IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 004213

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Heather Amy Robertson
Date of birth:	9 August 1938
Date of death:	28 July 2022
Cause of death:	1(a) Complications arising from a fall with C2 fracture and neck of femur fracture
Place of death:	Northern Hospital, 185 Cooper Street, Epping, Victoria, 3076
Keywords:	Aged care, Falls prevention, Supervision

INTRODUCTION

1. On 28 July 2022, Heather Amy Robertson was 83 years old when she passed away at the Northern Hospital. At the time of her death, she lived in an aged care facility in Greensborough. She is survived by her husband, Ivon Robertson, and her children, Owen and Melita.

BACKGROUND

2. Mrs Robertson's medical history included Alzeimer's and vascular dementia, chronic fatigue syndrome, chronic hip pain and anxiety/panic disorder. She resided at Trinity Manor, an aged care facility in Greensborough.

3. Mrs Robertson suffered a fall on 3 November 2021 and broke her left neck of femur. After this fall, she was not able to ambulate without assistance.[1]

THE CORONIAL INVESTIGATION

4. Mrs Robertson'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.

5. 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.

6. 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.

[1] Statement of Carolyn Simpson, undated; Trinity Manor progress notes.

7. This finding draws on the totality of the coronial investigation into Mrs Robertson's death, including statements and other evidence obtained from the aged care facility where she resided. 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.[2]

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

Circumstances in which the death occurred

8. On 23 July 2022, Mrs Robertson was assisted by staff to a table in the dining room where she had her dinner. At around 5.30pm, after she had finished her dinner, Mrs Robertson stood up and walked into an adjoining lounge area before losing her balance and falling to the ground.

9. The dining room was supervised by two staff members but they did not observe Mrs Robertson getting up from the table and walking into the adjoining lounge area where she fell as they were assisting another resident and had left the dining room. The CCTV footage discloses that the staff were absent from the dining room for about 7 minutes.[3]

10. Shortly after her fall, staff located Mrs Robertson and contacted nursing staff, who provided appropriate medical care. An ambulance was subsequently called which transferred Mrs Robertson to the Northern Hospital where she was found to have sustained a fracture of the vertebrae and right neck of femur. She did not recover from her injuries and was managed conservatively. In consultation with her family, Mrs Robertson was referred to palliative care and passed away on 28 July 2022.[4]

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[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] Statement of Carolyn Simpson, undated; Trinity Manor progress notes.

[4] Medical Deposition dated 28 July 2022; Incident report dated 23 July 2022.

Identity of the deceased

11. On 28 July 2022, Heather Amy Robertson, born 9 August 1938, was visually identified by her husband, Ivon Robertson.

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

Medical cause of death

13. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine conducted an examination on 1 August 2022 and provided a written report of his findings dated 12 August 2022.

14. A post-mortem computed tomography (**CT**) scan revealed a right neck of femur fracture and C2 vertebral fracture but no intracranial haemorrhage.

15. Dr Beer provided an opinion that the medical cause of death was 1 (a) Complications arising from a fall with C2 fracture and neck of femur fracture.

16. I accept Dr Beer's opinion.

REVIEW OF CARE

17. A statement was obtained from Trinity Manor which set out the circumstances of the incident and the policies and procedures in place relating to falls prevention. I am satisfied that Trinity Manor had reasonable and appropriate falls prevention strategies in place to address Mrs Robertson's risk profile, which were consistent with their policies and procedures.

18. Mrs Robertson required assistance whenever she was ambulating and also during mealtimes.[5] There was a previous incident on 3 January 2022, where Mrs Robertson suffered an injury to her leg when she attempted to get up from her chair while sitting in the dining room. The progress notes relating to this incident record that "*close supervision*" of Mrs Robertson to "*prevent future incidents*".[6]

[5] Functional assessment dated 18 June 2022.
[6] Trinity Manor progress notes, p 71.

19. The Catering Policy in place at Trinity Manor provides that "*There should be a care staff member in the dining room at all times when residents are dining to monitor residents and to provide assistance as required*".[7]

FINDINGS AND CONCLUSION

20. Mrs Robertson was not being adequately supervised by staff when she was in the dining room at her aged care facility on 23 July 2022. As a result of this lack of supervision, Mrs Robertson was able to get up from her chair and leave the dining room unnoticed and walk unaided to an adjoining lounge area, where she lost her balance and fell.

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

    a) the identity of the deceased was Heather Amy Robertson, born 9 August 1938;

    b) the death occurred on 28 July 2022 at Northern Hospital, 185 Cooper Street, Epping, Victoria, from complications arising from a fall with C2 fracture and neck of femur fracture; 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) that Trinity Manor 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 Mrs Robertson'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.

[7] Trinity Manor Catering Policy Process 26.0, p 6.

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

Ivon Robertson, Senior Next of Kin

Director of Clinical Governance, Trinity Manor

Constable Olivia Lawrie, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 16 January 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.