IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 4853

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**BS***
Date of birth:	1 January 1926
Date of death:	26 October 2013
Cause of death:	1(a) COMPLICATIONS OF HEAD INJURIES IN SETTING OF DEMENTIA
Place of death:	Doutta Galla Nursing Home, 120 North Road, Avondale Heights, Victoria

* This is a redacted version of the original signed finding. Names have been replaced with initials to preserve the privacy of BS's family.

HER HONOUR:

Background

1. BS was born on 1 January 1926. He was 87 years old when he died on 26 October 2013 from injuries sustained in an assault.

2. BS had been employed as a police officer in Italy before moving to Australia with his wife, Olga, in 1950. Thereafter he worked as a boiler maker and security guard.

3. Mr and Mrs S welcomed four children and later several grandchildren and great-grandchildren. It is clear BS was the much-loved patriarch of his family and is still dearly missed.

4. In approximately 2008, BS began to suffer the effects of dementia. In December 2012 he moved to Doutta Galla Nursing Home in Avondale Heights (**the nursing home**).

5. BS's medical history included vascular dementia, cerebrovascular accident, non-ST elevation myocardial infarction, atrial fibrillation, seizures, and hypertension.

The coronial investigation

6. BS's death was reported to the Coroners Court 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.

7. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[1]

8. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

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[1] In the coronial jurisdiction facts must be established on the balance of probabilities 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.

9. 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.

10. BS's death was investigated by Victoria Police and criminal charges were laid against the person who assaulted him. I received a coronial brief of evidence at the conclusion of the criminal proceedings. I then obtained a copy of the plea and sentencing remarks (*The Queen v David Rose* [2015] VSC 614).

11. Coroners are also obliged under the Act to avoid unnecessary duplication of inquiries and investigations (section 7). Further, if charges are laid in respect of a reportable death, as here, Coroners are not required to make the usual findings if they do not hold an inquest and the making of findings would be inappropriate in the circumstances (section 71 of the Act).

12. After perusing all the material I was satisfied that the circumstances of BS's death were clear and that an inquest was not necessary. However, I determined that I should make findings as there was a public interest in exploring possible prevention opportunities arising from the circumstances of BS's death.

13. In March 2016, I chaired a roundtable meeting with relevant experts regarding resident-to-resident aggression in Australian aged care facilities, which I discuss below.

14. In mid-2016, the coronial investigation was taken over by the State Coroner. Advice was obtained from the Coroners Prevention Unit and further material was obtained from the nursing home. In January 2019 the matter was reassigned to me. I have had regard to all material obtained during the investigation, although I shall not refer to it in detail.

Identity of the deceased

15. BS was visually identified by his son on 26 October 2013. Identity was not in issue and required no further investigation.

Circumstances in which the death occurred

16. On 28 September 2013, BS (aged 87) was assaulted on two occasions by a fellow resident, David Rose (aged 68) after he wandered into Mr Rose's room uninvited. The assaults were partly captured on closed-circuit television (**CCTV**) and occurred at 4.53am and 9.45pm.

17. Nursing home staff were unaware of the first assault, but found BS wandering the corridor after the second. He had a cut to his forehead, was bleeding from his mouth, and the left-hand side of his jaw was swollen. Staff attended to BS's injuries and called an ambulance which conveyed him to Sunshine Hospital.

18. At hospital, BS was found to be suffering from intracranial bleeding, which was not appropriate for operative management due to the risk involved. The bleed was expected to extend due to his clopidogrel (an antiplatelet medication) and aspirin medications.

19. BS subsequently returned to the nursing home for palliative care. He passed away in his sleep at 7.20am on 26 October 2013 with his wife by his side.

20. Mr Rose pleaded guilty to one charge of intentionally causing serious injury to BS. In his police record of interview he gave an account of BS coming into his room on the first occasion and putting his fingers and hands on his chest and then in his mouth. Mr Rose lost his temper and told him to get out or he would kill him. BS said *'my room, my room'* before starting to walk out with Mr Rose's walker. Mr Rose grabbed him, pulled and pushed him before throwing him out into the corridor. He warned him if he came back he would kill him.

21. According to Mr Rose, when BS came back into his room that night he again said *'this is my room'* before putting his hands on Mr Rose and scratching, punching and trying to get him out of bed before again grabbing his walker. CCTV footage showed Mr Rose punching BS repeatedly in the corridor.

22. The learned sentencing Judge had regard to Mr Rose's prior mental health history and various expert reports which referred to Mr Rose having a variety of disorders affecting his mental health and cognitive functioning. His Honour said *'I do not find that you were suffering from an acute mental illness at the time of the offending but I find that your various mental conditions are likely to have contributed to your offending against [BS]'*. His

Honour also found that Mr Rose posed a risk of harm to co-residents and staff of his current nursing home.

