IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 4595

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Josephine Helen Clarke
Date of birth:	26 November 1948
Date of death:	11 September 2018
Cause of death:	1(a) Complications of a subdural haemorrhage (palliated) sustained in a fall
Place of death:	Monash Medical Centre, 246 Clayton Road, Clayton, Victoria

INTRODUCTION

1. On 11 September 2018, Josephine Helen Clarke was 69 years old when she died following a fall.

2. Prior to her illness, Mrs Clarke lived in Box Hill South with her husband, David Clarke, who adored her.

3. In the months preceding her death, Mrs Clarke had a long stay at Monash Health with complications from an initial presentation on 9 June 2018 for a subarachnoid haemorrhage due to bleeding from a left vertebral artery aneurism. She was thereafter admitted to the Kingston Centre, which is a part of Monash Health, for rehabilitation.

4. On 11 September 2018, Mrs Clarke was found on her knees on the floor of the bathroom following an unwitnessed fall at the Kingston Centre. She deteriorated rapidly and was subsequently transferred to the intensive care unit at the Monash Medical Centre. She was diagnosed with an inoperable large left subdural haematoma. Mrs Clarke received palliative care and died later the same day.

5. Mrs Clarke's family kindly agreed to organ donation.

THE CORONIAL INVESTIGATION

6. Mrs Clarke's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

7. 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. It is important to noted that the purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

8. 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.

9. As part of the coronial investigation, a request for a falls statement was made to Monash Health to assess whether appropriate falls prevention strategies were in place.

10. Following a Request for Inquest from Mr Clarke on 6 December 2019, a coronial brief was prepared by Sergeant Greig McFarlane from the Police Coronial Support Unit. The brief includes statements from medical and nursing staff, including the forensic pathologist who examined Mrs Clarke. The email accompanying Mr Clarke's Request for Inquest, as well as emails from Mr Clarke dated 16 September 2018, 5 November 2018, and 12 January 2019, also form part of the coronial brief. I have also considered additional correspondence received from Mr Clarke dated 1 March 2019, 25 July 2019, 31 July 2020, 5 September 2020, and 22 September 2020.

11. This finding draws on the totality of the coronial investigation into Mrs Clarke's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Identity of the deceased

12. On 11 September 2018, Josephine Helen Clarke, born 26 November 1948, was visually identified by her step-daughter, Jacqueline Davies.

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

Medical cause of death

14. Forensic Pathologist, Dr Gregory Young, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 14 September 2018 and provided a written report of his findings dated 17 September 2018.

15. The post-mortem examination confirmed the presence of a large left subdural haemorrhage, associated with midline shift. Haemorrhage was also seen within the brainstem. The heart also

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

showed coronary artery calcification and the left lung showed increased markings in the left lobe.

16. Dr Young explained that a subdural haemorrhage is where blood collects in the space surrounding the brain, usually from bleeding due to trauma (such as that sustained in a fall). This may lead to headache, confusion, and eventual loss of consciousness and death where there is compression of essential centres in the brain. Decreased consciousness and mobility also predisposes to development of chest infections, deep vein thrombosis, and pulmonary thromboembolism. Which may also eventually lead to death.

17. Dr Young provided an opinion that the medical cause of death was *"1(a) Complications of a subdural haemorrhage (palliated), sustained in a fall"*.

18. I accept Dr Young's opinion.

Circumstances in which the death occurred

19. Mrs Clarke's medical history included type 2 diabetes, hypertension, hypercholesterolemia, and obstructive sleep apnoea.

20. On 7 June 2018, Mrs Clarke had an unwitnessed fall at home and two days later experienced symptoms including headaches, nausea, and vomiting.

21. On 9 June 2018, an ambulance was called, and she was transported to the Monash Medical Centre Emergency Department. A CT brain scan revealed a subarachnoid haemorrhage due to bleeding from a left vertebral artery aneurysm.

22. Mrs Clarke underwent treatment including the insertion of a right frontal extra-ventricular drain followed by stenting and coiling of the aneurysm.

