IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 5129

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:	Margaret Lillian Watkins
Date of birth:	28 February 1936
Date of death:	16 September 2020
Cause of death:	1(a) Complications of pelvic fractures sustained in a traumatic incident
Place of death:	University Hospital Geelong, Bellarine Street, Geelong, Victoria

INTRODUCTION

1. On 16 September 2020, Margaret Lillian Watkins was 84 years old when she died following a fall. At the time of her death, Mrs Watkins lived at Costa House aged care facility at Lara.

THE CORONIAL INVESTIGATION

2. Mrs Watkins'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.

3. 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.

4. 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.

5. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mrs Watkins's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into Mrs Watkins'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]

[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.

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

Identity of the deceased

7. On 16 September 2020, Margaret Lillian Watkins, born 28 February 1936, was visually identified by her daughter, Vicki Pilkington.

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

Medical cause of death

9. Forensic Pathologist, Dr Gregory Young, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 17 September 2021 and provided a written report of his findings dated 30 November 2020.

10. The post-mortem examination confirmed the presence of fractures of the right superior and inferior pubic rami in the pelvis. Posterior fractures of the left 10th to 12th ribs were also seen, but no overt fracture of the T3 thoracic vertebra was noted. The lungs showed increased markings and emphysema, and the heart showed coronary artery calcification. The examination also revealed bruises on the forehead, nose, right shoulder, right upper arm, right forearm, right hand, and right hip.

11. Dr Young explained that complications of a pelvic fractures such as those seen in Mrs Watkins may include chest infection (pneumonia), urinary tract infection, multi organ system failure, development of deep vein thrombosis and pulmonary thromboembolism, and exacerbation of pre-existing diseases (such as chronic obstructive pulmonary disease and chronic kidney disease).

12. Toxicological analysis of ante-mortem samples collected on 17 September 2020 identified the presence of morphine,[2] midazolam,[3] olanzapine,[4] and amlodipine.[5]

13. Dr Young provided an opinion that the medical cause of death was *"1(a) Complications of pelvic fractures sustained in a traumatic incident"*.

14. I accept Dr Young's opinion.

[2] Morphine is a narcotic analgesic used for the treatment of moderate to severe pain.
[3] Midazolam is used as a preoperative medication, antiepileptic, sedative-hypnotic, and anaesthetic induction agent.
[4] Olanzapine is an antipsychotic drug.
[5] Amlodipine is indicated for hypertension and angina.

Circumstances in which the death occurred

15. Mrs Watkins's medical history included chronic obstructive pulmonary disease, chronic kidney disease, Alzheimer's dementia, hypertension, distal radius fracture, depression, osteoarthritis, dermatitis, hypercholesterolaemia, and cataracts.

16. Mrs Watkins first entered aged care with her husband in about 2018 at which time her family observed signs of dementia. About the time of her husband's death later that year, Mrs Wakins's dementia worsened, and she required a higher level of care.

17. In early 2019, Mrs Watkins moved to Costa House at Lara, later moving to the dementia ward. Over following months, Mrs Watkins had a number of unwitnessed falls and was involved in an incident in which she struck another resident.

18. Mrs Watkins's daughter, Victoria Pilkington, noted that her mother suffered memory loss and had become increasingly confused. She often became disoriented and wandered around the aged care facility. She required full assistance with activities of daily life.

19. At approximately 3.45pm on 6 September 2020 a fellow resident entered the communal lounge room where he was provided with a sandwich. A short time later, Mrs Watkins also entered the lounge room and, without saying anything, approached the resident and slapped his hands whilst he was holding the sandwich. The resident swore at Mrs Watkins and extended his left forearm, causing him to lose his balance and stumble forward toward Mrs Watkins. He then thrust his left arm toward Mrs Watkins, which caused her to fall backward into a handbasin and onto the floor. The incident was captured on closed-circuit television footage.