23. On 5 November 2015, Mr Rose was sentenced to a five-year Community Corrections Order.

24. It is apparent from Mr Rose's own account that BS was confused when he entered Mr Rose's room. It was a dangerous combination of a confused older man and a much younger aggressive man; a combination which proved lethal.

Medical cause of death

25. On 27 October 2013, Dr Jacqueline Lee, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the body of BS and reviewed a post mortem computed tomography (CT) scan.

26. The autopsy revealed an organising right subdural membrane with no evidence of herniation. Contusions were noted on the left side of the face, left hip, and left leg.

27. Neuropathological evaluation revealed a mixed Alzheimer's and vascular dementia with multiple old large vessel and lacunar infarcts, bilateral chronic subdural membranes with more recent right subdural haematoma. Subarachnoid haemorrhage of the occipital lobe and right hippocampal sclerosis and old infarction in the left hippocampus and right medical temporal lobe were also seen.

28. Dr Lee explained the mechanism of BS's death was a general decline associated with early pneumonia and poor oral intake following head injuries. The head injuries worsened his underlying neurologic condition, which was the result of a mixed vascular and Alzheimer's dementia.

29. Toxicological analysis of post mortem specimens taken from BS identified acetone and carbamazepine (an anti-convulsant).

30. After reviewing toxicology results, Dr Lee completed a report, dated 7 May 2014, in which she formulated the cause of death as "*1(a) Complications of head injuries in setting of dementia*". I accept Dr Lee's opinion as to the medical cause of death.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was BS, born 1 January 1926;

(b) BS died on 26 October 2013 at Doutta Galla Nursing Home, 120 North Road, Avondale Heights, Victoria, from complications of head injuries in setting of dementia; and

(c) the death occurred in the circumstances described above.

Comments

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

1. As the events leading to the assault on BS were thoroughly examined in the criminal proceedings the focus of the coronial investigation was on public health and safety considerations, specifically whether deaths caused by resident-to-resident aggression in residential aged care facilities, could be prevented in future.

2. There are 28 documented resident-to-resident aggression deaths between 2000 and 2013 in Australian nursing homes.[2]

3. As explained above, in March 2016, I conducted a roundtable discussion about resident-to-resident aggression with a number of relevant experts, including Professor Joseph Ibrahim, Head of Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University.

4. The experts believed that deaths caused by resident-to-resident aggression were under-reported for several reasons including the limited reporting requirements under the *Aged Care Act 1997* (Cth) and associated Accountability Principles 2014. The effect of these legislative limitations is that if the perpetrator of resident-to-resident assault in an aged care facility has a pre-diagnosed cognitive or mental impairment, such as dementia, and a behaviour management plan has been put in place within 24 hours of the alleged assault, the

[2] Briony Murphy et al, 'Deaths from Resident-to-Resident Aggression in Australian Nursing Homes' (2017) 65 *Journal of the American Geriatrics Society* 2603.

assault does not need to be reported. Professor Ibrahim pointed out that the majority of residents in Australian residential aged care facilities have diagnoses of dementia (about 50 per cent), and that aggression is actually part of the pathology of dementia.

5. A recent systemic review of research into resident-to-resident physical aggression[3] identified the lack of clear data and research about this issue. Relevantly, the review found:

   (a) residents who are at increased risk of becoming targets (victims) are cognitively impaired, less dependent in their activities of daily living, exhibit wandering behaviours, and demonstrate socially inappropriate or disruptive behaviours. They are sufficiently mobile, which may lead them to put themselves in harm's way;

   (b) exhibitors (perpetrators) include those who are more aggressive, aware of their surroundings, and with fewer impairments affecting their activities of daily living than the general nursing home population; and

   (c) the most commonly reported trigger was communication issues. However, invasion of space was the second most commonly reported trigger and included issues associated with communal living such as privacy.

6. The circumstances of this case almost mirror the key findings identified by the systemic review.

7. On 10 February 2016 and 28 April 2017, Carlo Rizzi, Area Operations Manager of Doutta Galla Aged Services, provided statements and records to the Court.

8. Mr Rizzi confirmed that BS was known to wander and intrude into co-residents' rooms; this was noted as a risk in his records. A goal of his Extended Care Plan was to reduce the impact of his behaviour by diverting his attention, maintaining a routine, reinforcing positive responses, and redirecting BS back to his room when he wandered. Between 5 July 2013 and 17 October 2013, the progress notes recorded 14 instances in which staff reported BS entering or attempting to enter other residents' rooms. Indeed, many of the statements made by staff acknowledged BS's tendency to wander. Most of the progress notes indicated that staff simply redirected him from other residents' rooms. According to Mr Rizzi, other

[3] Noha Ferrah et al, 'Resident-to-resident physical aggression leading to injury in nursing homes: a systemic review' (2015) 0 *Age and Ageing* 1.

interventions, such as aromatherapy, massage, and PRN (as needed) temazepam had good effect when administered.

