IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 3726

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Caitlin English, Coroner
Deceased:	Doris Clare Spratling
Date of birth:	19 November 1922
Date of death:	11 August 2016
Cause of death:	I(a) Haemothorax complicating rib fractures sustained in a fall
Place of death:	Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria

INTRODUCTION

1. Doris Clare Spratling was a 93-year-old woman who lived in Forest Hill at a residential aged care facility at the time of her death.

2. Mrs Spratling died on 11 August 2016 at Box Hill Hospital following a fall at the facility.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mrs Spratling's death was reported to the Coroner as it appeared to be unexpected or unnatural or to have resulted, directly or indirectly from an accident and so fell within the definition of a reportable death in the *Coroners Act 2008.*

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. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist who examined Mrs Spratling, treating clinicians and investigating officers.

6. WorkSafe Victoria also conducted an investigation into Mrs Spratling's death. I have reviewed the brief compiled by the WorkSafe informant and have drawn on that material as to the factual matters in this finding. I note that the *Coroners Act* (2008) makes explicit that the intention of Parliament was that a coroner should liaise with other investigative authorities to avoid unnecessary duplication and to expedite the investigation of deaths.[1]

7. I have based this finding on the evidence contained in the coronial brief and in the WorkSafe brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[2]

IDENTITY

8. On 11 August 2016, Merilyn Spratling visually identified her mother Doris Clare Spratling, born 19 November 1922. Identity is not in dispute and requires no further investigation.

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[1] Section 7.

[2] This is 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.

BACKGROUND

9. Mrs Spratling was widowed and had two daughters, Merilyn and Coral and four grandchildren. She was admitted to the Uniting AgeWell Strathdon Community Residential Aged Care Facility **(the facility)** on 7 January 2008.[3] She enjoyed attending church services in the nursing home, engaging with the chaplains and attending group activities.[4]

10. Mrs Spratling had a medical history of Alzheimer's disease, hyperthyroidism, hypertension, osteoarthritis, gastroesophageal reflux disease, depression, two total knee replacements, a fractured right femur with recurrent dislocation and faecal and urinary incontinence.[5] Mrs Spratling was unable to mobilise independently and required the assistance of two staff members for all transfers.[6] She had no other falls or near falls in the 12 months prior to her death.[7]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

11. On the morning of 11 August 2016, two personal care assistants Thom Ngoc Nguyen and Everlyn Nakibuule attended Mrs Spratling to assist her with her hygiene activities. At approximately 7.20am, Ms Nguyen and Ms Nakibuule were using a hygiene sling attached to a straight bar ceiling track and the Molift Portable Ceiling Hoist **(the hoist)** to transfer Mrs Spratling from the bed onto a shower chair.[8]

12. Ms Nakibuule connected the hoist to the trolley on the ceiling track.[9] Ms Nguyen and Ms Nakibuule fitted a blue hygiene sling to Mrs Spratling and attached the sling to the hoist.[10] The blue sling had a safe working load of 272kg.[11] Ms Nakibuule then used the hoist remote to lift Mrs Nakibuule above the bed using the hoist machine.[12] There is some discrepancy between witnesses as to how high Mrs Nakibuule was lifted above the bed. Ms Nguyen states that Mrs Spratling was lifted *'about 10cm above the bed'*, however Ms Nakibuule states that she *'raised [Mrs Spratling] about 30 centimetres above the bed.'* Mrs Spratling

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[3] Advance Care Notes, Medical Directive, Clinical Notes and Residential Progress Notes regarding Doris Spratling (various), WorkSafe Investigation Brief.
[4] Resident Progress Notes report dated 12 August 2016, WorkSafe Investigation Brief.
[5] Statement of Uniting AgeWell undated, Coronial Brief.
[6] Residential Care Plan (Functional) dated 3 November 2014, WorkSafe Investigation Brief.
[7] See page 29 of Coronial Brief.
[8] Statement of Thom Ngoc Nguyen dated 13 October 2016, Coronial Brief; Statement of Everlyn Nakibuule dated 5 October 2016, Coronial Brief.
[9] Statement of Thom Ngoc Nguyen dated 13 October 2016, Coronial Brief.
[10] Statement of Thom Ngoc Nguyen dated 13 October 2016, Coronial Brief; Statement of Everlyn Nakibuule dated 5 October 2016, Coronial Brief.
[11] WorkSafe Entry Report V01032400199L dated 11 August 2016, Coronial Brief.
[12] Statement of Thom Ngoc Nguyen dated 13 October 2016, Coronial Brief.

was then moved laterally, using the hoist remote, clear of the bed to the end of the ceiling track to a position where Mrs Spratling could then be assisted into the shower chair.

