IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 000607

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: Edna May PULLEN

Delivered On:	8 October 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing Dates:	13 February 2014
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Ms D.E.FOY of Counsel, instructed by Ms S. Allen of Eastern Health, appeared on behalf of Eastern Health. Ms A. M. SHEEHAN of Counsel, instructed by S. Mouton of McCraken & McCracken, appeared on behalf of Debra Clements. Mr D. LEGGATT of DLA Piper, appeared on behalf of Ms Amy Lipow. Ms A. L. Wood, instructed by Ms P. Chatfield of St Vincent's Health, appeared on behalf of St Vincent's Hospital.
Police Coronial Support Unit	Leading Senior Constable K. RAMSEY, assisting the Coroner

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of EDNA MAY PULLEN

and having held an inquest in relation to this death at Melbourne

on 13 FEBRUARY 2014

find that the identity of the deceased was EDNA MAY PULLEN

born on 17 May 1918, aged 93

and that the death occurred on 13 February 2012

at St Vincent's Hospital, Victoria Parade, Fitzroy, Victoria 3065

from:

I (a) SUBDURAL HAEMORRHAGE IN THE SETTING OF A FALL (PALLIATED)

in the following circumstances:

BACKGROUND AND PERSONAL CIRCUMSTANCES[1]

1. Edna Pullen was a 93-year-old widow who lived independently at Ringwood Retirement Village. Her medical history included breast and bowel cancer, bowel obstruction, right elbow and hip fractures, right extensor tendon injury, vasovagal episodes, bilateral hearing loss and hypertension.[2] For all these medical issues, Mrs Pullen was cognitively intact, mobile and able to attend to most activities of daily living without assistance, although her daughter, Debra Clements, had arranged a meals on wheels service three times per week and weekly assistance with laundry and cleaning through the local council.[3]

2. While shopping with her daughter on 24 November 2011, Mrs Pullen fell and struck her head.[4] She was taken initially to Maroondah Hospital where a subdural haematoma was diagnosed and then transferred to St Vincent's Hospital [St Vincent's] for a craniotomy and evacuation of the haematoma. There were no intra-operative complications; however, Mrs

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[1] This section is a summary of facts that were uncontentious, and provide a context for those circumstances that were contentious and will be discussed in some detail below.

[2] E-Medical Deposition Form completed by Dr S. Rasiah on 14 February 2012.

[3] Exhibit A.

[4] Exhibit A.

Pullen's admission was complicated by a vasovagal episode, hyponatraemia, anaemia and a urinary tract infection.[5]

3. On 13 December 2011, after her medical conditions stabilised, Mrs Pullen was transferred to St George's Hospital[6] [St George's] for rehabilitation. However, on 3 January 2012, she developed constipation and abdominal distension and was transferred back to St Vincent's for treatment. Although Mrs Pullen's constipation resolved, her admission was complicated by a syncopal/pre-syncopal episode, supra-ventricular tachycardia [SVT] and postural hypotension. Once stabilised, she had no further episodes of SVT and, on 9 January 2012, was returned to St George's.[7]

4. Mrs Pullen's physical rehabilitation at St George's proceeded well. With the assistance of a physiotherapist, she regained much of her functional independence so that by late January 2012 she was able to walk 150 metres using a four-wheeled frame [4WF] and could transfer to and from a chair and manage steps independently.[8] Mrs Pullen was keen to be discharged home but was somewhat anxious about how she would cope.[9]

5. On 19 January 2012, as part of the planning for her discharge, Mrs Pullen underwent an Aged Care Assessment conducted by St Vincent's Aged Care Service, to determine her post-discharge support needs and her eligibility for government funding. Mrs Pullen was deemed eligible to receive transitional care provided by nursing and allied health professionals in her local area.[10] Accordingly, on 20 January 2012, St George's referred Mrs Pullen to the Eastern Health Transition Care Program [TCP] for case management, care and restorative services.[11]

6. On 24 January 2012 at St George's, there was a family meeting attended by Mrs Pullen, Mrs Clements, Eastern Health TCP Case Manager, Lorraine Anderson, and St George's

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[5] E-Medical Deposition Form completed by Dr S. Rasiah on 14 February 2012.

