IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 005736

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Nickolaos Vlahos
Date of birth:	5 December 1928
Date of death:	27 October 2021
Cause of death:	1(a) Head and neck injuries sustained in a fall in a man with multiple co-morbidities
Place of death:	Hope Aged Care Brunswick 34 Lux Way, Brunswick, Victoria, 3056
Keywords:	Aged care, Falls prevention, Supervision

INTRODUCTION

1. On 27 October 2021, Nickolaos Vlahos was 92 years old when he passed away after a fall at the aged care facility where he was residing. He is survived by his children, Helen Nicola and Steven Vlahos and his grandchildren. At the time of his death, Mr Vlahos lived at Hope Aged Care in Brunswick.

BACKGROUND

2. Mr Vlahos' medical history included hypertension, chronic kidney disease, dementia with cognitive decline, diverticulitis, permanent pacemaker, and recurrent falls.

3. In February 2021, Mr Vlahos suffered a fall at home in which he sustained a chronic traumatic subdural haematoma.

4. On 14 May 2021, Mr Vlahos was discharged from Brunswick Private Hospital, where he was undergoing investigations for cognitive impairment and hallucinations. The following day, Mr Vlahos was admitted to the Royal Melbourne Hospital for abdominal pain and vomiting and he was treated for potential aspiration pneumonia.

5. On 25 May 2021, he was discharged from the Royal Melbourne Hospital to Hope Aged Care, where his wife also resided. Prior to his admission, Mr Vlahos lived independently at home with support from his children and mobilised with the assistance of a four-wheeled frame or walker. He was also his wife's carer prior to her admission to the facility. Mrs Vlahos passed away on 12 June 2021.

6. At the time of his admission to Hope Aged Care, Mr Vlahos was assessed and categorised as a high falls risk. He was recorded as requiring half-hourly observations due to his increased falls risk and known impulsivity.

7. Mr Vlahos had six falls while he was a resident at Hope Aged Care. The falls occurred in his bedroom and bathroom. He spent six days in the Austin Hospital in August 2021 after the third fall in which he sustained a head injury and fractured ribs.[1]

[1] Letter from Helen Nicola to the Coroners Court of Victoria dated 15 November 2021; Statement from Anupama Dahal dated 21 February 2022; Medical records, North Reservoir Medical Centre.

THE CORONIAL INVESTIGATION

8. Mr Vlahos' 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.

9. 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.

10. 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.

11. Evidence has been obtained from Hope Aged Care, the forensic pathologist and Mr Vlahos' General practitioner.

12. On 28 July 2022, Helen submitted a request for an inquest into her father's death.[2] A mention hearing was held on 12 December 2022 to discuss the progress and limitations of the investigation. On 15 February 2023, I determined that it was not necessary to hold an inquest.[3]

13. This finding draws on the totality of the coronial investigation into the death of Mr Vlahos including the evidence referred to in the above paragraph. While 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.[4]

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[2] Form 26, Request for Inquest into Death dated 28 July 2022.

[3] Form 28, Decision by Coroner whether an Inquest will be held into Death dated 15 February 2023.

[4] 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

14. On 27 October 2021, Helen and her daughter visited Mr Vlahos in his room while he had his lunch. They then helped him into bed where they left him sleeping at around 1.45pm.[5]

15. On the afternoon of 27 October 2021, Mr Vlahos was transferred by staff from his room to the dining area and seated for afternoon tea. His was walker was placed next to his chair. The Clinical Care Coordinator at Hope Aged Care stated that Mr Vlahos was encouraged to come out of his room to socialise and attend lifestyle activities and that he required supervision during mealtimes.

16. CCTV footage from the facility revealed that at approximately 3.40pm, Mr Vlahos left the dining room, undetected and without the assistance of staff or his walker and returned to his bedroom.

17. At approximately 3.56pm, realising that Mr Vlahos was no longer in the dining room, staff checked his room and found him on the floor of his bathroom, unresponsive and with a visible head injury. The Registered Nurse on duty was notified and arrived shortly afterwards. On assessment, the Registered Nurse found that he was not breathing and they were unable to detect a pulse. Emergency services were contacted, and Victoria Police and Ambulance Victoria paramedics arrived a short time later. Responding paramedics were unable to find signs of life and pronounced Mr Vlahos deceased at 5.00pm.[6]

Identity of the deceased

18. On 27 October 2021, Nickolaos Vlahos, born 5 December 1928, was visually identified by his daughter, Helen Nicola.

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

[5] Letter from Helen Nicola to the Coroners Court of Victoria dated 15 November 2021.
[6] Statement from Anupama Dahal dated 21 February 2022; Statement from Anupama Dahal dated 5 April 2022; CCTV footage from Hope Aged Care.

Medical cause of death

20. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine conducted an examination on 28 October 2021 and provided a written report of her findings dated 21 February 2022.

21. A post-mortem CT scan of Mr Vlahos' body identified fractures to the left side of his head and orbit, and to the second cervical vertebra with dislocation.

22. Toxicological analysis of post-mortem samples identified the presence of a number of clinically indicated drugs in therapeutic concentrations.

23. Dr Fronczek provided an opinion that the medical cause of death was 1 (a) Head and neck injuries sustained in a fall in a man with multiple co-morbidities.