20. Staff provided first aid to Mrs Watkins and initially observed some minor injuries including a hematoma to the right side of her head and a scratch on her nose. She was able to move all of her limbs but complained of pain in her lower back. After staff subsequently observed Mrs Watkins to be slightly dragging her right leg as she walked and pain analgesia proved ineffective, a general practitioner was contacted who advised she be taken to hospital.

21. Mrs Watkins was subsequently taken to University Hospital Geelong where she was found to have acute pubic ramus fractures and a T3 thoracic vertebral fracture (acute or subacute), acute kidney injury, and raised C-reactive protein and white cell count suggestive of infection. She was treated with intravenous fluids and antibiotics, but deteriorated, with increasing oxygen requirements. A chest x-ray showed bilateral pneumonia.

22. Mrs Watkins transitioned to end-of-life comfort care and passed away on 16 September 2020 with her daughter, Victoria, by her side.

23. Statements in the coronial brief reveal that the fellow resident who Mrs Watkins had slapped had a severe cognitive impairment (with features suggestive of frontal lobe dysfunction) and had been diagnosed with dementia and Alzheimer's disease. He had a history of aggressive behaviour with both staff and fellow residents. His condition meant that he was unable to moderate his behaviour and emotional responses. Although he had been prescribed oxazepam to assist, it had little effect. His family did not consent to use of ongoing chemical restraint so behavioural strategies were implemented to reduce the risk of the resident responding when others came into his perceived space, which he did not like.

24. Following Mrs Watkins's death, a consultant in geriatric medicine and a dementia consultant both recommended the resident receive ongoing management with psychosocial and environmental interventions as antipsychotic medication was unlikely to be efficacious. He has since been transferred to another facility and has not been charged in relation to Mrs Watkins's death.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Margaret Lillian Watkins, born 28 February 1936;

    (b) the death occurred on 16 September 2020 at University Hospital Geelong, Bellerine Street, Geelong, Victoria, from complications of pelvic fractures sustained in a traumatic incident; and

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

COMMENTS

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

26. Resident-to-resident aggression in aged care facilities is a theme that arises somewhat regularly in this Court. Persons who, like the unnamed resident in this case, have a history of aggressive behaviour and are difficult to manage due to cognitive impairment are not uncommon in aged care facilities. Indeed, where an aged care facility provides care to a cohort of residents with similar behavioural issues, violence or aggression can easily erupt due to

poor impulse control. It is a dilemma that must be addressed now in a country in which the population is ageing rapidly. This Court has previously considered this issue and the theme that commonly arises in these cases is that more research is needed to determine best practices. In order for this to happen, resident-to-resident aggression incidents and data needs to captured clearly and in a useful way.

Previous coronial finding – the call for accurate reporting

27. In March 2016, Coroner Rosemary Carlin 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.

28. 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 (as they were then drafted). The effect of these legislative limitations meant that if the perpetrator (for want of a better description) of resident-to-resident assault in an aged care facility had a pre-diagnosed cognitive or mental impairment, such as dementia, and a behaviour management plan was put in place within 24 hours of the alleged assault, the assault did 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.

29. A relatively recent systemic review of research into resident-to-resident physical aggression[6] 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

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

(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.

30. In the *Finding into death without inquest regarding BS*,[7] Coroner Carlin advocated for more research to be undertaken to determine appropriate staffing levels and skill mix, appropriate education and training, prevention strategies, nursing home design, policies, guidelines, and legislation. Her Honour noted that further research as to how best to address, manage, and prevent resident-to-resident aggression was needed. Notably, her Honour highlighted that the starting point for any prevention opportunities was accurate recording 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.

31. Her Honour therefore supported mandatory reporting of all incidents of aggression involving physical contact whether or not the perpetrator has any form of cognitive or mental impairment and made the following recommendations:

(a) 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;

(b) 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

(c) that the Commonwealth Department of Health consider publicly reporting on incidents of physical aggression in residential aged care services each year.[8]

32. While the Department of Health did not formally respond to those recommendations, in May 2020, Acting Assistant Secretary Ingrid Leonard advised the Court that the Department of Health had initiatives underway which would address Coroner Carlin's recommendations. Ms Leonard stated that the Department of Health was *"undertaking preparatory work for the*

[7] COR 2013 4853, dated 30 May 2019, available at: https://coronerscourt.vic.gov.au/sites/default/files/2019-07/SB_485313.pdf.