13. Ms Nakibuule states *'[Mrs Spratling] was then moved clear of the bed as Thom walked around the bed to the same side as me to hold [Mrs Spratling's] legs and I was planning to put the shower chair in position. During this time the lifting machine separated from the overhead ceiling track. I was facing [Mrs Spratling] at this time. [Mrs Spratling] fell to the ground and the lifting hoist jumped or bounced on the ground twice and rolled around on the floor before coming to a rest. Doris was on the ground in the same orientation that she would have been in bed and the lifting hoist was on the ground close to her head'.* [13]

14. Ms Nguyen states *'Then I went to go to the other side to help the resident into the shower chair but I was just at the end of the bed I heard two loud noises and I saw the resident on the floor next to the bed and the machine hoist on the floor far from the resident...[Mrs Spratling] was in the same orientation as she would have been in the bed and the sling was still attached to her. The lifting attachment had detached away from the ceiling track and was on the ground. The attachment point which forms a part of the ceiling track was in the end most position, that is closest to the wardrobe in the room'.* [14]

15. Ms Nguyen immediately pressed the emergency button and Ms Nakibuule left the room to seek assistance from nursing staff. A nurse, care manager and night shift supervisor came to Mrs Spratling's aid.[15] Neurological observations of Mrs Spratling commenced at 7.26am. Emergency services were contacted at approximately 7.29am and an ambulance arrived shortly afterwards.[16]

16. Paramedic Colin Kicker states that staff told him that *'the lifting machine had failed and [Mrs Spratling] fell to the floor from bed height hitting her head on the floor'*.[17] On examination, he found Mrs Spratling was found to be unresponsive to central pain stimulus, eyes were open, she was breathing, and she was *'displaying symptoms of a cerebral event (stroke)'*.[18] Mrs Spratling was conveyed by ambulance to Box Hill Hospital.[19]

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[13] Statement of Everlyn Nakibuule dated 5 October 2016, Coronial Brief.
[14] Statement of Thom Ngoc Nguyen dated 13 October 2016, Coronial Brief.
[15] Statement of Thom Ngoc Nguyen dated 13 October 2016, Coronial Brief.
[16] Uniting AgeWell Victoria Incident Management Report dated 11 August 2016, Coronial Brief; Clinical records of Eastern Health
[17] Statement of Paramedic Colin Kicker dated 27 January 2017, Coronial Brief.
[18] Statement of Paramedic Colin Kicker dated 27 January 2017, Coronial Brief.
[19] Statement of Paramedic Colin Kicker dated 27 January 2017, Coronial Brief.

17. On arrival at Box Hill Hospital at 8.12am, Mrs Spratling's condition deteriorated, she stopped breathing and nursing staff were unable to detect a pulse.[20] Basic cardiopulmonary resuscitation was commenced but ceased soon after based on Mrs Spratling's poor prognosis and written advanced directives that accompanied her from the nursing home.[21] Mrs Spratling was pronounced deceased at 8.30am.[22]

CAUSE OF DEATH

18. On 15 August 2016, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an inspection of Mrs Spratling's body and provided a written report, dated 15 August 2016. In that report, Dr Lynch concluded that a reasonable cause of death was '*I(a) Haemothorax complicating rib fractures sustained in a fall*'.

19. Toxicological analysis of post mortem specimens detected trace levels of paracetamol.

20. I accept Dr Lynch's opinion as to cause of death.

CORONIAL INVESTIGATION AND REVIEW OF CARE

Investigation

21. The incident was extensively investigated internally by Uniting AgeWell, externally by the Victorian WorkCover Authority and further investigated by a coronial investigator in relation to the equipment used and the relevant work practices at Uniting AgeWell, including staff qualifications, training, work policies, work practices and general facility quality controls. On 4 September 2018, I met with the WorkSafe investigators to discuss the design and operation of the safety latch and the dissemination of information about the incident to the manufacturer and residential aged care facilities.