[6] St George's Hospital operates under the auspices of St Vincent's Health.

[7] E-Medical Deposition Form completed by Dr S. Rasiah on 14 February 2012.

[8] Exhibit K (Coronial Brief of Evidence, Discharge Summary Physiotherapy dated 1/2/12).

[9] Exhibit K (Coronial Brief of Evidence, St Vincent's GEM & Rehabilitation Discharge Summary dated 1/2/12).

[10] Exhibit K (Coronial Brief of Evidence, Aged Care Client Record dated 19/01/2012). Mrs Pullen was in receipt of a Home and Community Care package prior to her hospitalisation.

[11] As its name suggests, Transition Care Program is designed to be in place for a finite period post-discharge and is aimed at assisting older people to achieve further functional improvement, increased independence and to live safely in their preferred environment [see Exhibit D].

Occupational Therapist,[12] Amy Lipow,[13] where Mrs Pullen's TCP Care Plan[14] was discussed and agreed.

7. During the meeting, Mrs Clements raised concerns about her mother's ability to enter her home independently[15] and so Ms Lipow determined that a home assessment was indicated and arranged for one to occur prior to Mrs Pullen's anticipated discharge on 1 February 2012. The home assessment was conducted on 31 January 2012 and, following Ms Lipow's favourable report to the treatment team and Ms Anderson, Mrs Pullen was discharged on schedule.[16]

CIRCUMSTANCES PROXIMATE TO DEATH

8. At bout 11am on 1 February 2012, Mrs Clements collected her mother from St George's. On the way to Mrs Pullen's home, they went to the McDonald's drive-through, shopping for shoes and to a podiatry appointment scheduled by TCP.[17]

9. On arrival at her mother's unit, Mrs Clements unlocked the doors and went inside to open curtains and turn on lights. While entering her home, using a four wheel frame [4WF] Mrs Pullen tripped and fell backwards, striking her head wound. Emergency services were called and Mrs Pullen was transported by ambulance to St Vincent's.[18]

10. At St Vincent's, a subdural haematoma was diagnosed. Initially, after discussions between the neurosurgical registrar and her family, Mrs Pullen was managed non-surgically and a Not For Resuscitation order was put in place. However, with some improvement in her condition,

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[12] Two occupational therapists (one unnamed) attended the family meeting, or part thereof, however only Ms Lipow's involvement is relevant to this investigation [see Exhibits D & G].

[13] Ms Lipow was only present for part of the family meeting. She was called into it after Mrs Clements raised concerns about Mrs Pullen's access and egress to her home.

[14] TCP services and policies were discussed along with Mrs Pullen's needs. TCP would coordinate the provision of the following services upon Mrs Pullen's discharge home: personal care three times per week for 1.5 hours (showering, some meal preparation, supervised access to garden); home care once each week for 1.5 hours (domestic tasks); respite/shopping assistance once per week for two hours; five meals home delivered per week; medication monitoring seven days each week (Mrs Pullen was insufficiently dexterous to manage her own medications); equipment (high backed chair and a kitchen trolley), continence products and dietetic supplements; podiatry (on off); physiotherapy, occupational therapy, case management and dietetics. [see Exhibits D and K (Coronial Brief of Evidence, Eastern Health Total Care Progress Notes)].

[15] Exhibits A, D and G.

[16] Exhibit G. In her statement [Exhibit A], Mrs Clements indicated that her mother was originally due to be discharged from St George's on 31 January 2012 but, following the family meeting on 24 January, and given that a home assessment was not available until 31 January, Mrs Pullen's discharge date was anticipated to be 1 February 2012.

[17] Exhibit A.

[18] Exhibit A.

a craniotomy and evacuation of haematoma was performed on 8 February 2012 without complications.

