IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 003534

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Nazlou (Helen) Danilidis
Date of birth:	20 May 1930
Date of death:	25 June 2024
Cause of death:	1a : COMPLICATIONS OF A FRACTURED NECK OF FEMUR SUSTAINED IN AN UNWITNESSED IN-HOSPITAL FALL 2 : VALVULAR HEART DISEASE, PULMONARY HYPERTENSION, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Place of death:	Northern Hospital 185 Cooper Street Epping Victoria 3076

INTRODUCTION

1. On 25 June 2024, Nazlou (Helen) Danilidis was 94 years old when died whilst she was an admitted patient at the Northern Hospital. Prior to her death, Nazlou lived at 4 Keller Close, Greenvale, Victoria, 3059 with her son, Conrad Danilidis.

2. Nazlou had a reported past medical history that included hypertension, congestive heart failure, pleural effusion and severe aortic stenosis. Nazlou utilised oxygen at home with Conrad prior to developing worsening dyspnoea and severe breathing difficulties.

THE CORONIAL INVESTIGATION

3. Nazlou'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.

4. 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.

5. 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.

6. Victoria Police assigned Senior Constable Benjamin Farrugia to be the Coronial Investigator for the investigation of Nazlou'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.

7. This finding draws on the totality of the coronial investigation into the death of Nazlou (Helen) Danilidis 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]

8. In considering the issues associated with this finding, I have been mindful of Nazlou's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

9. On 10 June 2024, Nazlou presented to Northern Hospital in Epping with worsening dyspnoea causing shortness of breath symptoms.[2] Nazlou was admitted for treatment and on 20 June 2024, she was identified as a 'high falls risk' due to onset confusion with her surroundings and a falls risk mitigation strategy was employed by hospital staff. The strategy included:[3]

    a) A wireless Curbell sensor alarm mat[4] placed on her bed;

    b) A bed next to the nurse's station;

    c) Hourly rounding supervision;[5] and

    d) A Lowlow bed was considered but not used as Nazlou was not deemed to be impulsive.

10. Between 21 and 22 June 2024, Nazlou was observed to be agitated and in pain and was administered lorazepam and oxycodone to relieve these symptoms. Nazlou received oxygen therapy for hypoxia[6] but would often remove the therapy.[7]

11. On 22 June 2024, at about 11.00 pm, Nazlou was found by nursing staff in her bathroom sitting on the floor by the sink. Nazlou's oxygen saturation was very low and it appeared that

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[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.

[2] *Coronial Brief*, Statement of Lisa Cox dated 21 October 2024.

[3] Ibid.

[4] https://curbellmedical.com/bed-and-chair-sensor-pads/ accessed on 13 November 2024

[5] Intentional rounding is the structured process whereby nurses in hospitals carry out regular checks, usually hourly, with patients using a standardised protocol to address issues of positioning, pain, personal needs and placement of items.

[6] Hypoxia causes a reduction of oxygen supply to a tissue below physiological levels despite adequate perfusion of the tissue by blood.

[7] *Coronial Brief*, Statement of Lisa Cox dated 21 October 2024.

her sensor mat did not alarm when she had left the bed.[8] Nazlou was reported to have complained of left wrist and left hip pain. Nazlou was later found to have a fractured left femur and was assessed as not fit for surgery due to her comorbidities and transferred to palliative care. Nazlou passed away on 25 June 2024 at 2.00 am.[9]

Identity of the deceased

12. On 25 June 2024, Nazlou (Helen) Danilidis, born 20 May 1930, was visually identified by their son, Conrad James Danilidis.

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

Medical cause of death

14. Forensic Pathologist Dr Hans De Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 27 June 2024 and provided a written report of his findings dated 9 July 2024.

15. The post-mortem examination findings were consistent with the reported circumstances.

16. Post-mortem CT scans evidenced fractures of the left neck, bilateral large pleural effusions, bilateral lung consolidations, calcifications of the coronary artery, aortic valve and mitral valve, pericardial effusion and cholelithiasis.

17. Dr De Boer provided an opinion that the medical cause of death was 1(a) complications of a fractured neck of femur sustained in an unwitnessed in-hospital fall in the setting of valvular heart disease, pulmonary hypertension, chronic obstructive pulmonary disease, atherosclerotic cardiovascular disease and I accept Dr De Boer's opinion.

