IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 3006

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Amended pursuant to s.76 of the ***Coroners Act 2008*** on 14 October 2013

Inquest into the Death of: MEHMET HASAN

Delivered On:	22 August 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne
Hearing Dates:	15 and 16 April 2013
Findings of:	HEATHER SPOONER, CORONER
Police Coronial Support Unit	Leading Senior Constable Tracey Ramsey
Counsel for Dr Vaughan	Ms Magee, Ms Hughes

I, HEATHER SPOONER, Coroner having investigated the death of MEHMET HASAN

AND having held an inquest in relation to this death on 15 and 16 April 2013
at MELBOURNE
find that the identity of the deceased was MEHMET HASAN
born on 7 March 1923
and the death occurred on 23 July 2010
at Lorikeet Lodge Aged Care, 24-28 Moorooduc Highway, Frankston 3199
from:

1 (a) COMPLICATIONS OF SUBDURAL HAEMATOMA AND FRACTURED HIP FOLLOWING A TRAUMATIC INCIDENT AT THE NURSING HOME

In the following circumstances:

1. Mr Hasan was aged 87 when he died. He was born in Cyprus and spoke Turkish but very little English. Mr Hasan had been a resident at Lorikeet Lodge Aged Care Complex since November 2007. His family visited there. Mr Hasan had a past medical history that included dementia, type 2 diabetes mellitus (NIDDM) and bullous pemphigoid.

2. Due to the dementia diagnosis Mr Hasan was assigned to the Dementia Unit. At times he could become physically resistive and this combined with his lack of English and occasional verbal outbursts could be disturbing and distressing for all concerned.

3. Mr Hasan was considered a 'high risk' patient. This was defined by Lorikeet's risk assessment as being a danger to himself and others, and lacking insight and cognition. He was a known high falls risk which included his tendency to lower himself onto the floor or ground level. Mr Hasan undertook physiotherapy whilst at Lorikeet Lodge to improve ambulation, joint and muscle strength and to prevent or minimise falls.

4. The death of Mr Hasan was reported to the Coroner by the Registrar of Births Deaths and Marriages as the medical death certificate that was filed for registration referred to the presence of possible trauma associated with the death including a subdural haematoma and fractured hip.

5. The Coroners Act 2008 contains information about what constitutes a 'reportable death'(to the coroner) and s.4(2)(a) states in part that such deaths include:

> *'a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury;'*

Medical Review of Cause of Death

6. The medical records were obtained and reviewed by the coroner, a pathologist and a medical clinician at the Victorian Institute of Forensic Medicine (VIFM). Dr Neate formulated the cause of death that was accepted. Dr Neate noted as follows:

> *"87 year old man who died from complications following a fall on 12/6/10. On 15/6/10 he was sent to hospital and had acute on chronic subdural (treated conservatively) and a fractured hip treated surgically. He recovered from the fracture and was returned to the nursing home and he deteriorated and died (palliated) 6/52 after fall. The fall appears to have occurred from a staff member pushing the patient from a chair. This is noted by another staff member and issues about mandatory reporting are discussed."*

Investigation, Issues and Inquest

7. Having regard to the reference to a traumatic incident in the cause of death as formulated, I directed that a police investigation should be conducted into the surrounding circumstances.

8. Several issues became apparent from my investigation including whether the death was causally linked to a fall or push on 12 June 2010, whether that fall or push was accidental or deliberate, the investigation of Ms King's complaint against Ms Wilson and the failure of Dr Vaughan to report the death to the coroner.

9. After considering the coronial brief I decided to convene an inquest on 15 and 16 April 2013. Witnesses to three incidents involving Mr Hasan on 12 June 2010 were called to give evidence.

10. Ms Megan King, a Division 2 Nurse told the inquest about three incidents on 12 June 2010. She had only worked at the facility for four months whereas the other staff who gave evidence at the inquest had clearly enjoyed long standing working relationships. Ms King told the inquest about the incidents:

    - At about 1.30pm, an unwitnessed fall occurred in the hallway when Ms King and others assisted Mr Hasan;

- At about 1.45pm Ms King was concerned that Mr Hasan might fall off his chair, as he had moved himself right to the very edge. Ms King asked Ms Kylie Wilson, Personal Care Assistant (PCA) to assist in repositioning Mr Hasan on the chair but she allegedly pushed him off the chair with one hand saying *'let him fall'*. He fell on his right side. Ms Wilson was then alleged to have said 'just leave him there' and kicked him.
- Later when Ms King was trying to get Mr Hasan back up off the floor Ms Wilson let go of Mr Hasan and pushed him against Ms King whereupon Mr Hasan fell to his knees.