11. Post-operatively, computerised tomography [CT] scans demonstrated reduction of the blood clot, however, the clot was replaced by cerebrospinal fluid causing a midline shift.[19] Following a discussion with Mrs Pullen's family concerning her grave condition and poor prognosis, palliative care was initiated on 11 February 2012. Mrs Pullen continued to deteriorate and was kept comfortable until her death at 8.40pm on 13 February 2012.[20]

INVESTIGATION – SOURCES OF EVIDENCE

12. This finding is based on the totality of the material the product of the coronial investigation of Mrs Pullen's death. That is the brief of evidence compiled by Constable Leigh Kellett of the Fitzroy Police Station, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of Counsel. All of this material, together with the inquest transcript, will remain on the coronial file.[21] In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

13. The purpose of a coronial investigation of a *reportable death* is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[22] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is

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[19] A shift of the brain beyond its centre line and is considered ominous due to its association with a distortion of the brain stem.

[20] E-Medical Deposition Form completed by Dr S. Rasiah on 14 February 2012.

[21] From the commencement of the *Coroners Act 2008* (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

[22] Section 67(1) of the *Coroners Act 2008*. All references which follow are to the provisions of this Act, unless otherwise stipulated.

confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[23]

14. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[24] Coroners are also empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[25] These are effectively the vehicles by which the prevention role may be advanced.[26]

15. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including in a finding or comment any statement that a person is, or maybe, guilty of an offence.[27] However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions *if the coroner believes an indictable offence may have been committed in connection with the death.*[28]

FINDINGS AS TO UNCONTENTIOUS MATTERS

16. In relation to Mrs Pullen's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. Her identity and the date and place of death were not at issue. I find, as a matter of formality, that Edna May Pullen born on 17 May 1918, aged 93, late of Ringwood Retirement Village, 17/8 Albert Street in Ringwood, died at St Vincent's Hospital, Victoria Parade, Fitzroy, Victoria 3065, on 13 February 2012.

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[23] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[24] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[25] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[26] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[27] Section 69(1).

[28] Sections 69 (2) and 49(1).

17. Nor was the cause of Mrs Pullen's death contentious. On 15 February 2012, Forensic Pathologist, Dr Heinrich Bouwer of the Victorian Institute of Forensic Medicine performed a preliminary examination of Mrs Pullen's body. He also reviewed the medical deposition from St Vincent's, the circumstances of the death as reported by police to the coroner and post-mortem CT scanning of the whole body and provided a written report of his findings.

18. Dr Bouwer advised that he found evidence of a right-sided chronic subdural haematoma with mass effect, right temporal lobe intraparenchymal haemorrhage and evidence of recent right cranial surgery on post mortem CT scans, consistent with the reported circumstances. In the absence of a full autopsy, Dr Bouwer advised that it was reasonable to attribute Mrs Pullen's death to subdural haemorrhage in the setting of a fall (palliated).[29]

19. I find that Mrs Pullen died of subdural haemorrhage in the setting of a fall (palliated).

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

20. In common with many other coronial investigations, the primary focus of the coronial investigation and inquest into Mrs Pullen's death was on the circumstances in which she died. Specifically, the adequacy of the discharge planning by St George's for Mrs Pullen's safe return home, with particular emphasis on the home assessment conducted on 31 January 2012, and whether any or each of these caused or contributed to Mrs Pullen's death. The evidence in relation to these issues will be examined in turn after canvassing some preliminary matters.

PRELIMINARY MATTERS

21. Prior to her first fall, on 24 November 2011, Mrs Pullen mobilised independently.[30] She had some prior experience of using a mobility aid, having used a 4WF of similar design to that brought to her by her daughter during her St George's admission[31] while recovering from a hip fracture in 2010.[32]

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[29] Exhibit K (Coronial Brief of Evidence, Medical Investigation Report of Dr H. Bouwer dated 6/3/12).

[30] Transcript page 5.

[31] The 4WF bought by Mrs Clements was assessed by St George's and found to be suitable and safe for Mrs Pullen's use [Transcript page 7].

[32] Transcript page 5.

