



## FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign King at Adelaide in the State of South Australia, on the 14<sup>th</sup> day of December 2023 and the 19<sup>th</sup> day of January 2024, by the Coroner's Court of the said State, constituted of Ian Lansell White, Deputy State Coroner, into the death of Aileene Bell.*

*The said Court finds that Aileene Bell aged 85 years, late of Southern Cross Care, McCracken Views, 31 Adelaide Road, McCracken, South Australia died at McCracken, South Australia on the 31<sup>st</sup> day of August 2020 as a result of general inanition on a background of vascular dementia and a recent right neck of femur fracture (operated). The said Court finds that the circumstances of her death were as follows:*

### **1. Introduction, reason for Inquest and cause of death**

- 1.1. Aileene Bell was born on 13 October 1934, and died on 31 August 2020 at her residential care facility, McCracken Views. She was 85 years old.
- 1.2. This is a mandatory Inquest pursuant to Section 21 of the Coroners Act 2003 as Mrs Bell was a protected person under the Guardianship and Administration Act 1993 at the time of her death and it was not a death solely due to natural causes.
- 1.3. Mrs Bell had undergone a right hip and open reduction and internal fixation at Flinders Medical Centre<sup>1</sup> on 6 August 2020 following a witnessed fall at her residential care facility on 5 August 2020. She was discharged on 9 August 2020.

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<sup>1</sup> FMC

- 1.4. While Mrs Bell was initially alert upon her return to McCracken Views, she became less mobile and less responsive over time. A decision was made to institute comfort care and Mrs Bell passed away on 31 August 2020.
- 1.5. The case notes from McCracken Views and the FMC were reviewed by Dr Alexandra Yuill of Forensic Science SA<sup>2</sup> and discussed with forensic pathologist, Dr Karen Heath in a pathology review. The pathology review report suggested a cause of death of '*general inanition in a person with vascular dementia and a recent right fractured neck of femur (operated)*'.<sup>3</sup>
- 1.6. Dona Attard, Deputy Registrar of the Community Stream of the South Australia Civil and Administrative Tribunal,<sup>4</sup> has provided an affidavit in relation to the guardianship orders in place at the time of the death Mrs Bell.<sup>5</sup>
- 1.7. Ms Attard stated that Mrs Bell was subject to an administration order, a limited guardianship order and a special powers order at the time of her death.
- 1.8. Ms Attard confirmed the guardianship order with special powers<sup>6</sup> was issued on 8 November 2018.<sup>7</sup> Mrs Bell's joint guardians were her friend, Vanita Mahoney and her niece, Nerile Heikkinen. The application for special powers was made as a result of Mrs Bell's brother attempting to remove her from McCracken Views to be closer to him, despite their estrangement.
- 1.9. A review of this order was underway at the time of Mrs Bell's death.

## **2. Background**

- 2.1. Mrs Bell had been a resident of McCracken Views for approximately five years. She had been assisted to move into this facility by her friend, Vanita Mahony. Mrs Bell was estranged from her two adopted children at the time of her death, but remained in contact with her niece, Ms Heikkinen. Attached to the affidavit of Ms Attard is the application of Ms Heikkinen to become the joint guardian of Mrs Bell. Mrs Heikkinen stated that she made this request as Ms Mahony had reported difficulties managing the paperwork side of her duties as full guardian.

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<sup>2</sup> FSSA

<sup>3</sup> Exhibit C1a

<sup>4</sup> SACAT

<sup>5</sup> Exhibit C5

<sup>6</sup> Including a power of detention

<sup>7</sup> Exhibit C5, DA10

- 2.2. Ms Heikkinen referred to having only good, fun memories of her '*mad aunt*' and expressed gratitude to Ms Mahony for the dedicated care and attention she provided to Mrs Bell.
- 2.3. I received two affidavits from staff at McCracken views, Ms Patricia Davies<sup>8</sup> and Ms Kelly Jones.<sup>9</sup> Ms Davies, who was care coordinator at the time of the death of Mrs Bell, had daily contact with her. She stated:
- ‘I know that I am not to have favourites, but Aileene was one of mine and it still upsets me to think of her when she fell and her time afterward. It was awful and I am still sad that she is gone.’
- She described Mrs Bell as a lovely lady who was affectionate, but who could also be feisty. Ms Davies recalled that Mrs Bell was very much loved and cared for beautifully at McCracken Views.
- 2.4. Ms Jones, a registered nurse, also described Mrs Bell as a very well-liked resident. In her affidavit she stated, '*I still have a soft spot for her*'.<sup>10</sup>

