IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003306

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Jean Meyer

Delivered On:	30 April 2024
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank
Hearing Dates:	30 April 2024
Findings of:	Coroner Katherine Lorenz
Counsel Assisting the Coroner:	Dr Declan McGavin, Coroner's Solicitor
Keywords	Homicide; dementia; aged care; resident on resident death

INTRODUCTION

1. On 20 June 2023, Jean Meyer was 96 years old when she died in hospital from complications following a fractured distal right femur sustained in a fall at the residential aged care facility where she lived. The fall was caused by a fellow resident who had severe dementia and has subsequently passed away.

2. Jean was a resident at Archie Gray Nursing Home, an 11-bed high-level care facility joined to Kaniva Hospital and operated by West Wimmera Health Service. Jean had been a resident from November 2022 after her care requirements increased following a previous fall with hip fracture.

THE CORONIAL INVESTIGATION

3. Jean'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.

4. The Act recognises that it is in the public interest to hold a public hearing when a person causes the death of another: it is mandatory for the coroner to hold an inquest if the death occurred in Victoria, the coroner suspects the death was the result of homicide, and no person or persons have been charged with an indictable offence in respect of the death.[1]

5. 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.

6. 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] The Act, section 52(2)(a); section 52(3)(b).

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

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Jean'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.

8. This finding draws on the totality of the coronial investigation into the death of Jean Meyer 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.

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

Circumstances in which the death occurred

9. On 13 June 2023, at approximately 7.50am, the director of nursing noted that the call bell system was not working.

10. Within the whole of the Kaniva Hospital facility there is a call bell system provided by XACOM, a company which provides critical communication systems such as nurse call stations. Each resident's room, and other rooms and public spaces, are fitted with call bell buttons mounted on the wall. All call bells in resident and patient rooms have both a call bell and emergency call function.

11. Residents and patients have additional calls bells attached to a 4m lead from the wall for semi-mobile access. In addition to call bells, residents may also have a sensor mat next to their bed, on their chair, and/or a pendant alarm to wear around the neck. An ongoing assessment of a residents falls risk and cognitive ability determines what type of calls bell systems/sensor mats are in place.

12. When a call bell is activated, the room number will appear on annunciators attached to the ceiling throughout the facility. When a call bell is cleared or there are no active calls, the

annunciators display the current time. Call bells also alerted staff via a mobile phone which is carried while on shift. Each call bell is checked at the start of every shift.

13. When there is a fault with the call bell system, staff instead perform 15-minutely visual checks of all residents which is documented in a rounding sheet with the time and date.

14. XACOM, with the local IT department, were able to fix the call bell issue. However, the system repeatedly faulted over the course of the day and staff continued to perform 15-minutely checks.

15. Just before 3pm, an EN heard someone calling for help. They entered Jean's room and found her on the floor in the centre of the room with an obvious deformity to her hip suggestive of a neck of femur fracture (hip fracture).

16. Jean stated to the nurse that a fellow resident, Cynthia Hicks, had pushed and punched her onto the floor. Cynthia had come into her room twice and was fossicking around the chocolates and lollies in the room. Jean attempted to redirect Cynthia out of her room, but she came back in shortly after. Jean had reportedly pressed the call bell to call for assistance; however, owing to the faults at the time, staff were not notified. Jean's account was consistent with CCTV footage from the hallway.

17. Cynthia had severe dementia and was not oriented to time, place, or person. She had lost her ability to communicate and required a high level of care and near constant supervision to maintain her safety and the safety of other residents. Cynthia had a history of becoming physically aggressive with staff and had an extensive behavioural management plan which was developed in consultation with Dementia Australia and a specialist geriatrician.

18. Cynthia's doctor and staff at the nursing home opined that because of her severe cognitive impairment, Cynthia would have no understanding or memory of this incident. She would also not have the required cognitive ability to take any sort of deliberate action against another person.

19. Paramedics conveyed Jean to Wimmera Base Hospital where she was diagnosed with a fractured right distal femur and referred for surgery. The treating ED doctor provided an

opinion that Jean's prognosis was poor considering her co-morbidities and reduced pre-morbid mobility and function. Hip fractures are generally operated on regardless of prognosis as they can be a palliative treatment as part of pain management. Jean was transferred to Ballarat Hospital and underwent an open reduction and internal fixation (**ORIF**) of the right femur on 15 June 2023.

20. Jean's post-operative period was complicated by aspiration pneumonia requiring high-flow oxygen, intravenous antibiotics, and intravenous fluids. Unfortunately, Jean continued to deteriorate despite this treatment. As a result, and in discussion with Jean's next of kin, Jean was referred to the palliative care team and transferred to the palliative care ward at the Queen Elizabeth Centre on 19 June 2023.

21. On 20 June 2023, in the early hours of the morning, Jean passed away.

Identity of the deceased

22. On 20 June 2023, Jean Meyer, born 10 March 1927, was visually identified by her friend, Gladys Kyle, who completed a statement of identification.

