IN THE CORONERS COURT
OF VICTORIA
AT HAMILTON

Court Reference: COR 2011 000580

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, Mr Jonathan G Klestadt, Coroner, having investigated the death of Margaert Grace McCreddan

without holding an inquest:
find that the identity of the deceased was Margaret Grace McCreddan
born on 27 March 1951
and the death occurred 13 February 2011
at
from:
1a INCISED WOUND TO RIGHT THIGH AND EXSANGUINATION

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

Mrs. McCreddan was a 59 year old widow who lived alone in a house in Mt. Napier Road, Hamilton. She was suffering from a number of health issues and was prescribed morphine by her treating doctor in Penshurst. There had been concerns expressed by family and friends about the level of medication she was prescribed, describing it as making her excessively sleepy and prone to hallucinations.

In late 2009 she was hospitalised for pneumonia which resulted in a 3 month convalescence in Hamilton and Melbourne. Following her discharge she spent some 3 weeks in a nursing home in Penshurst where her dosage of morphine was reduced, but upon discharge home her doctor again prescribed the higher doses which resulted in her again being observed to be adversely effected.

She was described as "wonky" on her feet and subject to relatively frequent falls and near falls. She was described as walking with a shuffling gait and was unable to regain her feet without

assistance when she fell. Despite this fact, her regular consultations with her doctor and the support of "Aspire", a mental health support agency, there appears to have been no falls mitigation strategy developed, nor any suggestion that a Personal Alarm might be an appropriate tool.

Despite her medical issues, Mrs McCreddan had a small but close circle of friends, and despite her limited mobility she seemed to have a relatively rich social life. She was assisted by and seemed close to Mrs. Ros Morey, and was also relatively closely associated with Mr. Steven Barker and Mr. Ricky McNamara, although the two sets of friends did not interact with each other.

The last person to see Mrs. McCreddan alive was Mrs. Morey who attended her home on the evening of Thursday the 10th of February 2011. It was planned that they would go out together the following day, but at approximately 8.30 am on the morning of Friday the 11th Mrs. McCreddan rang and cancelled the outing. She gave a fictitious reason to her friend and it appears she may have had other plans.

In a statement to police Mr. Barker has suggested that he and Mr. McNamara had arranged to have a BBQ with Mrs McCreddan "on the day that Margy (Mrs.McCreddan) had passed away", and that they had attended her home at 10.00am that day to pick her up. However later in the statement he says "At about 2.00pm that same day Ros's daughter Angie came around and told me that Margy had been found dead...during the afternoon." As will be seen below that is not consistent with Mr. Barker having been at the premises of the deceased on the morning of Sunday the 13th, so I regard it as either an error in the transcription of his statement or the result of some confusion on his behalf.

I accept that Mr. Barker and Mr. McNamara attended Mrs.McCreddans address, probably on the morning of Friday the 11th of February, and that after receiving no response to their knocking on the door, they left.

After attempts by both Mrs. Morey and Mrs. McCreddan's daughter Belinda to contact her by phone on Saturday the 12th and Sunday the 13th were unsuccessful, Mrs Morey attended the Mt. Napier Road address and let herself into the house with keys in her possession. She found the detritus of her snack with Mrs. McCreddan still in the kitchen, and on further inspection discovered the lifeless body of her friend in the rear bedroom of the house. Shortly after 3.00pm Ambulance officers attended the premises following a 000 call. Police attended shortly thereafter.

Mrs. McCreddan was found partially clothed, lying on the floor of the rear bedroom. She had a large ragged puncture wound between four and six centimetres in diameter of the front of her upper thigh. The forensic pathologist who examined the body of the deceased discovered that the would was approximately 10 centimetres deep. She was surrounded by a large quantity of blood.

She was positioned between a bed in the room and to the right of a doorway from the spare room where her skirt was located. Evidence suggests that she may have left her skirt in the spare room as was her habit before entering the bathroom/shower which is accessed from the room she was found in.

Near the deceased's feet was a broken pedestal fan. It had been supported by 4 metal legs, or feet

made of thin steel bent in an open or "C" shape for strength. The legs were approximately 300 millimetres long and 50 millimetres deep and were initially attached at the base of the pedestal at right angles to each other, however when discovered one leg had been bent back at almost 90 degrees to it's original position. Three of the legs had plastic protective caps at the outer end, but the third, which remained firmly attached to the base had no protective cap and had significant blood staining down its length.

