IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 002438

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

Section 67 of the ***Coroners Act 2008***

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Caroline Monique Hall
Delivered on:	16 December 2024
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	16 December 2024
Place of death:	Austin Health, Austin Hospital, 145 Studley Road, Heidelberg, Victoria, 3084
Counsel assisting the coroner:	James Whyman, Coroner's Solicitor
Key words	In-care; Falls Death; Supported Disability Accommodation (**SDA**)

INTRODUCTION

1. On 12 May 2021, Caroline Monique Hall was 52 years old when she passed away at the Austin Hospital. At the time, Ms Hall lived in specialist disability accommodation at Burke House operated by Vivid Care in Echuca. Ms Hall was also an NDIS participant.

2. Ms Hall was born in 1968 to parents Alison and Michael Hall. She was a difficult baby and had issues feeding however various doctors assured her family that she was just a fussy eater.

3. Ms Hall was first diagnosed with an intellectual disability when she was 15 years old. Around the same time, she developed severe epilepsy and was placed on medication. According to her sister, Samantha Meaden, this medication caused side effects that affected her for the rest of her life.

4. Ms Hall left school shortly after receiving her diagnoses and attended a literacy and typing course run by volunteer-run organisation. Generously, she also donated her time volunteering at the local hospital where she was born as well as at the local vet.

BACKGROUND AND PERSONAL CIRCUMSTANCES

5. When she was 19 years old, Ms Hall self-harmed by cutting and at the time explained that voices in her head made her do it. Ms Hall was subsequently diagnosed with schizophrenia.

6. In her early twenties Ms Hall moved out of the family home and lived independently in Bendigo. Although she lived by herself, she continued to receive regular support and visits from her family as well as support from local mental health services. During this time, she put on a significant amount of weight and developed diabetes.

7. When she was 25 years old, Ms Hall returned to live with her parents and resided in a bungalow at the rear of the property. In the ensuing years she continued to have seizures despite numerous visits to doctors and trials of different medications. Ongoing seizures resulted in multiple falls and severe head and spinal injuries. The head injuries caused further deterioration in her physical and mental health, and she became reliant on walking sticks and frames for mobility.

8. When she was 45 years old, Ms Hall moved to live in disability support care at Burke House operated by Vivid Care in Echuca due to her deteriorating condition and elevated care needs. She received 24-hour care and lived in the shared accommodation with five other residents.

Ms Meaden noted her sister was "*far happier at Burke House*"[1] and that she got along well with the other residents and the staff.

THE CORONIAL INVESTIGATION

9. Ms Hall'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. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

10. 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.

11. 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.

12. Victoria Police assigned First Constable Mitchell Siggs to be the Coronial Investigator for the investigation of Ms Hall's death. The Coronial 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.

13. This finding draws on the totality of the coronial investigation into the death of Caroline Monique Hall 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.[2]

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[1] Statement of Samantha Meaden dated 9 October 2021.

[2] 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

14. On 10 May 2021, Caroline Monique Hall, born 19 November 1968, was visually identified by her sister, Samantha Meaden, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

16. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 13 May 2021 and provided a written report of her findings dated 3 June 2021.

17. Examination of the post-mortem computerised tomography (**CT**) scan showed a fracture of the 5th and 6th cervical vertebrae. There was possible dislocation at the level of the 9th and 10th thoracic vertebrae.

18. The post-mortem external examination showed generalised oedema and numerous bruises, seemingly aged and associated with sites of medical intervention.

19. Routine toxicological analysis of post-mortem samples detected morphine,[3] midazolam,[4] olanzapine,[5] levetiracetam,[6] valproic acid,[7] metformin,[8] benztropine,[9] citalopram[10] at levels broadly consistent with normal therapeutic use.

20. Dr Archer provided an opinion that the medical cause of death was *1(a) spinal injuries sustained in falls in a woman with multiple medical comorbidities*.