Lifting machine

22. The machine used in the incident was a Molift (Etac) Nomad Portable Ceiling Hoist, article number 1200003 **(the hoist)** with a safe working load of 235kg. The hoist is a remote controlled, automatic lifting machine which connects to an overhead tracking system. The hoist machine was attached to the patient sling and used to extend / retract the hoist webbing

[20] Statement of Dr Paul Buntine dated 27 September 2016, Coronial Brief.
[21] Statement of Dr Paul Buntine dated 27 September 2016, Coronial Brief.
[22] Statement of Dr Paul Buntine dated 27 September 2016, Coronial Brief; Clinical records of Eastern Health

in order to lift / lower the patient. A "Flexi-link" carabiner clip (**safety hook**) connected the hoist webbing to the ceiling track assembly by a trolley strap assembly that acted as an extension strap. An extension rod (**aluminium wand**) was used to operate the safety hook in order to attach it to the lower 'D-ring' of the trolley strap.[23]

23. The hoist was serviced and inspected on an annual basis.[24] It had most recently been inspected and serviced on 18 July 2016 by Health Hoists Patient Lift Specialists (**Health Hoists**). Health Hoists supplied a new strap, hand control and an 'Emergency Lower Sticker'. It was noted that the overall hoist condition was good.[25]

Uniting AgeWell Care, Manual Handling Policy and Procedures

24. Uniting AgeWell employs manual handling systems of work for transferring residents requiring a high level of care from their beds. The procedures for transferring residents using a ceiling hoist are detailed in the Uniting AgeWell Manual Handling Resource Book for Care / Lifestyle / Administrative / Maintenance / Community Staff 2016.[26] The Resource Book was updated on 18 July 2016 and included procedures to ensure that the safety hook was correctly locked and in good condition and to check all of the ceiling hoist connections to ensure that they are secure prior to transferring residents.[27]

25. An Occupational Health and Safety Risk Assessment and Control Plan for the use of ceiling hoists undertaken in October 2013 identified that the ceiling hoists had a manufacturer-designed retrofit to hook directly into the ceiling track trolley and that staff were trained in pre-transfer and cross checks to ensure safety prior to transferring residents.[28]

26. Mrs Spratling last underwent a falls risk screening assessment on 15 December 2015. Her falls management plan was reassessed on a three-monthly basis. There had been no change to Mrs Spratling's fall status at the time of the incident due to her reduced mobility.[29] The

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[23] Report on Incident: Workplace incident involving patient hoist, which occurred at Uniting Agewell Victoria, 17 Jolimont Road, Forest Hill, Vic on 11 August 2016 at approximately 7.20am, Report prepared by Tia Gaffney dated 2 February 2017, WorkSafe Investigation Brief.

[24] Statement of First Constable Katie Shanahan dated 11 January 2017, Coronial Brief.

[25] Health Hoists Patient Lift Specialists Comprehensive Hoist Service / Inspection Report dated 18 July 2016, WorkSafe Investigation Brief; Statement of First Constable Katie Shanahan dated 11 January 2017, Coronial Brief.

[26] Uniting AgeWell Manual Handling Resource Book for Care / Lifestyle / Administrative / Maintenance / Community Staff 2016 dated 18 July 2016, WorkSafe Investigation Brief.

[27] Uniting AgeWell Manual Handling Resource Book for Care / Lifestyle / Administrative / Maintenance / Community Staff 2016 dated 18 July 2016, WorkSafe Investigation Brief.

[28] Uniting AgeWell OHS Risk Assessment and Control Plan for use of ceiling hoists dated October 2013, WorkSafe Investigation Brief.