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

Medical cause of death

24. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 21 June 2023 and provided a written report of the findings.

25. The post-mortem examination showed findings in keeping with the clinical history.

26. Dr Beer provided an opinion that the medical cause of death was *1(a) complications following a fractured distal right femur.*

27. I accept Dr Beer's opinion.

FURTHER INVESTIGATION

Homicide Investigation by Victoria Police

28. The Coroner's Investigator initially commenced a criminal investigation into Jean's death including possible manslaughter charges against Cynthia. However, owing to Cynthia's advanced dementia, it was not appropriate to pursue the matter further. Cynthia passed away at the nursing home on 13 October 2023.

Call Bell Faults

29. The call bell system at the facility was upgraded around November 2022. This was conducted by XACOM in conjunction with the IT contractor for West Wimmera Health Service. This included replacement of the existing bus controller, an external piece of hardware.

30. There was a fault soon after this installation with an unknown cause that appeared to be rectified after resetting the system. There were no further issues for the next two months. However, since then, the frequency of faults gradually increased.

31. On 13 June 2023, following the repeated faults, West Wimmera Health Service, in conjunction with XACOM, replaced the bus controller as this was thought to be the underlying source of the issue. However, faults started to occur again within two days.

32. On 19 June 2023, following a meeting between the IT department, XACOM, a senior electrician, and other West Wimmera Health Service staff, the controller was relocated from the nurses' station to the main communications room. The input from the fire installation panel was also removed.

33. Since then, there have been no further issues with the call bell system.

FINDINGS AND CONCLUSION

34. Having held an inquest in relation to the death of Jean Meyer, I make the following findings pursuant to section 67(1) of the Act:

    a) the identity of the deceased was Jean Meyer, born 10 March 1927;

b) the death occurred on 20 June 2023 at Queen Elizabeth Centre 102 Ascot Street South, Ballarat Central, Victoria, 3350, from *complications following a fractured distal right femur*; and

c) the death occurred in the circumstances described above.

35. Having considered all the evidence, I find that Cynthia Hicks significantly contributed to the death of Jean Meyer by causing the fall which subsequently caused the death.

36. I am unable to find that had the call bell system been operational at the time, the altercation would have been avoided and thus prevented the death. In any event, I note that this issue appears to have been resolved which negates the need for any coronial recommendations.

37. I also note that the fifteen-minute rounding in lieu of working call bells was a reasonable alternative in the circumstances, and that the issue was appropriately escalated on the day of the incident after repeated faults.

COMMENTS

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

38. Each year, the Court investigates several cases involving aged care residents with dementia causing the death of other residents. This was recently examined by the State Coroner, Judge John Cain in his findings delivered on 2 November 2023.[2] I reiterate those comments and have reproduced some of them below.

39. A criminal charge in most of these cases is not appropriate as there is no public interest served in pursuing any such charges. Instead, I consider that it is critical that residential aged care providers continue work to improve their processes for preventing and responding to resident-to-resident aggression.

40. Unfortunately, resident-to-resident aggression will continue to pose a significant challenge for residential aged care providers due to a combination of factors, including an increasing ageing

[2] COR 2020 002367.

population, an increase in the number of vulnerable people entering care and the difficulties of administering care to a large group of residents with varying levels of needs and cognitive impairment. Proactive approaches by care providers to regularly monitor, reassess and manage resident risks are vital.

41. It is apparent that further research is required to determine best practice in addressing, managing, and preventing resident-to-resident aggression. The Royal Commission into Aged Care Quality and Safety (**the Commission**) was set up in 2018 to consider issues related to the quality of residential and in-home aged care.

42. The Commission's final report, '*Care, Dignity and Respect*' was tabled in the Australian Parliament on 1 March 2021. This report included 148 wide-ranging recommendations for fundamental reform of the aged care system. The Commission identified four areas in need of immediate attention: food and nutrition; care and support for people living with dementia; elimination and reduction of restrictive practices; and palliative care. Several recommendations were targeted at improving care arrangements for those suffering with dementia.

43. In response to the recommendations of the Commission, the Australian Government, in consultation with state and territory governments, is currently developing a new National Dementia Action Plan (the **Plan**). A consultation paper has been published with feedback now submitted. The Plan is now in the final stages and is anticipated to be in place in 2024 and will span over 10 years with specific actions included that promote a collaborative national approach to drive improvements for people living with dementia, their carers and families throughout Australia.[3]

44. The Australian Government has recognised the critical need to improve care and support for residents of aged care with complex needs and I am hopeful that these initiatives may reduce the risk of deaths occurring in similar circumstances.

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

[3] https://www.health.gov.au/our-work/national-dementia-action-plan

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.

Signature:

Coroner Katherine Lorenz

Date: 30 April 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 inquest. 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.