22. Mrs Pullen's 4WF was a foldable, powder-coated metal framed apparatus about 80 cm high and 62 cm wide with adjustable handlebars. It was fitted with brakes operated from the handlebars and a padded platform that could be used as a seat. Its 20 cm rear wheels were rubber-coated, the front wheels swivelling to facilitate steering while the rear ones were fixed in place.[33]

23. Ringwood Retirement Village is a 27-unit, independent living community. The common area of the village is managed by a body corporate and, provided the unit is returned to its original state on sale, there is no impediment to an owner adapting the exterior of a unit during the period of his or her occupancy.[34]

24. Mrs Pullen owned unit number 17, a single-storey, one bedroom brick home.[35] The path to the front door is concrete and there is a porch post about one metre in front and to the right of the entrance. There is a 10 cm high brick step at the entrance, that forms part of the threshold. The threshold itself is about 2 cm high, such that there is a 'combined' step up into the carpeted entrance of the unit of around 12 cm.[36]

25. Entry to Mrs Pullen's unit was through a self-closing spring hinged flywire door that opened outwards, left to right, and a wooden front door that opened inwards, from left to right.[37] Although there was no specific evidence at inquest about how quickly Mrs Pullen's flywire door closed, the village manager, Mr Perkins, observed that generally the doors shut quickly at first but slowed as they neared the closed position.[38] In common with others, Mrs Pullen's flywire door was capable of being held open by positioning a slide on the closing mechanism and the speed at which the door closed automatically could also be adjusted.[39]

26. Mrs Clements had taken her mother on day leave from St George's towards the end of her admission, on 14, 21 and 28 January 2012. On 21 January 2012, the outing was to Mrs Pullen's home. Mrs Clements gave evidence that on this occasion she unlocked her mother's

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[33] Exhibit K (Coronial Brief of Evidence, photographic exhibits).

[34] Transcript page 96. The possibility of an owner removing the flywire door was canvassed at inquest. Ringwood Retirement Village Manager, Mr Perkins, stated that owners could do so without seeking permission.

[35] Exhibit A.

[36] Exhibit K (Coronial Brief of Evidence, photographic exhibits).

[37] Exhibit K (Coronial Brief of Evidence, photographic exhibits).

[38] Transcript page 94.

[39] Transcript pages 94-95.

front doors and held open the flywire door while Mrs Pullen used her 4WF to negotiate up the step and into her home.[40]

DISCHARGE PLANNING & FAMILY MEETING OF 24 JANUARY 2012

27. The referral documents Ms Anderson received from St George's provided (among other things) a synopsis of Mrs Pullen's current and relevant previous medical history, an indication of her level of pre-morbid functioning, details of the community services she had accessed prior to admission and those she utilised while in hospital.[41] The referral indicated that Mrs Pullen's risk of falls had been assessed as low and that an assessment of her home by an occupational therapist was not required.[42] The St George's clinician who referred Mrs Pullen to TCP followed up with a telephone call during which Mrs Pullen's specific needs were discussed.[43]

28. At a family meeting on 24 January 2012 Mrs Pullen's post-discharge needs were discussed and how these would be met through the TCP. Ms Anderson outlined a nine-point plan for personal, respite and home care, meal delivery, daily medication management, and ongoing physio and occupational therapy, dietetics and case management.[44] Mrs Clements signed the TCP client agreement on her mother's behalf and at her request.[45]

29. Mrs Clements told Ms Anderson that she was concerned about her mother's ability to get in and out of her home safely.[46] She asked that a home assessment be conducted.[47] Ms

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[40] Transcript page 6-7.

[41] Exhibit K (Coronial Brief of Evidence, Eastern Health Referral to Transition Care Program (Community Program). Whilst at St George's, Mrs Pullen had utilised physiotherapy, occupational therapy, a social worker, speech therapist and dietician in addition to nursing and medical expertise.

[42] Ms Anderson was not supplied a copy of the Falls Risk Assessment, only its result, a score of "18 low risk" [Exhibit D]. In the relevant section of the referral form, the following notations were made: "OT home assessment: NOT REQUIRED. Single storey retirement village, shower recess, rails, hand-held shower, shower chair, rails in toilet, no steps front or back" [Exhibit K (Coronial Brief of Evidence, Eastern Health Referral to Transition Care Program (Community Program)].

