IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 006088

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Frances Mary Hayden
Date of birth:	14 August 1946
Date of death:	17 October 2024
Cause of death:	1a : COMPLICATIONS OF MANDIBULAR FRACTURES SUSTAINED IN A FALL 2 : MALNUTRITION, SCHIZOAFFECTIVE DISORDER, OSTEOPOROSIS
Place of death:	Arcadia Aged Care Service 120 McCracken Street Essendon Victoria 3040
Keywords:	Aged care; Falls death

INTRODUCTION

1. On 17 October 2024, Frances Mary Hayden was 78 years old when she died of complications arising from fractures she sustained in a fall. At the time of her death, Frances lived in care at Arcadia Aged Care Service, 120 McCracken Street, Essendon Victoria 3040.

2. Frances was born and educated in Melbourne where she worked as a music teacher. She was diagnosed with a schizoaffective disorder when she was 23 years old, and struggled with anorexia from that time, although she managed to keep working part time. She loved travel and her local book club.[1]

3. She lived in the family home in East Malvern for most of her life, but in 2022, her brother Peter helped move her into Arcadia Aged Care after a fall, then visited her frequently.[2]

4. In 2024, her carer at Arcadia noticed a significant amount of blood in her sanitary pad. Upon medical review at northern health she declined to have further investigations done regarding her significant family history of bowel cancer and opted for conservative management. From August 2024, she began to lose weight and although subsequent investigations showed her large bowel to be grossly impacted, she continued to refuse further treatment. [3]

THE CORONIAL INVESTIGATION

5. Frances'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.

6. 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.

7. 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

[1] Statement of Peter Hayden, *Coronial Brief*.
[2] Ibid.
[3] Statement of Andrea Roos, *Coronial Brief*.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

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

9. This finding draws on the totality of the coronial investigation into the death of Frances Mary Hayden 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.[4]

10. In considering the issues associated with this finding, I have been mindful of Frances's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

11. On 25 September 2024, she suffered a witnessed fall at the facility that was subsequently confirmed to be a fracture of her jaw. [5]

12. With limited oral intake, Frances continued to lose weight and generally decline, despite being offered support from a dietitian, and she passed peacefully on 17 October 2024.[6]

Identity of the deceased

13. On 17 October 2024, Frances Mary Hayden, born 14 August 1946, was visually identified by their carer for the last one and a half years, Ms Upeshi Mudiyanselage.

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

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[4] 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.

[5] Statement of Andrea Roos, *Coronial Brief*.

[6] Ibid.

Medical cause of death

15. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 18 October 2024 and provided a written report of his findings dated 23 October 2024.

16. The post-mortem CT scan confirmed the already documented fractures, and whilst the physical examination did not reveal any other discreet cause of death, her body mass index of 13.3 was severely underweight which itself carries a significant risk of death due to metabolic derangements and infections.

17. Given the straightforward and well documented presentation of the case, I did not order toxicological testing.

18. Dr de Boer provided an opinion that the medical cause of death was 1(a) COMPLICATIONS OF MANDIBULAR FRACTURES SUSTAINED IN A FALL, in the setting of 2 MALNUTRITION, SCHIZOAFFECTIVE DISORDER, OSTEOPOROSIS, and I accept his opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Frances Mary Hayden, born 14 August 1946;

    b) the death occurred on 17 October 2024 at Arcadia Aged Care Service, 120 McCracken Street, Essendon, Victoria, 3040, from 1(a) COMPLICATIONS OF MANDIBULAR FRACTURES SUSTAINED IN A FALL in the setting of 2 MALNUTRITION, SCHIZOAFFECTIVE DISORDER, OSTEOPOROSIS; and

    c) the death occurred in the circumstances described above.

20. Having considered all of the evidence, I am satisfied that Frances's care was reasonable and appropriate at all material times, and that she was appropriately given agency to make the choices that affected her life.

I convey my sincere condolences to Frances'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:

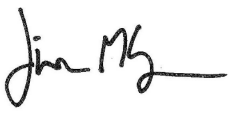
Peter Hayden, Senior Next of Kin

Scott Shelly, Barry Nilsson

Tiffany Boulton, Churches of Christ Care

Senior Constable Timothy Folk, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 10 September 2025

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.