In the circumstances I adopt the view of Sergeant Mark James of the Hamilton Police who attended the scene. He formed the view that the deceased had entered the room from the spare room and fallen against the fan, pushing it over and causing the base and legs to tip leaving the unprotected leg upward. As she continued to fall the opposite leg has folded under as her full weight has borne upon it while the unprotected end of the other leg has pierced her thigh. Following the infliction of the wound the deceased has made minimal efforts to raise herself before succumbing to either shock or loss of blood.

I am satisfied on the available evidence that the fall which was the cause of the injury occurred on the morning of Friday the 11th of February between 8.30 and 10.00 o'clock. Although no post mortem examination was conducted the external examination of the deceased suggests that she died from loss of blood.

At my request the Coroner's Prevention Unit has investigated this matter and has been unable to discover any deaths arising from wounds caused in similar fashion. In part their conclusion is as follows.

"The absence of a plastic cap on the leg of the pedestal fan that injured Mrs. McCreddan may reflect the inexpensive manufacturing process for these products. Australian standards for pedestal fans (and other small electrical devices) are based on electrical safety, and not on the design of the structural components."

However the issue of falls prevention is, or should be, well understood. The CPU report makes the following observations.

1. *It is unknown to the degree that her medical care providers considered Mrs McCreddan's ability to live independently at home. Her general frailty and limited mobility would have been plainly evident*
2. *Mrs McCreddan was unable to rise after a fall without assistance. The length of time remaining on the ground after a fall is associated with an increasing risk of death.*
3. *The Chronic Disease Management items in the Medical Benefits Schedule provides eligible people with up to five Medicare-funded allied health services per year as part of a GP-coordinated management plan. This type of multidisciplinary care can include referrals to a physiotherapist and occupational therapist to implement falls prevention interventions, such as home environmental audits and tailored home-based exercise programs. Home environmental modifications have been shown to be moderately effective in preventing falls, but the modifications generally need to be enacted by external providers rather than the client or family member to be efficacious.*
4. *There is evidence that the uptake of these allied health items by GPs has been limited, and that GPs may not fully understand the role of occupational therapists and physiotherapists in falls prevention.*

5. .....

6. *Personal care alarms are items which are worn by an individual, usually a pendant or wrist band, which can be activated to alert either a friend or family member that they require urgent assistance. While it cannot be said that Mrs McCreddan would have survived her grievous injury had she had a personal care alarm, it could have ensured a timely emergency response to her urgent situation. Her health care providers, aware of her limited mobility and inability to recover herself after a fall, could have referred Mr McCreddan to this service, to ensure that she received prompt attention whenever she fell.*

7. *The Australian Commission on Safety and Quality in Health Care have published best practice guidelines for the prevention of falls and harm from falls in community care. The Guidelines state that personal alarms may be beneficial for older people who forget or do not realise their risk of falls, but that they are not preventative. Good practice should include the following;*

    a. *Identifying those older people who are at risk in the community;*

    b. *Assessing them in their own homes and modifying the home environment and behaviour so the older person is as safe as possible;*

    c. *Involving their carer, family and neighbours where possible to provide additional surveillance;*

    d. *Encouraging them to enrol in an exercise program specifically for falls prevention and undertake regular exercises either at home or in a class; and*

    e. *Providing them with a personal alarm to use if they do fall, and ensure they wear the alarm at all times (including in the shower or in bed-both of which are high-risk times).*

***RECOMMENDATIONS**

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. I recommend that the Royal Australian College of General Practioners further promote the use of the existing Medicare items in providing falls prevention plans for patients at risk of falls and if barriers currently exist which limit the uptake of these items to consult with the Commonwealth Department of Health and Aging to determine how these barriers may be overcome.

2. I recommend that a copy of the finding be distributed to the Australian Competition and Consumer Commission to inform their product safety surveillance system and to assist them in their regulation of consumer products in Australia.

Signature:

Mr Jonathan G Klestadt

Date: 16/01/2013