CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Savvas Epsimos
Hearing dates:	12,13,14 September and 20 October 2016
Date of findings:	20 October 2016
Place of findings:	State Coroner's Court, Glebe
Findings of:	**Deputy State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – Cause and manner of death Aged care facility Falling out of bed
File number:	2014/365946
Representation:	**Mr Durand Welsh, Sergeant, Coronial Advocate Assisting** **Mr Mark Lynch for Dr Cordato and Dr Payda** **Mr Ben Clark for BUPA Australia**

Findings:	**Identity of deceased**: The deceased person was Savvas Epsimos. **Date of death**: Mr Epsimos died on 12 December 2014. **Place of death**: He died at St George Hospital, Kogarah. **Manner of death:** The death was a result of Mr Epsimos falling out of bed when he was a resident at the BUPA Care Services at 741 Forest Rd, Bexley on the 8 December 2014. **Cause of death:** The medical cause of the death was complications of large right subdural haematoma.

Table of Contents

The Coroners Act 2009 (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the findings of an inquest into the death of

Introduction:

In May 2013 Savvas (Sam) EPSIMOS was admitted to BUPA Care Services at 741 Forest Rd, Bexley. According to BUPA records, he was classed as a patient receiving residential care at a high level. He was suffering from a number of medical conditions including cognitive impairment, gastro-oesophageal reflux disease, Type 2 diabetes, depression, osteoarthritis, incontinence, osteoporosis, insomnia and vitamin D deficiency. He had also previously suffered a bowel perforation in 2012 and had also suffered a fracture to the neck of his right femur.

On Monday 8 December 2014 Mr EPSIMOS was a resident in room 10. The room is a two bed room located in the high care unit of BUPA Care Services.

A number of staff were present on or near the ward at around 7:00 a.m. when Sam EPSIMOS reportedly suffered a fall while in his room. No staff members report witnessing the incident but Assistant in Nursing (AIN) Kasaya GOCK was the first staff member at the scene. Sabita DHUNGNA, another AIN, was the second staff member on the scene. A number of other staff members arrived shortly afterwards. The circumstances leading up to the fall and the events that immediately follow are the primary focus of this inquest.

The Inquest:

An inquest is different from other types of court hearings. It is neither criminal nor civil in nature and the coroner does not make determinations and orders which are binding on the parties, such as in civil litigation, nor determine whether a person is guilty or not of an offence, such as in criminal proceedings.

The formal findings that need to be made are: who, when, where, how and why a person's died. There is no issue with who, when, where and why. This inquest was held with a focus on the manner of death. In particular, the following issues were examined:

- What level of unassisted physical movement did Savvas EPSIMOS have?
- What were the immediate circumstances that lead to Savvas EPSIMOS's injuries?
- Why was the bed raised prior to Savvas EPSIMOS becoming injured?

- Did any environmental aspects of the room contribute to the injuries or hinder treatment for the injuries?

- What policies were in place to mitigate the risk of falls and how was Savvas classified within this framework?

- How did staff usually move Savvas EPSIMOS to the toilet?

- What is the policy to be followed after a resident falls and was it followed?

Social Background:

Savvas EPSIMOS, also known as Sam EPSIMOS, was born in Greece on the 25 October 1930. In the late 1950's he immigrated to Australia and worked at Warragamba Dam and later found employment at Reschs Brewery. His final job before retiring in 2001 was as a janitor at Central Local Court.

He was married to Poula EPSIMOS and had two children, John EPSIMOS and Chris EPSIMOS. Both his sons cared deeply for him and both attended the court proceedings. I offer them my sincere condolences.