23. On 18 June 2018, Mrs Clarke suffered a cardiac arrest after choking on a food bolus. Testing revealed a further ventricular haemorrhage with moderate vasospasm, and she was re-admitted to the intensive care unit.

24. On 26 July 2018, Mrs Clarke was transferred to Kingston Centre for inpatient rehabilitation following her deconditioned state.

25. The next day, she was subject to a MET call and transferred back to Monash Medical Centre, where she had a complicated course with multiple medical issues.

26. On 7 August 2018, Mrs Clarke returned to Kingston Centre. Assessment by a multidisciplinary team resulted in a plan for her ongoing care, part of which was a high risk of falls assessment. Mrs Clarke was non ambulant and required assistance from nursing staff with all aspects of care including hygiene, feeding, and transfers. According to Julie Galloway, Director of Nursing at the Kingston Centre, Mrs Clarke's progress was slow and minimal in relation to mobility, sitting, standing, balance, and personal activities of daily living. Fluctuating fatigue and cognition contributed to her slow progress and she *"remained vague and disoriented at times"*.[2]

27. While at the Kingston Centre, Mrs Clarke had three unwitnessed falls on 11, 21, and 23 August 2018. None of these caused any injury. She required constant supervision due to her high falls risk.

28. On 11 September 2018, Mrs Clarke was transferred to the toilet in a commode chair. She was thereafter left alone by staff to open her bowels. Nursing staff returned to check on her twice. On the third occasion, nursing staff found Mrs Clarke on her knees on the floor. She did not know if she had hit her head. Mrs Clarke did not appear to have an apparent injury and was transported back to bed using a hoist.

29. She thereafter became confused and unresponsive and deteriorated quickly; a code blue was called.

30. Mrs Clarke was transported to the Monash Medical Centre where it was ascertained she had a subdural haematoma. She was palliated and passed away the same day.

FURTHER INVESTIGATIONS AND FAMILY CONCERNS

31. Following Mrs Clarke's death and as part of the coronial investigation, Kingston Centre was asked to provide a falls statement detailing the incident, together with their Falls Prevention Policy.

32. Ms Galloway indicated Mrs Clarke was deemed a 'high falls risk'.[3] Mrs Clarke had a falls risk score of 23 (high falls risk being greater than 17) and, according to the Monash Health guidelines, this required Mrs Clarke to have 'constant supervision'. The interventions for

---

[2] Coronial Brief, p 17.
[3] Coronial Brief, p 15.

medium to high risk are listed on the Falls Prevention MRI33 Form, and additional options for high risk fall patients include the requirement of 'constant supervision.'[4]

33. In her first statement, Ms Galloway described Mrs Clarke's fall on 11 September 2018 as follows:

> *On 11/09/2018, at approximately 1015, Mrs Clarke was taken to the toilet in a commode chair on her request as she wanted to use her bowels. Shortly after being taken to the toilet she was found on the floor on her knees, and facing the door. She was not certain whether or not she had hit her head, and there was no obvious external injury evident to the head or face to indicate a significant head strike. Mrs Clarke was assisted back to bed using a hoist, neurological observations were taken – BP 190/100, HR 116, respiratory rate 22, Pupils unequal, O2 saturations 95% and BGL 10.1.*[5]

34. Ms Galloway described what happened before and after the fall:

> *Before the fall, Mrs Clarke was transferred to the toilet on a commode chair. Mrs Clarke asked for privacy and the duty nurse continued to work in the vicinity, working between the ward bay and bathroom and checked on Mrs Clarke on two occasions.*
>
> *After the fall, following a nurse check during her toileting for the third time, Mrs Clarke was on the floor, kneeling down. She did not recall how she had a fall and did not know if she hit her head. Mrs Clarke was transferred back to bed utilising a hoist lifter.*[6]

35. Included with Ms Galloway's statement was an incident report, which detailed the fall as follows:

> *Pts observations taken this morning all within normal range. Pt asked to go to toilet to use her bowels and stated she would be there a while. Nurse went and checked on pt twice as she deemed her safe enough to leave as didn't seem confused. On the third time the nurse found pt on her knees on the floor. Pt was stating she banged her head. A hoist was used to transfer pt back to bed. Dr and nurse in charge informed of fall. The Drs on ward were attending to another Code Blue so the pt was transferred back*