[8] 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.

*implementation of the Serious Incident Response Scheme (**SIRS**)",* which would replace current compulsory reporting requirements. She stated that the SIRS is *"expected to mandate reporting of a broader range (than at present) of serious incidents in residential aged care to the Aged Care Quality and Safety Commission".* The range of incidents reported would include resident-to-resident aggression, even where the alleged perpetrator has an assessed cognitive or mental impairment. This response appeared to address the crux of Coroner Carlin's recommendations.

The Serious Incident Response Scheme

Research leading to implementation

33. In preparing to implement the SIRS, the government asked KPMG to collect data regarding the prevalence of serious incidents involving residents in aged care residential services. In November 2019, KPMG completed its report titled 'Prevalence Study for a Serious Incident Response Scheme (SIRS)'.[9]

34. Data was collected during a six-month period from 1 February to 31 July 2019. Resident-on-resident incidents that met the definition of a reportable assault under the *Aged Care Act 1997*, but which were exempt from being reported to the Department, were categorised as 'Type 1 incidents'.[10]

35. In total, there was a total of 1,259 Type 1 incidents reported for the six-month period from the 178 services in the sample.[11] Unreasonable use of force was reported in the majority of incidents (95.0 per cent).[12] For each Type 1 incident, the respondent was also asked to select all behaviours that were displayed by the alleged perpetrator. One behaviour type was selected in 1,206 of the 1,259 (95.8 per cent) Type 1 incidents and two behaviour types or more were selected in 55 incidents (4.4 per cent). Pushing or shoving, kicking, hitting, punching, slapping, biting and/or burning behaviour was the most common behaviour type, being reported in 1,038 (82.3 per cent) of Type 1 incidents.[13]

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[9] Available at: https://www.health.gov.au/sites/default/files/documents/2020/06/prevalence-study-for-a-serious-incident-response-scheme-sirs_0.pdf.

[10] Pursuant to the version of the *Aged Care Act 1997* in place at the time, incidents were exempt from the requirement to report where a reportable assault was perpetrated by a resident with an assessed cognitive or mental impairment, and care arrangements are put in place within 24 hours to manage the behaviour, or when an allegation or suspicion relates to the same, or substantially the same, factual situation or event as an earlier allegation or suspicion of a reportable assault, and that earlier allegation or suspicion was reported to the Department.

[11] KPMG, Prevalence Study for a Serious Incident Response Scheme (SIRS), November 2019, p 26.

[12] KPMG, Prevalence Study for a Serious Incident Response Scheme (SIRS), November 2019, p 28.

[13] KPMG, Prevalence Study for a Serious Incident Response Scheme (SIRS), November 2019, p 29.

36. KPMG noted that at *"a national level, over a 12-month period, there may be tens of thousands of incidents."*[14] It was clear that capturing this data was vital to further research.

Implementation

37. The SIRS subsequently commenced on 1 April 2021 and is administered by the Aged Care Quality and Safety Commission. The SIRS includes incident management and reportable incident obligations.

38. According to the Aged Care Quality and Safety Commission, the SIRS *"requires aged care providers to identify, record, manage, resolve, and report all serious incidents to the [Commission] that occur, or are alleged or suspected to have happened, in a residential aged care service."*[15]

39. The Aged Care Quality and Safety Commission notes that the SIRS covers a broader range of non-reportable incidents and includes reports of *all* incidents that are alleged or suspected to have occurred, or witnessed, between consumers of a residential aged care service, including when a *consumer who commits the incident has a cognitive or mental impairment* (such as dementia). Reportable incidents include unreasonable use of force. Where the incident causes, or could reasonably have been expected to have caused, physical or psychological injury or discomfort requiring some form of medical or psychological treatment, the incident must be reported to the Commission within 24 hours of the residential aged care service becoming aware of the incident.