FAMILY CONCERNS

18. In her email to the court dated 27 June 2024, Nazlou's daughter, Patricia Golby, expressed the following concerns:

    a) Patricia had been visiting Nazlou whilst at Northern Hospital and had concerns with the adequacy of staff monitoring for falls risks and that the sensor mat to detect falls was not activated at the time of the fatal incident; and

[8] Ibid.
[9] Ibid.

b) If the sensor mat was working, why no one attended to assist Nazlou?

19. I have considered the above concerns noted by Nazlou's family in my investigation and acknowledge that they required further investigation by the Court.

CPU REVIEW

20. As a result of receiving the family's concerns relating to medical care and management of Nazlou's falls risk, I referred her case to the independent practitioners in the Health and Medical Investigation Team of the Coroners Prevention Unit (**CPU**)[10] to review the medical care Nazlou received at Northern Hospital.

21. To gain a fuller picture of Nazlou's clinical course, I directed that further information be obtained from Northern Health, and the Court subsequently received an additional statement from Lisa Cox, Chief Nursing and Midwifery Officer, Northern Health.

22. Ms Cox's statement confirmed that a falls structured clinical incident review was undertaken after Nazlou's death and the review identified that:[11]

> *Interventions in place could have been better documented in the EMR, however a lowlow bed was considered and not indicated.*
>
> *Ms Danilidis was placed close to the nurse's station and falls sensor mat was in place on the day of the fall. It is noted that the sensor mat alarm did not activate despite being found to be operational before and after the incident. Northern Health can only speculate as to why the alarm was not activated, and speculates that it may have been due to positioning of the mat.*
>
> *Rounding was not documented as complete prior to the fall. It is unclear if the patient was asked if she needed to use the toilet.*
>
> *The patient had six bed moves during her hospital stay, which may have contributed to her increased confusion and disorientation.*

23. On review of Nazlou's relevant medical records and assessments, the CPU observed that there appeared to be a heavy reliance in the circumstances of Nazlou's care on electronic

[10] 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.

[11] *Coronial Brief*, Statement of Lisa Cox dated 21 October 2024.

surveillance and that rounding and toileting were not adequately documented. The CPU formed the view that the falls management interventions implemented at the time of the fatal incident failed to prevent Nazlou from walking to the toilet on her own, falling and fracturing her femur. The incident review appears to address the major of the issues identified in this case including the following recommendations:

The recommendations arising from this incident have been completed, namely, that the NUM and CNE to highlight the following – via huddles and email to nursing staff;

• placing sensor mats according to manufacture guidelines

• to implement and document purposeful rounding on every shift

• completion of all risk screening assessments including delirium and cognitive impairment on EMR on every shift

• Where possible to limit bed moves for patients over 65 with increased confusion, as this increases their risk of falls. [12]

FINDINGS AND CONCLUSION

24. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[13] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was Nazlou (Helen) Danilidis, born 20 May 1930;

[12] Ibid.

[13] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

b) the death occurred on 25 June 2024 at Northern Hospital, 185 Cooper Street, Epping, Victoria, 3076, 1(a) complications of a fractured neck of femur sustained in an unwitnessed in-hospital fall in the setting of 2 valvular heart disease, pulmonary hypertension, chronic obstructive pulmonary disease, atherosclerotic cardiovascular disease; and

c) the death occurred in the circumstances described above.

26. Having considered all of the evidence, I am satisfied that in the lead up to the fatal incident, Nazlou was in an unfamiliar environment, with confusion arising from medications to manage her pain and anxiety, and hypoxia from heart and lung failure. I find that whilst Northern Hospital implemented falls management interventions, these failed to prevent Ms Danilidis walking to the toilet on her own, falling and fracturing her femur.

27. I further find that whilst the available evidence indicates that Nazlou was on a palliative trajectory prior to her fall, her death was likely hastened by the fracture of her femur. I find that the falls management interventions were inadequate in the circumstances of this case and other strategies such as delirium assessment and appropriate supervision should have been implemented to reduce the risk of a patient falling.

RECOMMENDATIONS

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

(i) I recommend that Northern Health review their relevant falls risk mitigation strategies (including relevant policies and procedures) and ensure that the use of any sensor mat alarms require not only proper placement and positioning but should be tested to ensure activation and alarms are operational before implementation with a patient.

I convey my sincere condolences to Nazlou'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:

Patricia Goldby, Senior Next of Kin

Klara Pauls, Northern Health

Senior Constable Benjamin Farrugia, Coronial Investigator

Signature:

Coroner Simon McGregor

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.