[4] Coronial Brief, p 47.
[5] Coronial Brief, p 18.
[6] Coronial Brief, p 18.

to bed and neuro observations commenced. The first set of Neuro observations showed a GCS of 12 and High BP. The second set of neuro observations the GCS had dropped to 3 and BP was very high. The pt had become unrousable and a Code Blue was called.[7]

36. The incident report appears to have been prepared by Sandra Higgins, registered nurse. The investigation appears to have then been completed by Gail Dingle on 3 October 2018. In her incident follow-up findings, she stated:

> *Patient was cognitively intact and had requested to be left while she used the toilet.*[8]

37. Ms Galloway's statement also attached the 'Falls prevention standard care' implementation tool as well as the 'Post fall' procedure.

38. Yen Mei Toh, the nurse who was allocated to look after Mrs Clarke and four other patients on 11 September 2018, stated:

> *After breakfast and medication rounds at approximately 0945hrs, Josephine verbalised that she wanted to have a wash as she wished to get ready for her physio. Josephine had a wash on the bed and then she requested to go to the toilet to use her bowel. Sara-stedy (a standing transfer aid) was used with two nurses assisting to transfer Josephine onto the commode chair and she was taken to the toilet.*
>
> *Josephine was on the commode chair and commode chair was locked. She was reminded to use the call bed beside her when she finished opening her bowel. Josephine was checked on two occasions while she was in the toilet (approximately 5-10 mins interval). On each occasion when I checked on her, she replied she was not ready and had requested to be left a while to use the toilet. Josephine was again reminded to use the call bed once she finished and I told her that I would remain in her room for when she needed me.*
>
> *The third time when I checked on Josephine at approximately 1015hrs, she was found on the floor, with her knees on the ground, head facing the door. Josephine was conscious, aware that she had a fall and verbalised that she was trying to get up by*

[7] Comprehensive Report, Incident ID 1043117, p 1.
[8] Comprehensive Report, Incident ID 1043117, p 2.

herself. She verbalised that she might have hit her head when she attempted to get up from the floor.[9]

39. Su Hyung Yang, the nurse manager, stated:

> *... the nurse who found Mrs Clarke stated the patient has asked to go toilet and the patient requested to be left whilst she used the toilet.*[10]

40. In a second statement, Ms Galloway acknowledged Mrs Clarke's request for privacy was not recorded in the medical records, but it was recorded in the incident report and subsequent investigation.

41. When asked whether the level of supervision provided on 11 September 2018 was consistent with 'constant supervision' as identified for high falls risk patients like Mrs Clarke, Ms Galloway described 'constant supervision' as:

> *In the context of falls prevention, the supervision provided for Mrs Clarke on the day would be seen as reasonable in that the nurse would have been consistently present in the room providing care to Mrs Clarke, along with other patients in the room. Mrs Clarke was safely transferred by 2 nursing staff onto the commode chair on the toilet. Whilst in the toilet, and respecting Mrs Clarke's request for privacy, the nurse continued to supervise Mrs Clarke appropriately, and checked on her on two occasions during that time.*[11]

42. Ms Galloway agreed the Screening Tool in the Falls Prevention MRI33 form uses a legend that indicates 'N/A' means 'not available.' In Mrs Clarke's case, the strategies for patients who are at high risk who are considered for various strategies such as 'constant supervision' was marked 'N/A'. Ms Galloway stated the intent of the staff in the ward documenting 'N/A' was that it is 'not applicable' rather than 'not available.'

43. Ms Galloway did not expand on why these interventions were marked 'N/A' except to repeat the Quality Coordinator's assessment that Mrs Clarke was *"cognitively able to make decisions and had always called for assistance"*,[12] implying there was no clinical indication that Mrs Clarke required constant supervision.

