly developed anaemia likely secondary to the multiple fractures. Following a discussion with her family, a decision was made to transition her to end of life care with the cessation of ventilation and administration of palliative medications.

31. Mary's loved ones attended to say goodbye in hospital and she sadly passed away with her sister present at 11.00am on 26 December 2020.

32. Yooralla entered a contemporaneous Comprehensive Incident Report (**CIR**)[6] to the RiskMan system[7] on 11 December 2020.

33. The mechanical hoist equipment used on 11 December 2020 was reviewed by both the equipment manufacturer and WorkSafe Investigators and was found to be in working order and compliant with manufacturing specifications.

[6] Exhibit 3, WorkSafe Brief.

[7] Yooralla uses a comprehensive incident management system called RiskMan to track and report incidents involving clients. All disability care providers under the NDIS Code of Conduct have obligations in relation to the management and reporting of client incidents and registered providers have additional responsibilities under the conditions of their registration.

Identity of the deceased

34. On 26 December 2020, Catherine Mary Reid born 12 September 1940, was visually identified by her sister, Margaret O'Leary.

35. Identity was not in dispute and required no further investigation.

Medical cause of death

36. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine conducted an external examination on 29 December 2020 and provided a written report of his findings dated 4 January 2021.

37. The examination showed findings in keeping with the reported history. Dr Bedford observed an irregular cervical spine, severe scoliosis, mild cerebral ventricular dilatation, and very osteoporotic bones. There was an apparent left femoral neck fracture, left humeral neck fracture, and left tibia/fibula fractures. There was also evidence of some coronary artery calcification.

38. Dr Bedford provided an opinion that the medical cause of death was *multiple injuries in the setting of a fall* and noted *polio* as a contributing factor.

39. I accept Dr Bedford's opinion as to medical cause of death.

FURTHER INVESTIGATIONS

Yooralla Practice Review

40. Yooralla completed a Practice Review (**Review**) in relation to Mary's death which was completed in March 2021. The Review comprehensively explored the falls incident and made multiple findings.

41. It was noted that staff involved in the incident were up to date with their Manual Handling Training.

42. The Review found that the DSWs did not recheck the position of the loops on the spreader bar after freeing the sling from the wheelchair arm prior to resuming the lift of Mary to transfer her to bed. While not conclusive, the Review noted that it is possible that the interruption to the transfer to free the sling from the wheelchair caused the loop to become incorrectly fitted on the left side of the spreader bar prior to recommencement of the transfer.

43. The Review also found that the distance between Mary's starting and finishing points during the transfer by hoist may have been just over one metre. Yooralla identified this as a factor not specifically addressed in its manual handling procedures and recognised the need to specifically outline the need to minimise the distance between two points of transfer in its manual handling procedures.

44. The Review also found that there was a need to find a suitable alternative mechanism to the hooks on the spreader bars used at VASS so that sling loops can be secured through a locking mechanism.

45. The Review made multiple recommendations for improvements in relation to the above findings. I have discussed the corrective actions taken by Yooralla following the incident later in this finding.

WorkSafe Investigation

46. On 18 December 2020, WorkSafe inspectors attended the VASS facility to conduct an inspection. Yooralla were cooperative with the WorkSafe Investigation and provided them with the CIS, training records of employees and relevant policies.

47. After reviewing these materials and having inspected the equipment involved in the incident, WorkSafe issued an Improvement Notice to Yooralla dated 5 February 2021. The Improvement Notice directed Yooralla to take measures to control the risks associated with the use of overhead ceiling hoists and required compliance by 21 March 2021.

48. In response, Yooralla provided WorkSafe with further information outlining the various improvements and changes implemented since Mary's passing. I have also outlined these improvements later in this finding.

49. Following its investigation, WorkSafe did not commence a prosecution against any party in relation to Mary's death as it determined that there did not appear to have been a breach of the *Occupational Health and Safety Act 2004*.[8]

IMPROVEMENTS MADE SINCE THE DEATH

50. Following completion of its own internal investigations, as well as the review by WorkSafe, Yooralla's Manual Handling Policies relating to the use of overhead hoists were modified to include instructions to staff that:

    a) they are to ensure that all straps of slings are connected to the hooks on the spreader bar and that the shoulder straps are of equal length; and

    b) they must recheck all four loop connections on the hooks as soon as there is tension on the connecting strap loops and at any time the hoisting movement is halted. Further, that the 'hoist lead' should call out a verbal "check" for each loop connection each time a recheck is required.

51. In accordance with the WorkSafe Improvement Notice, Yooralla commenced replacement of all hoists and spreader bars at VASS to those with a self-closing latch design soon after Mary's fall. By June 2021, Yooralla had replaced all existing overhead lifts with Likorall Overhead Lifts with self-closing latch design.

52. Further, throughout 2021, Yooralla implemented a Manual Handling education rollout at VASS in which staff were required to undertake a refresher course for manual handling, and further training on the use of overhead hoists and procedure for hoist transfers. By 30 June 2021, 100% of staff had completed the training.

[8] Correspondence dated 21 April 2022.

53. I am satisfied in these circumstances that Yooralla acted quickly following Mary's fall to address any areas for improvement and implement safer practices at the VASS facility. I am further satisfied that improvements made and changes implemented since this incident will prevent similar falls from occurring in the future.

FINDINGS AND CONCLUSION

54. Pursuant to section 67(1) of the Act I make the following findings:

    a) the identity of the deceased was Catherine Mary Reid, born 12 September 1940;

    b) the death occurred on 26 December 2020 at the Austin Hospital, 145 Studley Road, Heidelberg from 1(a) *multiple injuries in the setting of a fall;* Contributing Factors: *Polio*; and

    c) the death occurred in the circumstances described above.

55. Having considered all of the circumstances, I am satisfied that Mary's death was the result of a tragic accident. I am also satisfied that having considered the changes already implemented, no further prevention opportunities arise from the circumstances of her death.

56. I convey my sincere condolences to Mary's family and friends for their loss, and I acknowledge the sudden and traumatic circumstances in which her death occurred.

57. I further recognise Mary's tireless commitment to her advocacy work and the legacy of achievements and important improvements to Australia's disability support sector that she leaves behind. It is also clear that she lived an inspirational life, was a very much loved member of her family and is missed by all her knew her.

ORDERS

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

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

Margaret O'Leary, Senior Next of Kin

Yooralla, c/- Kirsty Brockwell, Minter Ellison

Austin Hospital, c/- Scott Gan

Senior Constable Michele De Felice, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date : 30 November 2023

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.