IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 3360

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**SYLVIA VALERIE WOOLFORD**
Date of birth:	**18 August 1929**
Date of death:	**12 July 2018**
Cause of death:	**Complications of fractured neck of femur**
Place of death:	**Mercy Aged and Community Care Ltd- Mercy Place Corben and Mordialloc Residential Services, 9-15 Brindisi Street, Mentone Victoria 3194**

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Sylvia Valerie Woolford was an 88-year-old woman who was a long-time resident at Mercy Aged and Community Care Ltd- Mercy Place Corben and Mordialloc Residential Services **(Corben House)**, co-located at 9-15 Brindisi Street, Mentone Victoria 3194 at the time of her death.

2. On 3 June 2018, Mrs Woolford was found on the floor of the Corben House dining room, having suffered from a suspected fall. She was transported to Alfred Health-Sandringham Hospital where she underwent surgery to her hip.

3. On 6 June 2018, Mrs Woolford returned to Corben House.

4. On 10 July 2018, after continued deterioration of her health, Mrs Woolford was placed under palliative care.

5. On 12 July 2018, Mrs Woolford was located deceased in her bed.

6. Mrs Woolford's death was reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) **(the Act)**, because it occurred in Victoria, and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury.

INVESTIGATIONS

Forensic pathology investigation

7. Professor David Ranson, Forensic Pathologist at the Victorian Institute of Forensic Medicine **(VIFM)**, performed an external examination upon the body of Mrs Woolford, reviewed a post mortem computed tomography **(CT)** scan, medical records from Dr Peter Mitchell, closed circuit television **(CCTV)** footage of the incident and referred to the Victoria Police Report of Death, Form 83.

8. The post mortem CT scan showed the left hemiarthroplasty prosthesis. There was considerable faecal loading of the large bowel together with considerable generalised systemic atherosclerosis, including involvement of the aorta. Further calcification was seen in Mrs Woolford's arteries and cardiac valve.

9. Examination of the post mortem CT scan of Mrs Woolford's head revealed very severe cerebral atrophy with extensive dilation of the ventricular system associated with the loss of brain parenchyma.

10. Professor Ranson commented that deterioration in physical state is a common sequela following a fractured neck of femur and surgical repair in the elderly and death occurring in the weeks or a month or so following such an injury is not an uncommon sequelae.

11. Professor Ranson further commented that assessment of death in the elderly in these circumstances can be problematic, particularly where a person has received palliative care towards the end of their life. In elderly individuals, there is often a multiplicity of ongoing disease states which can contribute to death associated with a traumatic event. Mrs Woolford showed a number of these, as documented in her medical history and the post mortem CT scan.

12. Professor Ranson ascribed the cause of death to complications of fractured neck of femur.

Police investigation

13. Upon attending Corben House after Mrs Woolford's death, attending officers observed Mrs Woolford deceased in her bed. Mrs Woolford's medical history and details of her treating general practitioner were obtained, and a coronial investigation was immediately commenced.

14. Leading Senior Constable **(LSC)** Patricia Woodfield was the nominated Coroner's Investigator.[1] At my direction, LSC Woodfield investigated the circumstances surrounding Mrs Woolford's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by treating clinicians, Corben House employees and investigating officers.

15. During the investigation, police learned that Mrs Woolford consulted on Dr Peter Mitchell of the Cheltenham Medical Centre. Dr Mitchell detailed an extensive medical

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[1] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

history that included but was not limited to dementia, Alzheimer's disease, osteoporosis, osteoarthrosis, hypertension, hypothyroidism, uterine prolapse, renal failure and dermatitis. She was first admitted into the Memory Support Unit of Corben House on 17 December 2013 due to advanced dementia and Alzheimer's disease.

16. The Memory Support Unit is a locked area consisting of 12 individual rooms with adjoining bathrooms. The rooms are arranged around a central courtyard, the majority of which is covered by a roof and surrounded by a wall to create a sitting and communal meals area. The unit is staffed by two care attendants during the day and two "care staff who float between this and the other units of the facility at night". There is also a medication endorsed enrolled nurse team leader who rotates between the facility's various units.

17. On 3 June 2018, Mrs Woolford was found by Corben House staff alone on the dining room floor having suffered a suspected unwitnessed fall. She was lying on her left side with her legs splayed.

18. Mrs Woolford sustained a laceration to the left side of her head that required sutures and a fractured left neck of femur that required a hemiarthroplasty. She was transported by Ambulance Victoria to Alfred Health- Sandringham Hospital.

19. On 6 June 2018, Mrs Woolford returned to Corben House.

20. On 14 June 2018, Corben House conducted follow-up investigations into Mrs Woolford's suspected fall by way of reviewing the CCTV footage that covered the Corben House dining room area. The footage showed another female resident using her walking frame to push Mrs Woolford, causing her to fall from a standing position and land on her left side.