[29] Statement of Uniting AgeWell undated, Coronial Brief.

manual handling chart specific to Mrs Spratling required a minimum of two people and the use of a hoist during transfers.[30]

Employee qualifications and training

27. Ms Nguyen was a direct employee of Uniting AgeWell. Her employment records indicate Ms Nguyen had completed a Certificate IV in Aged Care and Lifestyle in 2001. She had commenced employment at Uniting AgeWell in 2006 and had completed annual manual handling training and competency assessments on the use of overhead tracks and lifting hoists.[31] On 19 April 2016, Ms Nguyen completed the Manual Handling Workbook for Nursing and Care Staff which included a practical competency assessment on ceiling hoist operation.[32]

28. Ms Nakibuule was engaged through Healthcare Australia Pty Ltd (**Healthcare Australia**), an employment placement company. Ms Nakibuule had completed a Certificate III in Aged Care and commenced working for Healthcare Australia in December 2007. She had completed initial and refresher training with Healthcare Australia which included online and practical components on manual handling, person hoisting and basic life support. Ms Nakibuule completed a Contractor Induction course with Uniting AgeWell on 9 August 2012 and had been a regular employee at Uniting AgeWell since 2013.[33] She completed theoretical and practical assessments on manual handling with Healthcare Australia on 12 March 2016 and 19 May 2016.[34]

Uniting AgeWell investigation

29. On 7 September 2016, Ruth Baxter, Quality Manager at Uniting AgeWell completed a root cause analysis of the incident. Ms Baxter noted that at the time of the incident a 'blue' sling was in use. The 'blue' sling is designed for extra-large people. Mrs Spratling's care plan specified use of a sling designed for medium people. However, this discrepancy did not contribute to the incident. It was noted on examination of the equipment after the incident that all hooks, the blue strap and connections, the Flexi-link and the Molift lifter were intact.

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[30] Uniting AgeWell Manual Handling Chart for Doris Spratling dated 18 April 2016, WorkSafe Investigation Brief.
[31] Statement of Thom Ngoc Nguyen dated 13 October 2016, Coronial Brief; Uniting Care Outer East Region – Strathdon Community Staff Orientation Checklist completed by Thom Nguyen dated 21 September 2016, WorkSafe Investigation Brief.
[32] Manual Handling Workbook for Nursing and Care Staff 2016 completed by Thom Nguyen dated 19 April 2016, WorkSafe Investigation Brief; Root Cause Analysis Record dated 7 September 2016, Coronial Brief.
[33] Statement of Everlyn Nakibuule dated 5 October 2016, Coronial Brief; Root Cause Analysis Record dated
[34] Statement of Everlyn Nakibuule dated 5 October 2016, Coronial Brief; Module results for Everlyn Nakibuule dated 12 March 2016, WorkSafe Investigation Brief; Healthcare Australia Manual Handling Practical certificate for Evelryn Nakibuule dated 19 May 2016, WorkSafe Investigation Brief.

It was noted that there was some sideways movement from the "keeper" on the Flexi-link but that the "keeper" still contacted the hook. There were *'no reported events of a similar nature... no evidence of broken or faulty equipment [and] no evidence of staff practice that was not in line with policy, practice standards or competency expectations'*.[35]

WorkSafe investigation

30. WorkSafe Investigators attended the facility on 11 August 2016 and immediately commenced a WorkSafe investigation. They took photographs and measurements of the scene, seized the hoist and associated components and spoke with Ms Nguyen, Ms Nakibuule, Occupational Health and Safety Officers and senior management of the facility.[36]

31. WorkSafe engaged Senior Forensic Engineer Tia Gaffney to investigate the most likely cause of the hoist malfunction and Mrs Spratling's fall.[37] Ms Gaffney attended the incident scene and inspected and tested the hoist components.[38] Ms Gaffney noted that the manufacturer's manual for the hoist specified that the safety hook ('Flexi-link') was intended to *'be attached directly to the trolley rather than to the hook at the bottom of the extension strap'* and that only *'when necessary'* is the trolley to have a suspended attachment hook.[39]

32. Ms Gaffney confirmed the fall occurred because the latch disconnected from the strap linkage but noted there was no obvious failure to any of the hoist components.[40] She observed *'the safety latch* [of the Flexi-link] *had considerable "play" resulting in an incomplete closure and was absent of any additional latch safety features'*.[41] Ms Gaffney conducted three loading tests of the flexi-link but was unable to replicate the malfunction which occurred on the date of the incident.[42] Ms Gaffney concluded *'the clip was not correctly attached to the strap D-ring on the date of the incident'* but conceded that it was