21. I accept Dr Archer's opinion.

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[3] Morphine is a narcotic analgesic used for the treatment of moderate to severe pain.
[4] Midazolam is a preoperative medication, antiepileptic, sedative-hypnotic, and anaesthetic induction agent
[5] Olanzapine is an atypical antipsychotic drug.
[6] Levetiracetam is an antiepileptic used for the control of partial onset seizures.
[7] Valproic acid is indicated for epilepsy, and as an adjunct in mania and schizophrenia where other therapy is inadequate.
[8] Metformin is an antidiabetic drug used to treat maturity-onset diabetes.
[9] Benztropine is used to control extrapyramidal disorders caused by antipsychotics
[10] Citalopram is a selective serotonin reuptake inhibitors (SSRIs) indicated for major depression and panic disorders.

Circumstances in which the death occurred

22. Ms Hall continued to suffer falls following her admission to Burke House. In a risk assessment completed at Burke House for Ms Hall on 1 June 2020, it was documented that she was prone to fall or become unsteady on her feet. It was also noted that clutter in her bedroom was a known falls hazard as she liked to collect items and she had a tendency to leave items on the floor, including food. The risk assessment documented that staff should assist Ms Hall tidy her room every evening to mitigate environmental fall hazards.[11]

23. Ms Hall experienced a period of rapid weight loss during her time at Burke House and began seeing a dietitian for her poor appetite and low sodium levels (hyponatremia). Her medications were altered which her sister felt led to a deterioration in her mental health. Although she had diet recommendations and fluid restrictions to manage her hyponatremia, Ms Hall was known to sneak out of her bedroom at night to eat and drink.

24. Ms Hall was managed by General Practitioner (**GP**) Dr Adrian Waldron of the Rich River Health Group since 2015. According to Dr Waldron, her medical issues included:

    i. Lifelong intellectual disability

    ii. Epilepsy.

    iii. Schizoaffective disorder.

    iv. Syndrome of Inappropriate Secretion of Antidiuretic Hormone (**SIADH**) resulting in chronic severe hyponatremia.

    v. Non-insulin dependent diabetes with worsening glyacemic control leading up to her death.

    vi. Osteoporosis.

    vii. History of multiple thoracic compression fractures.

    viii. Asthma, hypertension, and hyperlipidaemia.

25. The evidence suggests Ms Hall's health deteriorated markedly in 2021. She was admitted to the emergency department (**ED**) on three occasions in 2021 for seizure events. Attempts were

[11] Risk assessment dated 1 June 2020, coronial brief pg 108-110.

made, including restricting fluid intake, to improve Ms Hall's chronic severe hyponatremia throughout 2021 which was thought to be exacerbating her epilepsy. Dr Waldron stated that fluid restriction was difficult due to Ms Hall's intellectual disability. Her diabetes was also worsening with poor glycaemic control in the months leading up to her death.

26. Ms Hall last consulted Dr Waldron on 26 April 2021. He was not aware of any reported escalation of falls at the time. In relation to the quality of care Ms Hall received at Burke House, Dr Waldron stated:

> *I have no concerns regarding non-accidental injury with this lady as I believe her personal carers and family had provided a safe comfortable environment for Caroline for the many years I had known her given her many medical issues*.[12]

27. In the week prior to her death, Ms Hall became increasingly unwell. Burke House progress notes indicate she had periods of reduced appetite, insomnia, poor hygiene, migraines, hearing voices and generally feeling unwell. She refused meals throughout 6 May 2021 and spent much of the day sleeping in bed. The next morning it was noted she appeared unhappy and continued to refuse foods and most fluids.

28. At about 4.45 pm on 7 May 2021, disability support worker Ms Erin Childs heard a series of noises from Ms Hall's bedroom which she initially believed was the house cat. After hearing the noises multiple times, Ms Childs grew concerned that something may be wrong and attended Ms Hall's room with another disability support worker, Mr Peter Foran. On arrival they discovered Ms Hall lying on the floor on her left side situated between the bed and a chest of drawers.