---

[9] Coronial Brief, p 39.
[10] Coronial Brief, p 38.
[11] Coronial Brief, p 36.
[12] Comprehensive Report, Incident ID 1043117, p 4.

44. Dr Helena Ng, the Consultant Geriatrician responsible for Mrs Clarke's care during her admission to Kingston Centre, stated:

> *On the morning of Tuesday, 11 September 2018 at approximately 1030, Ms Clarke was found unresponsive in bed. Approximately 15 minutes prior, she had been taken to the toilet by nursing staff and left unattended for a brief period. On returning to check on her, they found her on her knees and when questioned, she reported she may have bumped her head but wasn't sure. No obvious signs of external injury to the face or head were evident at that time. Ms Clarke was returned to bed and routine post falls observations were commenced. The ward medical team were notified. We were attending a Code Blue for another patient on the ward at the same time. Shortly after returning to bed, Ms Clarke became confused and unresponsive and a Code Blue was called.*
>
> *I contacted Mr David Clarke ... by telephone shortly after the Code Blue commenced to inform him of his wife's sudden deterioration ...*
>
> *During my initial phone call, I conveyed to Mr Clarke the very serious nature of his wife's deterioration and the possibility that she might not recover from this event, as she remained unresponsive and unconscious throughout resuscitation efforts ...*[13]

45. The nursing entry in the Medical Records on 11 September 2018 at 1055 states:

> *Patient was found on the floor, knees on floor, head facing the door. Pt verbalised that she might have hit her head when she attempt (sic) to get up on the floor. Pt was bought back to bed via hoist x 3 assisted. Obs on arrived on bed ... About 5 mins later, non verbal when called. 1030hrs pt was unresponsive, called for help as per monash health protocol – code blue called.*[14]

46. A further nursing entry made at 1530 on 11 September 2018 confirms the details in Ms Toh's statement, detailed above.

47. During the coronial investigation, Mr Clarke wrote to the Court on a number of occasions outlining his concerns about his wife's care at the Kingston Centre. His concerns ultimately led to his lodgement of a Request for Inquest, which I refused on 18 September 2020.

---

[13] Coronial Brief pp 41-42.

[14] Monash Health medical records, p 415.

48. In summary, Mr Clarke's concerns included the following:

(a) Mrs Clarke was assessed as a 'high' falls risk which required constant supervision;

(b) Mrs Clarke's death was preventable as she was inappropriately left unsupervised on the commode in the bathroom prior to her fall and should not have been expected to press the button when ready given her confusion. Mrs Clarke's previous falls were from a sitting position and she would need to be continually *"propped up"*, otherwise she would *"flop"* to the left side;

(c) he disputed that Mrs Clarke was left unattended because she asked for privacy when she was taken to the toilet given her lengthy hospital stays during which she would have been *"pushed and prodded"* all over without embarrassment;

(d) the medical statements were inconsistent with the contents of the progress/nursing notes in the Medical Records and that the medical staff were not telling the truth;

(e) he did not agree that Mrs Clarke could make her own decisions and call for help if needed as she suffered from delirium and cognitive impairment;

(f) Mrs Clarke's fall was caused by negligence and failure of duty of care; and

(g) she was on the way to recovery and would have recovered but for this incident.

49. In light of the concerns raised by Mr Clarke, the Coroners Prevention Unit[15] **(CPU)** was requested to provide advice as to whether the falls prevention policies and care was reasonable and if any prevention opportunities were identified.

Request for privacy

50. Mr Clarke referred to conflict in the evidence in the coronial brief. Ms Galloway refers to Mrs Clarke requesting *"privacy"* when she was on the commode, however this is not recorded in the nursing notes made at the time. The request for privacy was the reason given as to why Mrs Clarke was not under supervision at the time she was going to the toilet. Mr Clarke's opinion was that his wife would not have asked for privacy, and:

[15] The Coroners Prevention Unit is staffed by healthcare professionals, including practising physicians, nurses and an aged care medical investigator. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, and any particular concerns which have been raised.