[43] The telephone call between Elizabeth Aspe [?] and TCP Clinical Co-ordinator (not Ms Anderson) occurred on 23 January 2012 and a note about it appears in Exhibit K (Coronial Brief of Evidence, Eastern Health Referral Total Care Progress Notes dated 23/1/12 at 10.30am.

[44] Six points were enumerated in Ms Anderson's notes (but ongoing physio- and occupational therapy, dietetics and case management were not listed) [see Exhibit K (Coronial Brief of Evidence, Eastern Health Referral Total Care Progress Notes dated 24/1/12 at 4.45pm]. A 10-point plan appears in Ms Anderson's statement which reflects the amendment to the plan – to include the provision of equipment – following Ms Lipow's home assessment [Exhibit D].

[45] Exhibit K (Coronial Brief of Evidence, Eastern Health Client Agreement – Transition Care Program dated 24/1/12).

[46] Mrs Clements also expressed a concern about a chair her mother had difficulty transferring to and from which was noted by clinicians and a management plan developed. Regarding the access/egress concerns I note, in passing, that at

Anderson facilitated the involvement of Ms Lipow who, upon hearing Mrs Clements' concerns, determined that a home assessment was indicated.[48] Ms Anderson completed a home visit risk assessment tool[49] and the home assessment was scheduled for 31 January 2012. Mrs Pullen's discharge from St George's was noted to be subject to the outcome of the occupational therapist's home assessment.[50]

30. Ms Anderson's notes of the family meeting clearly articulate both the plan for services and the actions to be taken, and by whom, to ensure these were in place when required.[51] After the meeting she initiated referrals to the third party service providers required on or after Mrs Pullen's anticipated discharge date.[52]

HOME ASSESSMENT ON 31 JANUARY 2012

31. A home assessment is a routine aspect of discharge planning for many geriatric patients of St George's. The aim is to assess the home environment prior to the patient's discharge to ascertain their level of independence and determine the assistance required on their return home, according to the observations made on the day of assessment. Assistive aids and equipment can be prescribed and/or provided as clinically indicated. Home assessments are not done in all instances, the decision to conduct one being a clinical decision made (generally) by an occupational therapist.[53]

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inquest Mrs Clements stated that she had articulated her concern during the family meeting as 'access in and out with the fly wire door,' that she definitely would have mentioned 'the step' [Transcript pages 7 and 44] and that in Ms Anderson's notes, the concern is recorded as 'due to step' [Exhibit K (Coronial Brief of Evidence, Eastern Health Referral Total Care Progress Notes dated 24/1/12 at 4.45pm.]. I note too that Ms Anderson's note was made several hours after the 9.30am meeting.

[47] Transcript page 7 and Exhibit G.

[48] Exhibit G.

[49] This tool is used to assess the environmental risks for clinicians/carers attending Mrs Pullen's home.

[50] Exhibit K (Coronial Brief of Evidence, Eastern Health Referral Total Care Progress Notes dated 24/1/12 at 4.45pm) and Exhibit G.

[51] See, generally, Exhibit K (Coronial Brief of Evidence, Eastern Health Referral Total Care Progress Notes dated 24/1/12 at 4.45pm). I note that some items requiring follow-up were assigned to individuals other than the TCP social worker. For instance, Mrs Clements was to follow up on an earlier funding application for an appropriate chair for her mother.

[52] Exhibit D.

[53] Exhibit G. Prior to a home assessment, there is usually a discussion between the occupational therapist and patient to ensure the latter understands the process and during which potential areas of focus are identified. In Mrs Pullen's case, this discussion occurred at the family meeting on 24 January 2012.