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[35] Root Cause Analysis Record dated 7 September 2016, Coronial Brief.
[36] WorkSafe Entry Report V01032400199L dated 11 August 2016, WorkSafe Investigation Brief; WorkSafe Entry Report V00037800234L dated 11 August 2016, WorkSafe Investigation Brief.
[37] Report on Incident: Workplace incident involving patient hoist, which occurred at Uniting AgeWell Victoira, 17 Jolimont Road, Forest Hill, Vic on 11 August 2016 at approximately 7.20am, Report prepared by Tia Gaffney dated 2 February 2017, WorkSafe Investigation Brief.
[38] Ibid.
[39] Ibid.
[40] Ibid.
[41] Ibid.
[42] Ibid.

not possible to ascertain the position of the various components during and after the incident which may have assisted in determining how the malfunction occurred.[43]

33. Ms Gaffney identified alternative design solutions may have been implemented to the flexi-link to reduce the risk of detachment, such as by use of a carabiner hook.[44] However, Uniting AgeWell advised that the rounded or carabiner hook is not suitable for use in ceiling hoists as these hooks require manual opening and closing, and due to the height of the hoist it is necessary to have a hook system that can be attached using a rod.

WorkSafe guidance

34. In July 2009, WorkSafe published a handbook providing guidance to workplaces on transferring people safely for health, aged care, rehabilitation and disability services. [45] The handbook advises that when transferring patients from a bed, overhead tracking hoists are to be used wherever reasonably practicable, all hoists and beds are to be electrically operated, a minimum of two handlers are used to manoeuvre the hoist with the patient in situ, staff carrying out the task are trained and competent in 'no lifting' patient handling procedures and in using the mechanical equipment and other aids in the handling task, and that the equipment used is readily available, in good condition and regularly maintained.[46]

35. In August 2013, WorkSafe published a Safety Alert on the safe use of ceiling hoists.[47] The Safety Alert recommended that, where practicable, permanently installed hoists that do not rely on latching hooks and / or wands should be used. Where portable hoists are used, it advised employers to *'ensure hoisting components between the hoist and ceiling rail lock together during engagement, and the components provide operators with confirmation of secure engagement...provide information and training to employees on how to properly check, connect and use hoists...require employees to undertake pre-operation and post connection checks when using hoists [and] arrange regular inspection, testing and maintenance of hoists'*.[48]

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[43] Ibid.
[44] Ibid.
[45] WorkSafe Victoria, 'A handbook for workplaces: Transferring people safely – Handling patients, residents and client sin health, aged care rehabilitation and disability services' dated July 2009.
[46] WorkSafe Victoria, 'A handbook for workplaces: Transferring people safely – Handling patients, residents and client sin health, aged care rehabilitation and disability services' dated July 2009.
[47] WorkSafe Safety Alert, 'Patient handling – Portable ceiling hoists: Information for employers about the safe use of ceiling hoists' dated August 2013.
[48] WorkSafe Safety Alert, 'Patient handling – Portable ceiling hoists: Information for employers about the safe use of ceiling hoists' dated August 2013.

Uniting AgeWell Response to the incident

36. Immediately following the incident, Uniting AgeWell withdrew all MoLift ceiling hoist models from service at the facility pending further enquiries.[49] Uniting AgeWell informed their ceiling hoist provider, CHS Healthcare of the incident. On the recommendation of CHS Healthcare, Uniting AgeWell replaced the trolley components of the ceiling tracks with larger fixed-point ceiling track attachments.[50] It was considered that a direct non-swivel trolley attachment increased safety compared to the swivel trolley attachment and hanging strap used at the time of the incident.[51]

37. In November 2016, the resource material provided to direct care employees was updated to reflect the ceiling hoist modifications. The Uniting AgeWell Manual Handling Resource Book states that workers must carry out a cross check, and the second worker confirms that the ceiling hoist is hooked on to the ceiling track and conduct a cross check to *'verify that all connections are secure and the wand is back in the hoist trolley'*.[52] Direct care employees underwent refresher training on the new fixed point systems and were required to complete the training on the use of the ceiling hoist equipment prior to using the ceiling hoists for resident transfers.[53]