11. Ms King also gave damning evidence about the language Ms Wilson allegedly used in the course of the incidents with Mr Hasan.[1]

12. Ms Wilson disagreed with that evidence and told the inquest that it was *'...a lie'* [2] however later in her evidence she did make some concessions about the nature and extent of any swearing that occurred.[3]

13. Ms Dennis, another Division 2 nurse working at the facility that day confirmed to the inquest that Ms King *'was very upset over what she had seen'* when she approached her alleging that Ms Wilson had pushed over Mr Hasan.[4] When Ms King asked what she should do, Ms Dennis advised her to report it to the Division 1 nurse in charge and fill out an incident report.[4] Ms Dennis felt that Ms King was being *'genuine'* when talking about the incident.

14. Ms Dennis also told the inquest that it was not uncommon to hear staff swearing in the course of their work.[5]

15. Ms Wilson denied the allegations of assault.[2] She did not have legal representation and I was uncertain about her understanding or ability to formally object to giving evidence. So although she gave her evidence willingly, I was left in some doubt about her capacity to object and decided that a certificate of indemnity pursuant to S.57 Coroners Act 2008 should nonetheless be granted.

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[1] T.36 and following

[2] T. 64

[3] T. 69

[4] T. 79

[5] T. 82

16. Another PCA, Mr Shane Cooper, conceded in part that he may have witnessed the first and last incidents but aspects of his evidence were unsatisfactory and his recall poor. When he told the inquest about nurses needing to look *'after their backs'* he seemed to have difficulty explaining exactly what he had meant by that.[4]

17. Ms Maryann Bruce, the Facility Manager and a Division 2 Nurse, made it clear that once she had spoken to the staff involved, she really doubted Ms King's complaint (although conceding Ms Wilson was in fact being supervised following two complaints of being *'too fast'*[6]. Ms Bruce was Ms Wilson's mentor and was partial to her (*'I think Kylie was being set-up by some people'*[7]). During her phone conversation with Senior Constable Wisniewski in the presence of Ms King she made her views plain.

18. When I queried Mr Wisniewski during his evidence about how off putting that must have been for Ms King who later had to front him at the police station to formalise her police complaint, he conceded she may have felt uncomfortable.[8] It was not surprising therefore that he described Ms King as *'very hesitant to make the statement'*[9] or that the police investigation did not proceed very far.

19. Following these incidents Mr Hasan was examined by nursing staff and after another alleged fall a locum was called and saw Mr Hasan. Although the locum did not diagnose a fractured hip, Dr Vaughan gave evidence about the difficulty and delay that can occur in determining that an elderly dementia sufferer has sustained an injury following a fall:

> *'..... the situation, the fracture or the problem becomes apparent in an acute sense?--- I think in a – sort of, someone with dementia where it's hard to get a good history from the patient, you know, you could – it could take some time before it becomes apparent. You know, the patient may initially be sort of restless and you can't quite put your finger on what's going on, and I mean you generally – I guess if there was, you know, if a patient had a fall you'd certainly be checking the hips to*

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[4] T. 79

[6] T.117

[7] T.119

[8] T.170

[9] T.169

make – you know, because of the common things from a fall can be a fractured hip and you always like to sort of flex the hips when you assess those sort of patients, and – but some patients with dementia you don't always – it's hard to ascertain whether they're in pain when you – you know, manoeuvring their hips and that sort of thing. It can be difficult at times.[10]

20. On 15 June Mr Hassan was transferred to Frankston Hospital Emergency Department and subsequently he underwent surgery for a fractured right hip. He returned to Lorikeet Lodge where his condition further deteriorated and on 23 July 2010 he passed away.