32. Prior to 24 January 2012, Ms Lipow had not been involved in Mrs Pullen's treatment, but was covering for a colleague who was on leave.[54] As preparation for the home assessment, she reviewed Mrs Pullen's medical file, with particular reference to the occupational therapist's initial assessment, and liaised with medical staff to confirm that Mrs Pullen was medically fit to participate in the assessment. Ms Lipow met with Mrs Pullen's physiotherapist who confirmed her mobility status and that she was able to negotiate steps independently using a 4WF.[55]

33. On the morning of 31 January 2012, Ms Lipow conveyed Mrs Pullen to her home with Mrs Clements following in her own car. On arrival, Ms Lipow accompanied Mrs Pullen as she used the 4WF to walk the short distance from the parking area to her unit. Ms Lipow then reiterated that the home assessment process was an opportunity for her to observe Mrs Pullen in her home environment and review her safety pending discharge home. The main entry point, bathroom and toilet, bedroom, seating and falls hazards[56] would each be reviewed and, on completion of the assessment, she would make any clinically indicated recommendations.[57] The assessment and its outcomes were recorded.[58]

34. The assessment commenced at the entrance to the unit. Mrs Clements stood on the concrete path behind Ms Lipow and her mother and observed from that vantage point.[59] She could not recall precisely how Mrs Pullen manoeuvred the 4WF and then herself inside – perhaps because of her vantage point[60] – but stated that it was quite a cumbersome process involving stops, starts and directions from Mrs Lipow.[61]

35. At inquest, Ms Lipow described how Mrs Pullen entered the unit under her direction in the following terms. Using her 4WF, Mrs Pullen approached the entrance and when she reached the door, turned right so that the left side of her body was perpendicular to the unit, allowing

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[54] Exhibit G.

[55] Exhibit G.

[56] See generally, Exhibit K, Coronial Brief of Evidence, St Vincent's Melbourne – Home Assessment Report dated 31/1/12.

[57] Exhibit G.

[58] Exhibit K (Coronial Brief of Evidence, St Vincent's Melbourne – Home Assessment Report dated 31/1/12).

[59] Transcript pages 8 and 21.

[60] Transcript pages 25-26.

[61] Transcript pages 27.

her to unlock the flywire door without leaning over the 4WF.[62] Once the flywire door was open, Mrs Pullen pushed her 4WF into the space, keeping the flywire door open and away from her body.[63] Next, she turned her body and the 4WF to the left, so that she stood facing the wooden door, which she then unlocked and opened.[64]

36. Next, Mrs Pullen lifted the 4WF's front wheels, brakes on, across the threshold and into the house stepping in behind it. She then stepped in with her other leg, taking the rear wheels of the 4WF with her and continued into her home. Ms Lipow indicated that during this last manoeuvre, the flywire door had likely moved slightly but that it amounted to no more than a 'very gentle touch' on Mrs Pullen's hip.[65]

37. Mrs Pullen then exited her home independently using the 4WF. As a result of this demonstration, Ms Lipow was satisfied that Mrs Pullen could safely and independently enter and leave her home using the 4WF.[66] However, she noted that Mrs Pullen may over-balance while trying to close her front door and so suggested that a tether be attached to the door handle which could be pulled to close the door.[67]

38. Mrs Clements remained concerned about her mother's ability to enter and exit her home safely. She asked whether the flywire door could or should be removed,[68] or semi-permanently tethered to the porch post,[69] so that it caused no impediment to Mrs Pullen's progress. Ms Lipow told her that removal of the flywire door was not necessary prior to

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[62] Transcript page 101.

[63] Transcript 102. I note Mrs Clements' evidence [Transcript page 53] that she recalled Ms Lipow telling her mother that the 4WF could be used to "bump" the flywire door out of the way. Ms Lipow did not concede that this was her advice and it appears likely that a miscommunication occurred given the occupational therapist's evidence concerning the 4WF's widest point keeping open the flywire door [Transcript page 114]. I also note Mrs Clements' assertion that Ms Lipow held open the flywire door for Mrs Pullen during the assessment. Initially, Mrs Clements stated that this did not occur [Transcript page 47] but when it was later put to her by Counsel that in an email to the Court dated 18 May 2012 that Ms Lipow had held open the flywire door she observed that given the email's contemporaneity with events, she stood by its content, suggesting that Ms Lipow may have held open the flywire door at some point, not necessarily while Mrs Pullen was negotiating entry to the unit [Transcript page 49-51]. For her part, Ms Lipow denied that she had held open the flywire door for Mrs Pullen during the assessment as this would have defeated its purpose [Transcript pages 109-110].