29. Ms Hall informed the attending disability support workers that she tripped over her basket. The basket was used to store Ms Hall's colouring books and other possessions. A texta was also seen on the floor which the workers believed may have caused Ms Hall to trip. According to Ms Childs, Ms Hall's bedroom was often cluttered no matter how many times staff assisted her tidy her bedroom.

30. The disability support workers asked Ms Hall if she was ok, and she reported that she could not get up and needed an ambulance. When asked where she was hurt, Ms Hall did not answer.

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[12] Statement of Dr Adrian Waldron dated 7 October 2021.

31. After about five minutes, Ms Childs and Mr Foran assisted Ms Hall into her recliner chair. She moaned as she was lifted but appeared comfortable once she was in her chair. An icepack was placed on Ms Hall's lower back. Her support workers continued to ask where Ms Hall was hurt but did not receive a definitive response.

32. When the disability workers temporarily stepped outside her room, Ms Hall was observed knitting. It appears Ms Childs was reluctant to phone for an ambulance despite the requests of Ms Hall and cited previous occasions when ambulances had been called for Ms Hall only to reveal there was nothing wrong with her. Moreover, Ms Childs noted Ms Hall complained of discomfort when speaking with Mr Foran and herself but appeared to revert to normal once left alone.

33. Ms Childs and Mr Foran phoned the Burke House manager, Ms Suellen Betts, and reported Ms Hall had an unwitnessed fall and appeared to be ok. Following discussions, a plan was made to administer paracetamol for pain relief, monitor Ms Hall, and call an ambulance if her condition deteriorated. Ms Hall tolerated the paracetamol although at the time it was administered, she told Ms Childs that she did not feel well.

34. At about 6.00 pm, Ms Hall walked unaided from her bedroom to the dining area and joined the other residents for dinner. She stayed at the dining table for about ten minutes, ate pizza and laughed with the other residents, before returning to her room where she continued to knit. Ms Childs reported it was normal for Ms Hall to only stay at the dining table for about ten minutes.

35. Later that evening, Ms Hall refused to have a shower, take her evening medication, or have her blood glucose levels tested. Ms Childs stated this was not unusual and that she continued to check on Ms Hall throughout the evening as she remained sitting in her chair knitting. Ms Childs felt Ms Hall seemed ok throughout the evening.

36. From 9.00pm onwards, Ms Childs was the only disability support worker on shift at Burke House and she believed that Ms Hall had put herself to bed that night. The bedroom light remained off throughout the night and Ms Hall was not seen exiting her bedroom. Ms Childs stated this was somewhat unusual as normally Ms Hall would fall asleep in her chair or be awake all night. Progress notes made by Ms Childs recorded that Ms Hall slept in her bed all night.[13]

[13] Daily Notes from Burke House, Coronial Brief pg 43.

37. The next morning, 8 May 2021, Ms Childs checked on Ms Hall at about 7.00am and found her still asleep. Ms Childs did not observe any signs that Ms Hall had suffered another fall overnight.

38. At 8.00 am, disability support worker Ms Shellianne Baker commenced a shift at Burke House. Both Ms Childs and Ms Baker entered Ms Hall's bedroom to provide her with her morning medications. She was difficult to rouse and remained in her day clothes from the day before.

39. The observed that she was lying on her back with her feet hanging off the edge of the bed; her skin appeared grey; she was cold to the touch; and there was a small amount of blood on Ms Hall's toes (which was torn but still hanging on) and chest.

40. Ms Hall was in an altered conscious state. Her speech was slow, she complained of excessive thirst, and appeared lethargic. She reported to Ms Childs and Ms Baker that she had a fall overnight, back and arm were sore and she asked for an ambulance. Ms Childs stated she responded and said "*no, that was yesterday*" with reference to the fall and Ms Hall clarified:

> *Caz told us that she had got up during the night and sat in her chair. She said that she tried to get out of her chair, got her foot stuck, ripped her nail and had fallen.*[14]

41. Ms Baker measured Ms Hall's blood glucose levels which returned an elevated level (24.2). Having seen the elevated levels, Ms Baker phoned for an ambulance at around 8.15 am.