Personally – I suspect they forgot about her and then found her on the floor – probably because she was confused and left alone or wanted to get to her physio she may have tried to move herself – therefore her death was caused by neglect of a duty of care in one or more incidents.[16]

51. In her second statement, Ms Galloway noted that whilst 'privacy' was not in the nursing notes, it was referred to in the critical incident form 'Incident follow up' which states:

Patient was cognitively intact and had requested to be left while she used the toilet.[17]

52. The request for privacy by Mrs Clarke is not recorded in the nursing entry in the Medical Records at 10.55am on 11 September 2018, and Mr Clarke disputes his wife would have asked for privacy. However, the evidence in support of her *"requesting to be left a while"* includes the statements from the nurse who was nursing Mrs Clarke at the time, Ms Toh, and her manager, Ms Yang. If she did not make a request for privacy, as contended by Mr Clarke, it is conceivable that she said she would be *"a while"*.

53. There is no direct evidence to the contrary that Mrs Clarke asked for privacy or to be left a while.

54. However, I also note the descriptions of Mrs Clarke's cognitive ability as *"cognitively intact"* and *"cognitively able to make decisions and had always called for assistance"* appear to be in contrast to Ms Galloway's first statement in which she described Mrs Clarke's cognition and fatigue as fluctuating. Mr Clarke confirmed his wife was suffering delirium and cognitive impairment.[18] This is supported by mental status assessments in the MRI33, which consistently provided a rating of 14, indicating that Mrs Clarke was assessed at consecutive assessments (the last being 4 September 2018) as confused, disorientated, and/or agitated. A score of 14 represents a major contribution to Mrs Clarke's cumulative falls risk scores ranging between 23 and 30. The part headed 'If the patient is cognitively impaired' has also been completed on each occasion.

55. In noting this apparent contrast, I also acknowledge that confused but compliant patients who are not impulsive or quite immobile may not require constant supervision if they are compliant and in a safe environment, such as a recliner chair or floorline bed.

---

[16] Coronial Brief, p 12.
[17] Comprehensive Report, Incident ID 1043117, p 2.
[18] Coronial Brief, p 10.

56. I also acknowledge that there are discreet nuances between recognising cognitive impairment as contributing to a falls risk and cognitive ability to make decisions. However, these nuances as they related to Mrs Clarke were not specifically borne out by the evidence.

High risk of falls requiring constant supervision

57. The CPU review of the statements and materials provided by Monash Health concluded that whilst Monash Health had appropriate systems for monitoring patients' falls risks and providing an appropriate post fall response for patients, there was a lack of clarity as to whether these were adhered to in Mrs Clarke's case.

58. In particular, Mrs Clarke was noted to be a 'high' falls risk who, according to Monash Health guidelines, would require 'constant supervision.' The description of 'constant supervision' was unclear in the context of whether it was reasonable to leave Mrs Clarke unsupervised in the toilet, and also it was noted that the need for constant supervision was marked 'N/A' on Mrs Clarke's falls prevention form.

59. A further statement was sought from Monash Health in an attempt to clarify the issue raised by the CPU. The additional information from Ms Galloway indicated that, whilst there may be an awareness by nursing staff of Mrs Clarke's need to have constant supervision, this was not indicated in the Falls Prevention Screening Tool MRI33 and this represented a departure from the Monash Health guidelines for falls prevention.

60. With respect to Mrs Clarke being left, whether for privacy reasons or not, the CPU advised that the limitations of nursing staff providing 'constant supervision' in a busy multi-bay ward environment for older patients should be acknowledged. It is often neither practical nor possible for all high risk falls patients to be in direct line of sight at all times. Subsequently, falls are common despite acceptable standards of nursing practice even when patients are identified as requiring 'constant supervision.'

61. It is also a common dilemma whether to leave a high risk falls patient to have privacy when opening their bowels. The CPU advised that the description provided by the duty nurse, that she remained on the ward bay and provided frequent check ins, may be considered to be a form of 'constant supervision.'

