IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005105

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Lorraine Joy Wight
Date of birth:	6 August 1946
Date of death:	12 September 2023
Cause of death:	1a: Airways obstruction by tissue paper
Place of death:	Kirralee Aged Care 207 Richards Street Ballarat East Victoria 3350

INTRODUCTION

1. On 12 September 2023, Lorraine Joy Wight was 77 years old when she was found deceased in her room. At the time of her death, Lorraine lived at Calvary Kirralee Aged Care ("Kirralee") in Ballarat East.

2. Lorraine had been previously married and divorced, and prior to her admission to Kirralee lived in Ballarat with her son, Raphael. She had a 17-year career as a nurse and in her spare time enjoyed gardening and watching AFL.

3. Lorraine's medical history included osteoarthritis, osteoporosis, gastro-oesophageal reflux disease, chronic pain, thyroid issues and hypertension. She also had a long history of depression, anxiety and behavioural problems.

4. Lorraine was admitted to Kirralee on 18 May 2017 following several admissions to Ballarat Health Services for decreased mobility and functional decline.

5. Within months of her admission to care, Lorraine's mobility had decreased significantly with no identifiable cause, and as such she preferred to stay in bed at all times.

6. Lorraine's general practitioner, Dr Sally McAleese, saw her every two weeks to monitor her medications and her depression and anxiety. According to Dr McAleese, Lorraine often exhibited challenging drug-seeking behaviour.

7. Lorraine's Behaviour Support Plan noted her drug-seeking behaviour, and stated that she exhibited inappropriate behaviours, including *verbal disruption, demonstrated by calling out, verbally combative, argumentative, abusive, upsetting staff, co-residents and interrupting other residents from her room,* which could be attributed to her diagnoses of depression and anxiety and impaired mobility, low mood, fear and boredom. The plan further noted that she lacked insight into her abilities and limitations and liked to maintain control.

THE CORONIAL INVESTIGATION

8. Lorraine'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.

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. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Lorraine's death. The Coronial 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.

12. This finding draws on the totality of the coronial investigation into the death of Lorraine Joy Wight 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.[1]

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

Circumstances in which the death occurred

13. On 5 September 2023, Lorraine told a staff member "I am going to throw myself on the floor". The staff member lowered her bed, removed the remote and notified the Registered Nurse (**RN**) in charge.

14. Lorraine had an unwitnessed fall on the morning of 6 September 2023. She told the attending RN that she "wanted to have a fall" because she was "sick of everything" but it "didn't work this time so I won't try it again". Lorraine was commenced on half-hourly supervision and a 7-day behaviour chart.

15. The Clinical Care Coordinator (**CCC**) emailed Dr McAleese regarding Lorraine's self-harm ideations, with Dr McAleese to review her on the next visit. Dr McAleese agreed with the

[1] 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.

plan of half-hourly observations and a behaviour chart. The CCC then completed relevant assessments with Lorraine including a Psychogeriatric Assessment Scale.

16. On 7 September 2023 Lorraine was asked if she was still suicidal, to which she responded "sort of".

17. On the evening of 7 September 2023, it was documented on Lorraine's behaviour chart that she had asked staff to "give her a bullet". It is unclear whether this was escalated to the RN in charge.

18. At around 3am on 11 September 2023, staff checked on Lorraine and found her with a lump of tissues in her mouth. She told them she was "cleaning her mouth". Staff removed all tissues from her room and recorded the incident in her progress notes. That evening, Lorraine told staff that she didn't succeed in what she wanted to do, which was to die, because the staff wouldn't let her.

19. Lorraine was noted to appear normal on 12 September 2023. She was last seen at 6:50pm by a staff member who delivered ice-cream as requested by Lorraine.

20. At 7:10pm, a PCW found Lorraine unresponsive with her mouth full of tissues. A Registered Nurse immediately assessed her and confirmed that she was deceased. Emergency services were called.

Identity of the deceased

21. On 22 September 2023, Lorraine Joy Wight, born 6 August 1946, was visually identified by her son, Raphael Wight, who completed a Statement of Identification.

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

Medical cause of death

23. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Lorraine Wight on 13 September 2023. Dr Archer considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan and VIFM contact log and provided a written report of her findings dated 3 October 2023.

24. Examination of the post mortem CT scan showed a relatively clear airway with a small amount of radio-opaque material in the larynx and in the mouth. Material was also seen in the oesophagus from the larynx to the stomach.

25. The external examination showed a tissue in the back of the oral cavity in a position that could potentially cause airways obstruction. Further tissue material was noted over the tongue.

26. There was no evidence of any injuries that could have caused or contributed to death, and no other remarkable features.

27. Toxicological analysis of post mortem blood samples identified the presence of oxycodone, duloxetine, mirtazapine and paracetamol, which Dr Archer commented was mostly in keeping with therapeutic use.

28. Dr Archer provided an opinion that the medical cause of death was 1(a) AIRWAYS OBSTRUCTION BY TISSUE PAPER.

INVESTIGATION OF INCIDENT

29. Calvary completed a Serious Clinical Incident Investigation following Lorraine's death, which noted that *whilst there were multiple attempts made by staff to mitigate risk, in hindsight these were inadequate. A hospital admission or formal mental health review was required.*

30. The investigation identified the following contributing/causal factors:

    a) Absence of policy for the deteriorating mental health of a resident resulted in no clear process of escalation.

    b) Multiple points of communication failure including no Riskman for suicide attempts, items not captured in handover and absence of resident Risk in Home Managers stand-up meeting notes impacted escalation of Lorraine's care.

    c) As a result of communication failure, an absence of policy guidance and because access to service is limited, no referral was made to mental health.

31. The investigation team considered that Lorraine required a mental health review, however acknowledged that access to mental health services was limited and unless staff had been able to communicate a clear high risk, Lorraine would not have received an assessment and interventions within a timeframe to prevent the fatal incident.

32. Calvary implemented several measures to address the shortcomings identified by the investigation, including the development and implementation of a National Aged Care Deteriorating Mental Health policy, review and update of handover sheets, Mental Health First Aid training for staff, and 'Toolbox' sessions on supporting residents with changed behaviours and risky actions, and when to escalate behaviours to the registered nurses and clinical care coordinator.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Lorraine Joy Wight, born 6 August 1946;

   b) the death occurred on 12 September 2023 at Kirralee Aged Care, 207 Richards Street, Ballarat East, Victoria 3350;

   c) I accept and adopt the medical cause of death ascribed by Dr Melanie Archer and I find that Lorraine Joy Wight died from airway obstruction by tissue paper, in circumstances where I find she intended to take her own life;

2. AND, I consider that the response of Calvary to the incident, including the investigation, has sufficiently identified the shortcomings in care that may have contributed to the circumstances of Lorraine Joy Wight's death, and that the preventative measures implemented are appropriate such that I do not need to make pertinent recommendations.

3. AND FURTHER, the evidence available to me does not enable me to make a finding as to the precipitating factor/s that influenced Lorraine Joy Wight to adopt the course of action she ultimately chose.

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

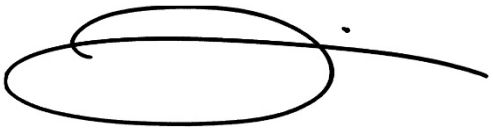
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Raphael Wight, Senior Next of Kin

Leading Senior Constable Jamie Bennett, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 21 May 2025

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.