40. The SIRS also requires every residential aged care service to have in place an incident management system, which includes protocols, processes, and standard operating procedures, to manage and respond to all incidents, and take preventative action.

41. I note the Commission published its first data report in May 2021.[16] This revealed that during the period 1 April to 12 May 2021, the Commission received 1,876 Priority 1[17] reportable incidents, of which 41 percent (778 incidents) included unreasonable use of force. However,

[14] KPMG, Prevalence Study for a Serious Incident Response Scheme (SIRS), November 2019, p 5.
[15] Aged Care Quality and Safety Commission, Serious Incident Response Scheme, available at: https://www.agedcarequality.gov.au/consumers/serious-incident-response-scheme.
[16] Aged Care Quality and Safety Commission, Serious Incident Response Scheme (SIRS) insight report, May 2021, available at: https://www.agedcarequality.gov.au/sirs/reports.
[17] Priority 1 reportable incidents are reportable incidents: that have caused or could reasonably have been expected to cause, a consumer physical or psychological injury or discomfort that requires medical or psychological treatment to resolve, or if there are reasonable grounds to contact the police, or when there is the unexpected death of a consumer or a consumer's unexplained absence from the service.

the Commission has not published the number of Priority 1 incidents that were attributable to resident-to-resident aggression.

Professor Ibrahim's recommendations

42. I note that Professor Ibrahim was also the lead author of the 'Recommendations for Prevention of Injury-Related Deaths in Residential Aged Care Services' published by the Health Law and Ageing Research Unit at the Monash University Department of Forensic Medicine, and that Chapter 7 of this report sets out 10 recommendations directed to reducing deaths related to resident-to-resident aggression. In addition to mandatory reporting of incidents, these include:

    (a) government, health department, regulators, providers and health professional bodies develop national standards describing the skills mix and staffing levels required to manage the needs of residents to prevent resident to resident aggression;

    (b) all relevant data on incidents of aggression and assault be reported publicly each year;

    (c) mandatory training for staff be extended to include training on the fundamentals of dementia and resident to resident aggression;

    (d) the physical environment of the aged care facilities be designed and used in a way that enables, rather than disables, residents with cognitive impairment;

    (e) clear, user-friendly definitions of the spectrum of aggressive behaviours be included in mandatory reporting legislation, policy and protocol documents; and

    (f) government agencies, advocacy groups and aged care providers develop and implement a community awareness campaign to increase the general public's understanding of dementia, its behavioural and psychological symptoms, and knowledge about the preventability of aggressive incidents among older adults.

43. Other coroners[18] have provided support for these recommendations in previous coronial findings and I also support them.

[18] See for example the *Finding into Death Without Inquest regarding Jane Nola Rolph*, COR 2018 5078, 4 May 2020, available at: https://coronerscourt.vic.gov.au/sites/default/files/2020-05/JaneNolaRolph_507818.pdf; *Finding into Death Without Inquest regarding Dorothy Lorraine Boyle* COR 2018 4408, 22 July 2020, available at: https://coronerscourt.vic.gov.au/sites/default/files/2020-07/BOYLE%20Dorothy%20-%202018%204408%20-%20Fall%20200720.pdf.

Royal Commission into Aged Care Quality and Safety

44. The Royal Commission into Aged Care Quality and Safety was established on 8 October 2018.

45. Professor Ibrahim provided evidence to the Royal Commission.[19] Part of his submission was dedicated to resident-to-resident aggression, which he considered a form of elder abuse and a form of assault, and he repeated his above recommendations.[20] He noted that cognitive impairment (including dementia) was a common feature, with 50 to 75 percent of residents involved in incidents of resident-to-resident aggression having some sort of cognitive impairment, but noted that prevalence of resident-to-resident aggression was difficult gauge due to data collection and analysis limitations.[21]