62. In the absence of one on one patient nurse ratios, the evidence and advice suggest 'constant supervision' depends on the circumstances and available resources. I note Mr Clarke's

concerns that his wife needed to be supervised even when in a seated position due her need to be propped to prevent her from collapsing to one side.

Negligence and failure of duty of care

63. As noted above, it is the role of the coroner to find the facts, not to apportion liability or blame.

COMMENTS

64. Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

65. I note that Monash Health appears to have deviated from its falls prevention guidelines by not recording Mrs Clarke's need for constant supervision in the Falls Prevention MRI33 Form. I also note the challenge of 'constant supervision' and the practicality or possibility for all high risk falls patients to be in direct line of sight at all times in a busy multi-bay ward environment. Further, if I accept that Mrs Clarke did ask for privacy, or to be left for a while, this is an additional factor and a dilemma for nursing staff regarding the 'constant supervision' requirement.

66. Whichever the circumstances, leaving Mrs Clarke unattended may have constituted a missed opportunity for prevention, despite acceptable standards of nursing practice given the challenges noted above. I take into account the varying descriptions of Mrs Clarke's cognitive ability and Mr Clarke's account that his wife had fallen from a seated position on previous occasions and needed constant 'propping'.

67. I am of the view the Monash Health falls related guidelines, with regards to the meaning of terms such as 'constant supervision' and how such supervision should be provided for each individual patient, are ambiguous and I will recommend that Monash Health take steps to clarify this term and other ambiguous terms. In this regard, I invited Mr Clarke to provide his input regarding my proposed recommendation. In a letter dated 22 September 2020, Mr Clarke reiterated that his wife's death was preventable and his concerns about the care she received. His response illustrated that the term 'constant supervision' has more than one meaning and its meaning varies significantly between family expectation and clinical practicality. Mr Clarke confirmed his view that Mrs Clarke was not constantly supervised and disagreed that even line of sight on the ward equated to constant supervision.

68. Mr Clarke's submission clearly demonstrates that many families equate constant supervision with 'constant observation', which is in fact the next level of supervision and a clinical

practice that is beyond the resources of most hospitals and most, if not all, nursing homes. To this end, I will also make a recommendation that Monash Health provide consumers and their families with information, for example in a FAQ brochure, about the falls prevention strategies used so that consumers and their families can make informed choices as to whether the care being offered is right for them.

69. Notably, Mr Clarke also observed that for patients with complex medical histories such as his wife, falls prevention may not be enough. Policies and procedures should instead be focussed on injury given the detrimental affect a small injury could have on someone like Mrs Clarke. While he suggested bed rails, helmets, and other protective injury equipment, I note that these strategies are not supported by evidence and in some instances actually result in an increase of falls.

70. I understand Mr Clarke may have some remaining concerns about the care his wife received which fall outside of my jurisdiction. Mr Clarke may wish to direct these to the Health Complaints Commissioner.

FINDINGS AND CONCLUSION

71. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was Josephine Helen Clarke, born 26 November 1948;

    (b) the death occurred on 11 September 2018 at Monash Medical Centre, 246 Clayton Road, Clayton, Victoria from complications of a subdural haemorrhage (palliated) sustained in a fall; and

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

RECOMMENDATIONS

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

1. Monash Health review its falls related guidelines and other supporting documents to clarify ambiguous terms or instructions including, but not limited to, 'constant supervision' and 'N/A';

2. Monash Health review its falls related guidelines and other supporting documents so that a patient's cognitive issues are more clearly identified and documented in order to inform the individual risk mitigation and intervention strategies to be put in place;

3. Monash Health review how the application and implementation of falls prevention mitigation and intervention strategies are recorded for individual patients with a view to providing consistent care; and

4. Monash Health review how consumers and their families are informed of falls prevention mitigation strategies and interventions with a view to reducing ambiguity.

I convey my sincere condolences to Mrs Clarke's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

David Clarke, senior next of kin

Monash Health

Sergeant Greg McFarlane, Victoria Police, Coroner's Investigator

Signature:

CAITLIN ENGLISH

DEPUTY STATE CORONER

Date: 25 March 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** (the Act), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within six months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.