Conclusions

21. There were shortcomings in the evidence and record keeping relating to the care of Mr Hasan over the days around this incident; an allegation that Mr Hasan had a further fall was not adequately documented and there was doubt about who had reported it anyway. Ms Bruce also told the inquest about an *'Elder Abuse Mandatory Reporting folder'*[11] held at the facility but subsequent searches failed to locate it and it could not be produced to the court when requested. The evidence of Ms Bruce regarding the incident and incident reporting, staffing and safety management, the record keeping and the manner in which she dealt with Ms King and her complaint left me in some doubt about the management and culture of the facility. The evidence of the behaviour of some staff including the allegation that swearing was not uncommon was also troubling.[12]

22. Although Ms Bruce told the inquest that part of her role was to improve the reporting culture at the facility I concluded that she was unsuccessful in this regard:

'The process was that if there was a report to a Division 1 nurse of an elder abuse issue that she did the investigation. I was to be one of the people that was called, including police, CIS, facility owners, family, a doctor and myself. But, because there was a culture that was set up that incident reports and the elder abuse was not followed, I went

[10] T.144-145

[11] T.111

[12] T. 34,36,42,82

in to follow, - to make sure it happened. So you say there was a culture of not filling in the incident reports? ----Yes"[13]

23. There was some doubt about the nature and extent of the telephone conversation between Ms Bruce and Dr Vaughan on Saturday 12 June 2010. Although there was no clinical note, Dr Vaughan told the inquest that he believed he would remember any allegation of assault or elder abuse if Ms Bruce had made that clear in their conversation.[14] Given my concern regarding Ms Bruces' handling of the complaint, the doctor's recollection, albeit limited, was preferred.

24. I also preferred the evidence of Ms King about the circumstances surrounding the incidents involving Mr Hasan including her quick report to Ms Dennis, however her evidence was in conflict with the version of Ms Wilson and to some extent with Mr Cooper. Having regard to the very serious nature of the allegations, I was unable to make an adverse finding against Ms Wilson to the standard and with the clarity and sufficient certainty that would be required.

25. There was no issue about the clinical care otherwise provided to Mr Hasan by Dr Vaughan and he accepted that the death should have been reported. Dr Vaughan also accepted the recommendations I made in the inquest into the death of *Mr Memodovski*[15] and the statutory obligations of doctors to report certain deaths to the coroner.

Finding

26. I find that a traumatic incident probably occurred involving Mr Hasan, whether due to rough handling or a deliberate or accidental act, I am unable to determine, however there probably was a causal link to the cause of death as formulated by the VIFM medical clinician.

27. After considering all the evidence I find that Mr Hasan unfortunately died from complications of subdural haematoma and fractured hip following a traumatic incident at the nursing home

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[13] T. 96

[14] T. 152

[15] Case No. COR 2009 5807.

Comment

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

The Aged Care Act 1997 sets out the requirements for the care of residents in licensed aged care facilities in Australia. A requirement of holding a license involves each facility undergoing accreditation by the Aged Care Standards and Accreditation Agency Ltd for compliance with all criteria under four standards.

The coronial investigation and inquest into the death of Mr Hasan identified areas in both Standards 1 & 2 where I could not be satisfied that compliance had occurred including management systems, staffing and organisational development, health and personal care.

The Aged Care Standards and Accreditation Agency Ltd sets out the requirements for licensed nursing homes. The areas of concern in the governance of the Lorikeet Lodge include the follow up and incident management system, the environment and safety management, and staffing management systems.

Verifying compliance with standards is outside my scope but the identification of areas that suggest poor governance and an environment where the possibility of elder abuse might be tolerated is not. The investigation and evidence about the circumstances surrounding the death of Mr Hasan warrant a referral with a copy of this finding to the following statutory bodies for consideration of a review of the practices at Lorikeet Lodge:

- Ageing and Aged Care Branch
  Department of Health
  12th Floor
  50 Lonsdale Street
  MELBOURNE 3000
  Australia

- Senior Rights Victoria (SRV) was established to Seniors Rights Victoria (SRV) is a Victorian government-funded specialist elder abuse service, established to assist with elder abuse concerns and to safeguard the rights, dignity and independence of older Victorians.

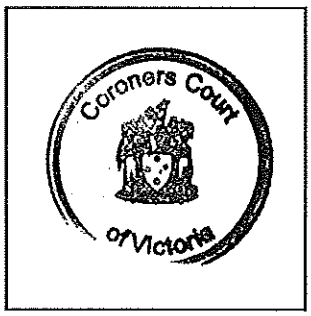
Seniors Rights Victoria
C/- COTA,
Level 4, 98 Elizabeth Street
MELBOURNE 3000
Ph: 1300 368 821

- Aged Care Complaints Scheme
  Australian Department of Health and Ageing
  GPO Box 9848
  (Your capital city and state/territory)

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

The Family of Mehmet Hasan
Constable Steven Wisniewski, Investigating Member, Frankston Police Station
The Chief Executive Officer, Lorikeet Lodge

Signature:



HEATHER SPOONER
CORONER
Date: 22 August 2013