46. The Royal Commission into Aged Care Quality and Safety delivered its final report on 26 February 2021.[22]

47. In its final report, the Royal Commission acknowledged Australia's ageing population and the parallel increasing need for aged care services.[23] This includes the need for complex care for residents with dementia who exhibit challenging behaviours, which necessitate support that requires skilful care.[24] The Royal Commission repeated Professor Ibrahim's estimation that more than half of people living in aged care facilities had a diagnosis of dementia, but the quality of care fell significantly short of the needs of this cohort.[25] Professor Ibrahim's call for mandatory dementia training for staff was echoed.[26]

48. The Royal Commission also lamented the lack of data, research, and innovation in the aged care sector[27] and similarly called for serious incident reporting, acknowledging that the government had by that stage already announced a new reporting scheme.[28]

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[19] Professor Ibrahim's statement is available at: https://agedcare.royalcommission.gov.au/media/4836.
[20] Royal Commission into Aged Care Quality and Safety, Statement of Professor Joseph Elias Ibrahim, 23 April 2019, see paragraphs 131 to 150.
[21] Royal Commission into Aged Care Quality and Safety, Statement of Professor Joseph Elias Ibrahim, 23 April 2019, paragraphs 136, 143-145, 150.
[22] Available at: https://agedcare.royalcommission.gov.au/publications/final-report.
[23] Royal Commission into Aged Care Quality and Safety, 2021, Final Report: Care, Dignity and Respect, Volume 1, p 61.
[24] Royal Commission into Aged Care Quality and Safety, 2021, Final Report: Care, Dignity and Respect, Volume 1, p 69.
[25] Royal Commission into Aged Care Quality and Safety, 2021, Final Report: Care, Dignity and Respect, Volume 1, p 92.
[26] Royal Commission into Aged Care Quality and Safety, 2021, Final Report: Care, Dignity and Respect, Volume 1, p 92.
[27] Royal Commission into Aged Care Quality and Safety, 2021, Final Report: Care, Dignity and Respect, Volume 1, pp 77, 144.
[28] Royal Commission into Aged Care Quality and Safety, 2021, Final Report: Care, Dignity and Respect, Volume 1, p 140.

49. The Royal Commission handed down a number of recommendations that are relevant in this case. These include:

(a) recommendation 15: establishment of a dementia support pathway;

(b) recommendation 16: specialist dementia care services;

(c) recommendation 59: increased access to Older Persons Mental Health Services;

(d) recommendation 96: responding to Coroner's reports;

(e) recommendation 100: serious incident reporting, noting that this should be regardless of whether the alleged perpetrator has a cognitive or mental impairment, and that the number of serious incident reports be published on a quarterly basis at a system-wide level, at a provider level, and at a service or facility level; and

(f) commendation 107: the creation of an Aged Care Research and Innovation Fund.

Conclusion

50. While there has been significant development in the area of resident-to-resident aggression since Coroner Carlin's 2019 finding, it is clear further research is needed to implement the recommendations of the Royal Commission and those espoused by Professor Ibrahim. The SIRS will go some way to informing change in the provision of aged care services to address and prevent resident-to-resident aggression.

51. While I commend the Aged Care Quality and Safety Commission's publication of insight reports, I encourage the Commission to go further by publishing specific data in relation resident-to-resident incidents which would be more in keeping with the spirit of the Royal Commission's recommendation. This in particular would provide a rich source of data and a strong starting point for ongoing research in this area with the aim of achieving the objectives Coroner Carlin highlighted in her finding – appropriate staffing levels and skill mix in aged care facilities, appropriate staff education and training, prevention strategies, nursing home design, policies, guidelines, and legislation to address, manage, and prevent resident-to-resident aggression.

52. I look forward to further developments in this area.

I convey my sincere condolences to Mrs Watkins'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:

Victoria Pilkington, senior next of kin

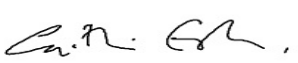
Barwon Health

Costa House (care of Ms Clare Amies, Chief Executive Officer, genU)

Aged Care Quality and Safety Commission

Sergeant Patrick Derksen, Victoria Police, Coroner's Investigator

Signature:



Caitlin English, Deputy State Coroner

Date: 14 January 2022

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 6 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.