9. On 24 September 2013, the progress notes record that BS was found knocking on another resident's door which upset the resident of that room. He was subsequently referred for a medical review with a view to send him for an Aged Psychiatry Assessment Team (**APAT**) assessment. Prerequisite testing before an APAT assessment was not completed before the assault that ultimately led to his death.

10. Mr Rizzi said Mr Rose was not known to exhibit physically aggressive behaviour towards residents and there were no incidents of physical aggression towards other residents during his residency. This was supported by statements from a number of staff members who indicated no awareness of aggression from Mr Rose. On the other hand, the nursing home records indicated that Mr Rose was occasionally aggressive toward staff and that he should be attended by male staff or by two female staff. It was also noted in the records that he had a prior episode of violence against his wife.

11. Mr Rizzi provided the Court with a number of Doutta Galla's policies and guidelines, which addressed resident-to-resident aggression and set out the requirements to report such incidents. The policies appear compliant with the requirements of the *Aged Care Act 1997* (Cth) at the time of BS's death.

12. Mr Rizzi was asked about other incidents that occurred in 2013. He indicated that in that year, 37 incidents of physical aggression occurred across all Doutta Galla Aged Services facilities. Of these, 32 were assessed as *'discretion not to report'* with five reportable to Victoria Police.

Conclusion

13. I acknowledge that administering care to a large group of patients with varying levels of needs and abilities, including cognitive impairment, is challenging.

14. It is clear more work needs to be undertaken in the area of resident-to-resident aggression in aged care facilities to determine appropriate staffing levels and skill mix, appropriate education and training, prevention strategies, nursing home design, policies, guidelines, and

legislation. Further research as to how best to address, manage, and prevent resident-to-resident aggression is needed.

15. I had originally intended to conduct an inquest to explore these issues, however given the delay that has already occurred in this matter and the fact that in the intervening period the Royal Commission into Aged Care Quality and Safety was established, I believe the most appropriate and efficacious course is to provide this finding to the Royal Commission for its consideration. I am aware that Professor Ibrahim has already given evidence to the Royal Commission.

16. That said, it seems to me that the starting point for any prevention opportunities is to have an accurate record of incidents of aggression so that a clearer picture can be gained, not only of the number of such incidents, but also the circumstances in which they occur.

17. I agree with the suggestion of the roundtable experts that the framing of reporting requirements around *'assault'* is problematic as that word connotes a criminal act and many incidents of aggressive or violent behaviour in aged care facilities may not involve criminal intent. Rather, there should be mandatory reporting to the Department of Health of all incidents of aggression involving physical contact whether or not the perpetrator has any form of cognitive or mental impairment.

18. Further, every residential aged care facility should have a documented process for recording and reviewing all incidents of resident to resident aggression and developing risk mitigation strategies.

17. The combination of an ageing population and an increase in the number of vulnerable people entering residential aged care means there is likely to be an increase in frequency of resident-to-resident aggression with more serious outcomes. It is therefore vital that the government explore these issues with this consideration in mind.

18. As indicated I am providing a copy of this finding to the Royal Commission into Aged Care Quality and Safety to inform their report.

Recommendations

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

1. That the Commonwealth Department of Health consider amending the *Aged Care Act 1997* (Cth) and the Accountability Principles 2014 to expand the reporting framework to capture all occurrences of physical aggression in residential aged care services regardless of intent and/or cognitive or mental impairment of the perpetrator or the victim; and

2. That the Commonwealth Department of Health consider developing a national database to capture all data on incidents of physical aggression in residential aged care services; and

3. That the Commonwealth Department of Health consider publicly reporting on incidents of physical aggression in residential aged care services each year.[4]

Publication

Given that I have made recommendations, I direct that this finding be published on the internet pursuant to section 73(1A) of the *Coroners Act 2008*.

I convey my sincere condolences to BS's family.

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

BS's family

Doutta Galla Aged Services Limited

Royal Commission into Aged Care Quality and Safety

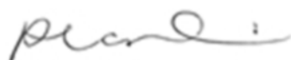
Senator the Hon Richard Colbeck, Minister for Aged Care and Senior Australians

The Hon Greg Hunt MP, Minister for Health

Commonwealth Department of Health

Detective Senior Constable Shaun O'Connell, Coroner's Investigator, Victoria Police

Signature:



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ROSEMARY CARLIN
CORONER
Date: 30 May 2019

[4] These recommendations are informed by Professor Joseph Ibrahim, 'Recommendations for prevention of injury-related in residential aged care services', Monash University, 2017 and Australian Law Reform Commission, 'Elder Abuse – A National Legal Response', Summary Report No 131, May 2017.