21. On 10 July 2018, Mrs Woolford was placed into palliative care.

22. On 12 July 2018 at approximately 5.40pm, a Corben House registered nurse located Mrs Woolford deceased in her bed.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. Mercy Aged and Community Care Ltd initially declined to provide information on the resident involved in the assault that led to Mrs Woolford's decline. After the service of a Form 4 compelling disclosure, further details on the perpetrator were provided but not her full name. Instead, the perpetrator was referred to only as "Ms J".

2. A subsequent statement to the Court detailed that,

> Ms J came from Carinya Residential Aged Care Services to Mercy Place Corben on 5 April 2018. On the date of admission, staff at Mercy Place Corben were informed that Ms J could become physically aggressive, agitated and verbally aggressive. The admission notes also record that Ms J could wander and could become impulsive and restless and that Ms J suffered from depression.

3. Ms J's principal diagnosis was vascular dementia.

4. Mercy Aged and Community Care Ltd detailed that in light of her history of aggressive behaviour, she was admitted to the same secured unit as Mrs Woolford so that she could be monitored at all times.

5. On 14 June 2018, it was discovered that Ms J pushed Mrs Woolford on 3 June 2018. After this discovery, the clinical care manager of Corben House emphasised the importance of adhering to hourly observations of Ms J. A note was left for her general practitioner requesting that she be referred to the Aged Persons Mental Health Team (**APMHT**). Ms J's general practitioner initially declined to make the referral.

6. On 1 July 2018, Ms J pushed another resident who had tried to enter her room. Following this incident, Ms J's general practitioner agreed to the referral to APMHT and she was subsequently admitted as an outpatient on 12 July 2018.

> The APMHT found that Ms J was a private person and that dementia residents who are disorientated or confused may appear intrusive to Ms J. In light of this finding, a plan was subsequently instigated to move Ms J from Court 1 to another unit […] which is quieter, and residents there were considered less likely to intrude on Ms J's personal space.

7. On 15 November 2018, Ms J moved to another facility.

8. On 20 October 2020, the Royal Commission into Aged Care Quality and Safety released data[2] obtained under compulsory notice from the Aged Care Quality and Safety Commission[3]. This data was generated by residential aged care services as part of their mandatory reporting requirements[4] and shows that between the years 2014 and 2019, there was an increase in the proportion of residential aged care services that reported an allegation of assault.

9. The ongoing collation, review and publication of this data is imperative to giving relevant regulatory bodies an accurate insight into the issues that need to be more adequately addressed in aged care settings.

10. I note that Mercy Aged and Community Care Ltd initiated their own CCTV review on 14 June 2018. Review of the CCTV footage showed Ms J pushing Mrs Woolford. Following this discovery, several risk management steps were taken to prevent a like event occurring. I consider this to have been appropriate action in response to the incident and have not identified any additional prevention opportunities.

11. I do, however, consider Mercy Aged and Community Care Ltd's initial refusal to provide details of the resident who assaulted Mrs Woolford, and continued refusal to provide identifying details, impeded the coronial process which attempts to examine if any systemic issues caused or contributed to the circumstances and whether the incident and ultimately, Mrs Woodford's death could have been prevented. This in turn acts as an impediment on the efforts at bettering the quality of aged care within Victoria and Australia at large. If the various aged care quality bodies are going to be able to better the quality of these necessary services, it is imperative that aged care facilities cooperate with requests specifically, that they facilitate full and frank disclosure when risks are identified.

12. Accordingly, this Finding will be distributed widely to include the Aged Care Quality and Safety Commission and the Royal Commission into Aged Care Quality and Safety.

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[2] https://agedcare.royalcommission.gov.au/system/files/2020-10/RCD.9999.0499.0009.pdf accessed on 26 October 2020

[3] Section 2(3C) *Royal Commissions Act 1902* (Cth)

[4] Outlined in section 63-1AA of the *Aged Care Act 1997* (Cth) for alleged and suspected assaults.

STANDARD OF PROOF

1. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw (1938)* 60 CLR 336. These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

   a) the nature and consequence of the facts to be proved;

   b) the seriousness of any allegations made;

   c) the inherent unlikelihood of the occurrence alleged;

   d) the gravity of the consequences flowing from an adverse finding; and

   e) if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

2. The effect of the authorities is that coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

FINDINGS

1. I find that Sylvia Valerie Woolford, born 18 August 1929, died on 12 July 2018 at Mercy Aged and Community Care Ltd- Mercy Place Corbin and Mordialloc Residential Services, located at 9-15 Brindisi Street, Mentone Victoria 3194 at the time of her death.

2. I accept and adopt the cause of death ascribed by Professor David Ranson and I find that the cause of Sylvia Valerie Woolford's death was complications of fractured neck of femur in circumstances where I find she sustained the abovementioned injury as the victim of an assault by another resident of the same aged care facility.

Pursuant to section 73(1A) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

I direct that a copy of this finding be provided to the following:

Tim Woolford

Simon Cooke, Mercy Aged and Community Care Ltd

The Proper Officer, Aged Care Quality and Safety Commission

Danielle Grant-Cross, Royal Commission into Aged Care Quality and Safety

Leading Senior Constable Patricia Woodfield

Signature:

AUDREY JAMIESON
CORONER
Date: **5 November 2020**