42. An Ambulance Victoria Non-Emergency Patient Transport vehicle arrived at about 8.45 am. Paramedics assessed Ms Hall's condition and determined her condition warranted an ambulance. Oxygen support was provided in the meantime.

43. An ambulance arrived a short time later and Ms Hall was subsequently taken to the Echuca Hospital. A CT scan was performed which showed an unstable C5 – C6 fracture, unstable fracture L1-2, severe canal stenosis with cord oedema of C3-5, epidural haematoma C7.

44. Ms Hall was intubated and transported via air ambulance to the Intensive Care Unit (**ICU**) at the Austin Hospital for a neurosurgical review. She was reviewed by clinicians who diagnosed quadriplegia requiring significant full-time care and likely lifelong ventilation. A family

[14] Statement of Erin Childs dated 15 November 2021.

meeting was held, and it was decided that given her poor prognosis, Ms Hall was for end of life care and organ donation.

45. She was transitioned to palliative care and was kept comfortable until she passed away on the morning of 12 May 2021.

FINDINGS AND CONCLUSION

46. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the Briginshaw gloss or explications.[15]

47. Moreover, the effect of the authorities is that Coroners should not make adverse comments or findings against individuals or institutions, unless the evidence provides a comfortable level of satisfaction that they departed materially from the standards of their profession and in so doing, caused or contributed to the death.

48. It is axiomatic that the material departure from applicable standards be assessed without the benefit of hindsight, on the basis of what was known or should reasonably have been known at the time, and not from the privileged position of hindsight. Patterns or trajectories that may be appreciated at a later time or may even obvious once the tragic outcome has come to pass are to be eschewed in favour of a fair assessment made without hindsight.

49. After Ms Hall's fall in the afternoon of 7 May 2021, she was seen knitting in her bedroom and walking unaided between her bedroom and the dining room. Despite her requests for an ambulance, the attending disability support workers did not observe any objective signs of injury.

50. The next morning, she was found in bed in an altered conscious state having deteriorated significantly over night.

51. Having considered all the evidence and to the applicable standard, I am satisfied that Ms Hall had a subsequent, unwitnessed fall sometime overnight between 7 and 8 May 2021 and that it was the injuries that resulted from that fall, not the fall in afternoon of 7 May 2021, that caused her paraplegia and led to her death.

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[15] Briginshaw v Briginshaw (1938) 60 C.L.R. 336 especially at 362-363. *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…"*.

52. The catastrophic nature of her injuries discovered at the Austin hospital are inconsistent with the observations of Ms Hall after her fall on 7 May 2021. Contemporaneous records and Ms Childs' account noted she walked to dinner unaided, incompatible with her later prognosis of quadriplegia made at the Austin Hospital days later.

53. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    i. the identity of the deceased was Caroline Monique Hall, born 19 November 1968;

    ii. the death occurred on 12 May 2021 at Austin Health, Austin Hospital, 145 Studley Road, Heidelberg, Victoria, 3084;

    iii. the cause of Ms Hall's death was spinal injuries sustained in falls in a woman with multiple medical comorbidities; and

    iv. the death occurred in the circumstances described above.

54. The available evidence does not support a finding that there was any want of clinical management or care on the part of the staff at Burke House that caused or contributed to Ms Hall's death. Without the benefit of hindsight, it was reasonable for Ms Childs and Mr Foran, after consulting with the Burke House manager, to follow their own assessment of Ms Hall's condition after her fall on 7 May 2021 and not to call for an ambulance, despite Ms Hall's request made in the aftermath of the fall.

55. I convey my sincere condolences to Ms Hall's family for their loss.

Pursuant to section 73(1B) 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:

Alison & Michael Hall, Senior Next of Kin

Austin Health

Vivid Care

National Disability Insurance Scheme Quality and Safeguards Commission

Senior Constable Mitchell Siggs, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 16 December 2024

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.