### **3. Medical history**

- 3.1. Mrs Bell's general practitioner was Dr Clive Fowler.<sup>11</sup> Dr Fowler stated that Mrs Bell suffered a long list of ailments including coeliac disease, an anxiety/depressive disorder, congestive cardiac failure (diagnosed in 2018), hypertension and atrial fibrillation. She had a pacemaker implanted in 2000.
- 3.2. Mrs Bell also suffered from vascular dementia which was in decline at the time of her death. According to Dr Fowler it had been in decline prior to her hip fracture.<sup>12</sup> He recalled that Mrs Bell's dementia did not result in aggressive behaviour, rather the difficulty in managing her condition arose from a lack of understanding and therefore a lack of compliance with medical advice and medications.
- 3.3. Dr Fowler was of the view that Mrs Bell was a '*high falls risk*'.
- 3.4. Ms Davies also described Mrs Bell as a high falls risk and recalled that she had many falls while at McCracken Views. The difficulty appeared to Ms Davies to be that Mrs Bell had no insight into her capabilities and just responded to her impulses. She

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<sup>8</sup> Exhibit C2

<sup>9</sup> Exhibit C3

<sup>10</sup> Exhibit C3

<sup>11</sup> Exhibit C4

<sup>12</sup> Exhibit C4, page 2

had no concept of what a walker would be used for, to the extent that it would have been a tripping hazard for her.<sup>13</sup>

- 3.5. Ms Jones recalled that Mrs Bell could not understand risk. If she wanted to walk somewhere she would try it. Accordingly, nursing interventions were put in place, such as a sensor mat, an ultra-low bed with crash mats either side, and hip protectors. She was also subject to 30-minute safety checks day and night.

#### **4. Circumstances leading to death**

- 4.1. On 5 August 2020 Ms Davies saw Mrs Bell get up from where she had been sitting in the Encounter room. Ms Davies tried to get to Mrs Bell in time to assist her, but was not able to, so Mrs Bell tripped on the leg of an armchair and fell very heavily. Despite the hip protectors she had been wearing, Ms Davies was confident that Mrs Bell had fractured something during the fall.
- 4.2. Mrs Bell was sent to the Victor Harbour Hospital where X-rays revealed a right neck of femur fracture. She was then transferred to the FMC for surgery. Mrs Bell was discharged on 9 August 2020. Upon her return, Ms Davies was surprised at how alert Mrs Bell appeared.<sup>14</sup> About a week later, however, her mobility decreased and then her food and fluid intake declined. Eventually, a decision was made to transition to comfort care, and Ms Davies was present when Mrs Bell passed away on 31 August 2020.
- 4.3. Dr Fowler reviewed the notes from the FMC which stated that the surgery went without complication.<sup>15</sup> Dr Fowler saw Mrs Bell after her return from hospital and was surprised at the rapidity of her decline.
- 4.4. Dr Fowler opined that the residence managed Mrs Bell very well and that she received all due care and attention whilst at McCracken Views.

#### **5. Coronial investigation**

- 5.1. Detective Brevet Sergeant Clark from the Coronial Investigation Section investigated Mrs Bell's death and provided a report to the State Coroner.<sup>16</sup> He expressed the view

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<sup>13</sup> Exhibit C2, page 2

<sup>14</sup> Exhibit C2, page 3

<sup>15</sup> Exhibit C4, page 3

<sup>16</sup> Exhibit C6

that the orders in place at the time of Mrs Bell's death were appropriate and that there was no other means of ensuring her health and safety.<sup>17</sup>

- 5.2. Detective Brevet Sergeant Clark was of the opinion that the care provided by McCracken Views and the FMC was more than adequate and that her home made every effort to keep and make Mrs Bell feel safe.<sup>18</sup>
- 5.3. There were appropriate strategies in place to mitigate the falls risk by McCracken Views. As noted by Ms Davies, chemical restraint would have been cruel and unnecessary. There was nothing that could have been done differently and humanely to prevent the fall.

## **6. Conclusions**

- 6.1. I refer to the pathology review conducted by FSSA. I find Mrs Bell's cause of death to be general inanition on a background of vascular dementia and a recent right neck of femur fracture (operated).
- 6.2. I find there are no concerns in relation to the lawfulness of orders made by SACAT. It is plain that the special powers order in particular was made in the best interests of Mrs Bell and to provide her with much needed stability of accommodation.
- 6.3. I find that the care Mrs Bell was provided with was exemplary. An appropriate balance was struck between ensuring her safety and respecting her freedom of movement.
- 6.4. Accordingly, I have no recommendations to make.

*Key Words: Death in Custody; Section 32 Powers*

*In witness whereof the said Coroner has hereunto set and subscribed his hand and*

*Seal the 19<sup>th</sup> day of January, 2024.*

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*Deputy State Coroner*

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<sup>17</sup> Exhibit C6, page 4

<sup>18</sup> Exhibit C6, page 17