CHS Healthcare Response to the incident

38. On 8 September 2016, CHS Healthcare issued an updated Flexi-Link Connection System User Guide to Uniting AgeWell stating that the Flexi-Link is to be connected directly to the track trolley only with no carabiner, strap extensions or other attachments to be used. CHS Healthcare also amended the guide to include an instruction that '*The worker / employee who attached the hoist and removed the aluminium wand is to then ask the other worker / employee to conduct a "CROSS CHECK" and the second person is to verify that all connections are secure, and the aluminium wand is back in the floor trolley'*.[54]

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[49] WorkSafe Entry Report V01032400199L dated 11 August 2016, WorkSafe Investigation Brief.
[50] WorkSafe Entry Report V01032400230L dated 12 September 2016, Coronial Brief.
[51] Report on Incident: Workplace incident involving patient hoist, which occurred at Uniting AgeWell Victoira, 17 Jolimont Road, Forest Hill, Vic on 11 August 2016 at approximately 7.20am, Report prepared by Tia Gaffney dated 2 February 2017, WorkSafe Investigation Brief; Email correspondence between Brett Linqvist and John Bridge dated 16 to 18 August 2016, WorkSafe Investigation Brief.
[52] Uniting AgeWell Manual Handling Resource Book for Care / Lifestyle / Administrative / Maintenance / Community Staff 2016 dated November 2016, WorkSafe Investigation Brief.
[53] WorkSafe Entry Report V0103240030L dated 12 September 2016, Coronial Brief; WorkSafe Entry Report V01032400259L dated 20 October 2016; Uniting AgeWell Memorandum to all direct care staff dated 20 October 2016, Coronial Brief.
[54] Flexi-link Connection System User Guide dated 8 September 2016, WorkSafe Investigation Brief.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

39. There is no evidence available to firmly establish the cause of the incident. It is unknown exactly how the device was connected on the day of the incident. Uniting AgeWell has acted in the aftermath of the incident by removing the extension strap and changing the swivel trolley on the ceiling track to fixed point attachments on ceiling hoists throughout all their facilities. These changes have made the system of lifting and transferring residents potentially safer.

RECOMMENDATIONS

40. Pursuant to section 72(2) of the Act, I make the following recommendations with a view to preventing deaths such as Mrs Spratling's:

41. I recommend that **Leading Age Services Australia**, the national peak body representing and supporting providers of age services across residential care, home care and retirement living, alert their members regarding this finding and encourage members to review their use of ceiling hoists in accordance with manufacturer's instructions and their compliance with the WorkSafe Safety Alert on patient handling and portable ceiling hoists dated August 2013.

42. I recommend that **Aged & Community Services Australia**, the leading peak body supporting church, charitable and community-based not-for-profit organisations that provide accommodation and care services to older Australians, alert their members regarding this finding and encourage members to review their use of ceiling hoists in accordance with manufacturer's instructions and their compliance with the WorkSafe Safety Alert on patient handling and portable ceiling hoists dated August 2013.

43. I recommend that **WorkSafe Victoria**, the Victorian health and safety regulator consider once again publishing a Safety Alert regarding the use of ceiling hoists by aged care facilities and consider amending guidance notes and publications on transferring people using hoists to highlight the need to comply with manufacturer's instructions and implementing a system of cross checking connections prior to use.

FINDINGS AND CONCLUSION

44. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Doris Clare Spratling, born 19 November 1922, died on 11

August 2016 at Box Hill, Victoria, from *'I(a) Haemothorax complicating rib fractures sustained in a fall'* in the circumstances described above.

45. I express my sincere condolences to Mrs Spratling's family for their loss.

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

Ms Merilyn Spratling, senior next of kin.

CHS Healthcare

Leading Age Services Australia

Aged & Community Services Australia

WorkSafe Victoria

First Constable Katie Shanahan, Victoria Police, Coroner's Investigator.

Signature:

CAITLIN ENGLISH
CORONER
Date: 10 December 2018