[64] Transcript page 102.

[65] Transcript pages 102 and 114.

[66] Transcript page 105.

[67] Exhibit G.

[68] Exhibit A.

[69] Transcript pages 10 & 30.

discharge given that Mrs Pullen had safely negotiated the entrance.[70] Mrs Clements also queried the suitability of constructing a ramp to the front door.[71] Ms Lipow explained the process of planning and erecting a ramp, with which TCP could assist, and advised Mrs Clements that no ramp was indicated for discharge.[72]

39. In light of Mrs Clements' concerns, Ms Lipow asked Mrs Pullen to enter and exit the unit a second time using the same method as before. Mrs Pullen successfully completed the tasks again.[73] Ms Lipow then completed her assessment of the rest of the unit.[74]

40. At inquest, Mrs Clements stated that she remained unconvinced that the entrance to her mother's unit was safe.[75] She stated that she was distressed and spoke openly to Ms Lipow of her concerns but that they reached an impasse; [76] Ms Lipow responding with words to the effect that 'it's just not possible … this is usual practice'.[77]

41. Ms Lipow, on the other hand, gave evidence that Mrs Clements did not express her concerns on 31 January 2012 in the manner she described at inquest.[78] Moreover, had Mrs Clements done so, she would have conveyed those concerns to the treatment team, including TCP.[79] Ms Lipow recalled discussing the concerns Mrs Clements did raise at length[80] and observed no disagreement or unease in the other woman by their conclusion. Indeed, both Mrs Clements and Mrs Pullen had agreed to her recommendations at the conclusion of the home assessment.[81] Outcomes were later communicated to Ms Anderson at TCP.[82]

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[70] Transcript page 105. I note Mrs Clements' evidence that tethering the flywire door 'wasn't part of the discussion' with Ms Lipow because there was an 'assumption' that Mrs Pullen would make it in the door independently. She conceded that 'with hindsight', tethering could have been done [Transcript page 65]. Ms Lipow noted that if she had considered the flywire door to present a hazard to Mrs Pullen, she would have prescribed a magnet be attached to hold open that door [Exhibit G].

[71] Exhibit A.

[72] Exhibit G.

[73] Exhibits A and G.

[74] Exhibit G.

[75] Transcript page 54.

[76] Transcript page 53.

[77] Transcript page 54.

[78] Transcript page 108.

[79] Transcript page 121.

[80] Transcript page 132.

[81] Exhibit G.

MRS PULLEN'S FALL ON 1 FEBRUARY 2012

42. In the early afternoon of 1 February 2012, Mrs Clements and her mother arrived at Mrs Pullen's home. They approached the front door of the unit, Mrs Pullen using her 4WF. Mrs Clements unlocked both the flywire door and the wooden front door, asking her mother to wait while she went inside to open curtains, turn on the lights and make sure there was plenty of space inside for her mother to enter safely.[83]

43. Mrs Pullen had followed her daughter into the space between the flywire door and the brick step. Mrs Clements testified that her mother stayed outside, standing behind her 4WF, facing the doorway, with the flywire door resting against her buttocks.[84] When Mrs Clements next turned towards the front door, she saw her mother coming through it.[85]

44. Mrs Clements observed her mother lift the 4WF's front wheels across the threshold, perhaps angled slightly to the left,[86] and step in with her right foot. Mrs Pullen then lifted the 4WF's rear wheels over the threshold, bumping the flywire door off her body with her buttocks, and stepped in with her left foot.[87] The in-swing of the flywire door caught the heel of Mrs Pullen's left shoe, causing her to over balance.[88] The 4WF continued forward into the unit while Mrs Pullen fell backwards, through the flywire door, landing on the concrete path. Mrs Clements exclaimed and went to her mother's aid.