24. I accept Dr Fronczek's opinion.

FAMILY CONCERNS

25. On 15 November 2021, Helen submitted written concerns to the Court on behalf of herself and Steven in relation to the care their father received at Hope Aged Care. In particular, they expressed concerns that their father, who had suffered multiple falls in the four months prior to his death and was assessed as requiring staff assistance for mobilising, was not adequately supervised at the facility and was able to leave the dining room unassisted. Helen also stated that their father's slow and unsteady walking when unassisted should have attracted staff attention. Helen reiterated her concerns regarding staff supervision in her request for an inquest.

26. On 27 April 2022, the Court wrote to Hope Aged Care advising that, after reviewing the evidence, I had formed the view that Mr Vlahos was not adequately supervised by staff during his afternoon tea on 27 October 2021. They were provided with an opportunity to respond to this proposed finding.

27. Mills Oakley, on behalf of Hope Aged Care, provided submissions in response to my proposed finding as to lack of supervision in the dining room on 27 October 2021 and also in response to Helen's request for an inquest.[7]

[7] Letters from Mills Oakley to the Coroners Court of Victoria dated 20 June 2022 and 26 August 2022.

28. Mills Oakley submitted that it was not open on the evidence for me to find that Mr Vlahos' supervision by staff was inadequate. They further submitted that the responsibility of staff to monitor Mr Vlahos every half-hour did not extend to one-on-one monitoring or to monitoring every entry or departure from the dining area. Further, they submitted that there was no indication Mr Vlahos required a higher level or frequency of supervision during mealtimes than the existing collective staff monitoring.

29. With respect to the forensic pathologist's findings, Mills Oakley submitted that Mr Vlahos' cause of death was likely due to natural causes, having regard to his pre-existing medical conditions and highlighted that the report of the forensic pathologist did not set out the cause of any such fall.

30. The matters raised by Helen are clearly relevant to the quality of the care her father received at Hope Aged Care. However, some of them are too remote from his death to be considered by me in this investigation. It is open for Helen to raise those matters with other bodies such as the Aged Care Quality and Safety Commission.

31. Governed by the statutory limitations, I have limited the scope of my review of the care provided by Hope Aged Care to the circumstances in which Mr Vlahos left the dining room on 27 October 2021 and returned to his room where he was subsequently found unresponsive.

REVIEW OF CARE

32. Mr Vlahos was appropriately assessed as a high falls risk upon his admission to Hope Aged Care using the Falls Risk Assessment Tool. The assessment was updated throughout his stay to account for the circumstances of the falls he had experienced. A number of mitigating strategies had been put in place to manage his risk, including half hourly observations by staff, a sensor mat next to his bed, a call bell within reach of the bed, use of non-slip shoes and the use of a walker when mobilising. Further, it was recorded that he required supervision for transfers and mobilising and during mealtimes.[8]

33. I consider that the falls prevention policies and the mitigation strategies in place for Vlahos were appropriate and reasonable in the circumstances and balanced the management of risk with the maintenance of dignity and independence.

[8] Incident Form; Falls/Safety Assessment; Progress notes; Statements from Anupama Dahal dated 21 February and 5 April 2022

34. The requirement of Mr Vlahos to be supervised during mealtimes was in addition to the requirement that he be subject to half hourly observations. However, I accept that there could be overlap of the requirements when Mr Vlahos was in the dining room.

35. I am not persuaded by the submission of Hope Aged Care that it is not open on the evidence for me to find that Mr Vlahos' supervision by staff in the dining room was inadequate. Hope Aged Care state that supervision of Mr Vlahos during mealtimes is collective staff monitoring and not on-on-one monitoring. I consider that this level of supervision is reasonable in the circumstances; however, it is clear that on 27 October 2021, Mr Vlahos was able to stand up and leave the dining room without his walker and return to his bedroom unassisted. He was able to do this notwithstanding that he was assessed as a high falls risk and required a walker to mobilise, required supervision for transfers, mobilising and during mealtimes, and was impulsive.

36. I consider that an adequate level of collective supervision in the dining room would have alerted staff to Mr Vlahos' movements and provided an opportunity for intervention. If staff had observed Mr Vlahos when he stood up from his table and left the dining room, they would have been able to arrange for him to be assisted to his room and to go to the toilet if necessary. I do not consider that this intervention would have necessarily prevented Mr Vlahos' death given his history of falls, impulsive behaviour and co-morbidities, but it is a matter sufficiently connected with the circumstances of his death to be included in this investigation.

37. I am also unpersuaded by the submission of Hope Aged Care that Mr Vlahos's death was likely due to natural causes. The opinion of Dr Fronczek, which I accept, is that Mr Vlahos died from the injuries (including a fractured skull and cervical vertebra) he sustained in the fall on 27 October 2021. They have adduced no evidence to challenge this opinion.

FINDINGS AND CONCLUSION

38. I find that Mr Vlahos was not adequately supervised by staff in the dining room at Hope Aged Care on 27 October 2021.

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

    a) the identity of the deceased was Nickolaos Vlahos, born 5 December 1928;

b) the death occurred on 27 October 2021 at Hope Aged Care Brunswick 34 Lux Way, Brunswick, Victoria, 3056, from Head and neck injuries sustained in a fall in a man with multiple co-morbidities; and

c) the death occurred in the circumstances described above.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) Hope Aged Care review its staffing arrangements in its dining rooms to ensure that there is adequate supervision of residents during mealtimes.

I convey my sincere condolences to Mr Vlahos's family for their loss.

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:

Helen Nicola, Senior Next of Kin

Hope Aged Care, c/- Mills Oakley

Constable Mathew Perta, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 15 May 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.