45. Mr Perkins and a visitor were summoned by the commotion and emergency services were called to attend.

46. Mrs Clements conceded at inquest that the method used by Mrs Pullen when attempting to enter her home on 1 February 2012 deviated somewhat from that used under Ms Lipow's

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[82] Exhibits G and D. Ms Lipow's recommendations were: (1) daughter to arrange string/tether to door knob at front door so that Mrs Pullen can close the door independently; (2) removal of manual reclining chair – discharge home with high back chair; (3) needs kitchen trolley for kitchen use and dinner tray; (4) needs personal alarm; (5) Needs community occupational therapist to follow up application for lounge chair; (6) personal care assistances as organised by TCP [see Exhibit K, (Coronial Brief of Evidence, St Vincent's Melbourne – Home Assessment Report dated 31/1/12)].

[83] Transcript page 34.

[84] Transcript pages 14 & 34.

[85] Transcript page 64.

[86] Transcript page 15.

[87] Transcript pages 14, 17 & 64.

[88] Transcript pages 14, 17 & 64.

direction during the home assessment.[89] She also stated that she did not hold open the flywire door for her mother, as she had done on the previous visit home, because she had been advised by clinicians not to 'baby' her mother.[90]

CONCLUSIONS

47. 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 explication.[91] The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

48. Having applied the applicable standard to the available evidence, I find that –

- The discharge planning undertaken by Mrs Pullen's treatment team at St George's Hospital was reasonable and appropriate.
- Mrs Pullen's referral to Transition Care Program was appropriate, particularly given her post-discharge care and support needs as identified during discharge planning.
- In consultation with Mrs Pullen and her daughter and in light of the discharge planning already undertaken to that point, Ms Anderson developed a comprehensive plan to meet Mrs Pullen's needs at home. Ms Anderson appropriately facilitated Ms Lipow's involvement in the family meeting of 24 January 2012 after Mrs Clements raised concerns about access and egress at her mother's home.
- Ms Lipow's decision that a home assessment was clinically necessary was sound. The assessment she undertook on 31 January 2012 was comprehensive and Mrs Pullen's safe and successful negotiation of entry and exit, twice, on that date provided a reasonable basis for Ms Lipow's assessment that the entrance to the unit presented no obstacles that needed to be addressed prior to and in order for her to be discharged the following day.

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[89] Transcript page 59.

[90] Transcript page 35.

[91] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp 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..."

- While I accept Mrs Clements' account of her mother's attempt to enter her unit on 1 February 2012, I am unable to determine precisely how Mrs Pullen fell, and fell backwards, given that her momentum in the act of climbing the front step (and that of the flywire door) seem most likely to have propelled her forwards, not backwards.
- I find that the manner in which Mrs Pullen attempted to enter her home on the day she was discharged from hospital was significantly different to the way she was instructed to do so during the home assessment the previous day. It seems likely that the "bump" employed to move the flywire door off her body – absent any account of the technique she used to enter the unit on 31 January 2012 – or an earlier manoeuvre that precipitated it, was the key difference between her successful and unsuccessful attempts to step inside her home.
- I accept Mrs Clements' evidence that the flywire door was implicated in the accident that produced Mrs Pullen's fall, and ultimately, her fatal injury.
- I find that Mrs Pullen's accident is unlikely to have occurred if the flywire door had been mechanically or manually held open, however, I am unable to conclude that there was any want of clinical management or care on the part of the staff of St Vincent's or St George's Hospitals, or by the staff of Eastern Health, that caused or contributed to Mrs Pullen's death.

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

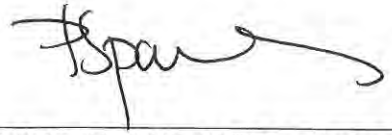
Ms Debra Clements

St Vincent's Health

Eastern Health

Constable Leigh Kellet, Fitzroy Police

Signature:



PARESA ANTONIADIS SPANOS
Coroner
Date: **8 October 2015**