The Evidence:

Circumstances leading up to the fall

The witness with the most knowledge of the immediate circumstances that lead to Savvas EPSIMOS's injuries is Assistant in Nursing Kasaya GOCK. At 7:00 a.m. on 8 December 2014, Kasaya GOCK was one of three Assistants in Nursing assisting the patients in the Avenue, a high care unit of the BUPA aged care facility at 741 Forest Rd, Bexley. She had been an Assistant in Nursing at BUPA Bexley for 22 years at the time of making her first statement to police on 17 February 2015. [1]

The other staff involved were Assistant in Nursing Sabita DHUNGNA and Assistant in Nursing Monica REEC. On the morning of 8 December 2014, Kasaya GOCK was working on one side of the floor, while Monica and Sabita worked on the other side of the floor. They were working through the patients in order to get them ready for the day. This involved assisting the patients with breakfast, toileting, showering and other necessary preparations. The arrangement was that if Kasaya needed assistance, such as when moving to the toilet a person requiring a two-person assist, she would call out for one of the other two AINs.

In Sabita DHUNGNA's evidence, it was not clear that there was any structured approach to working through the patients. There did not seem to be any hierarchy in

[1] Tab 7 Exhibit 1, Police Brief of Evidence

terms of needs or whether patients required a one-person or two-person assist. Sabita DHUNGNA said that although a registered nurse sometimes allocates the assistants in nursing between sides of the floor, the AINs also decide amongst themselves according to which side has more two-person assists.[2]

According to Sabita DHUNGNA, most of the patients on her side were two-person assists. The side that Kasaya GOCK was working that day had fewer two-person assists. Kasaya GOCK gave evidence that she was working with patients in room 11 when she heard Savvas EPSIMOS cry out in Greek that he wished to use the toilet. She then attended his room, room 10, and saw that he had his leg out and his covers off. She thought that maybe he would fall, so she moved him back into the bed. The bed is a narrow single bed with the ability to raise or lower.[3]She did not mention the leg being out in her statement dated the 17 February 2015, stating only that "I saw him leaning over the edge of the bed holding onto the bedside table."[4] It is a different version, but given the inevitable lapses in recall over time this of itself does not cast doubt on the version. The significant fact is that she saw him partially out of the bed.

Kasaya GOCK then raised the bed. Her stated intention was to obtain a lifter and then move Savvas EPSIMOS, with assistance from a second AIN, to a shower chair and then to the toilet.[5] Use of the lifter requires the bed to be raised from its lowest position. According to registered nurse Emmanuel MASIH, a falls risk patient's bed should be kept at the lowest setting due to the risk of falls.[6] This low bed setting policy does appear to have been complied with, as Kasaya admits to raising the bed and this raising of the bed is consistent with the presence of the lifter.

The discovery of Mr Epsimos on the floor

Both in Kasaya GOCK's statement and in evidence she stated that getting the lifter had taken longer than expected due to other equipment blocking access. She estimated the time to get the lifter was 2 to 3 minutes. When she returned to room 10, Savvas EPSIMOS was face down on the floor.[7]

According to the BUPA Incident Management policy, it is at this point she should have pressed the emergency buzzer, which would have resulted in the attendance of multiple staff members, including registered nurses Emmanuel MASIH and Yevlin YESUDASAN. The BUPA policy is that the fallen patient should not be moved until assessed by a registered nurse or enrolled nurse.[8]

[2] Evidence given in inquest on 12/9/16
[3] Evidence given in inquest on 13/9/16
[4] Tab 7 Exhibit 1, Police Brief of Evidence
[5] Tab 7 Exhibit 1, Police Brief of Evidence
[6] Tab 8 Exhibit 1, Police Brief of Evidence
[7] Tab 7 Exhibit 1, Police Brief of Evidence
[8] Tab 34 Exhibit 1, Police Brief of Evidence

Sabita DHUNGNA had been employed at BUPA Bexley for three years at the time of making her statement. Sabita DHUNGNA's evidence is that she heard Kasaya GOCK call for assistance. Sabita DHUNGNA gave evidence that she was able to leave the patient she was with unattended to go and see what Kasaya GOCK wanted. Initially, Sabita DHUNGNA attended the wrong room by mistake, but then located Kasaya GOCK in room 10. Ms DHUNGNA's version and Ms GOCK's version contradict each other in many important respects from this point.

Kasaya Gock's version

Ms GOCK's version is that she put one towel under Mr EPSIMOS's head and another under his neck. These towels had previously been carried into the room on the shower chair and placed on the bed. She then used the towel under his neck to wipe away blood on the floor so that there was no danger of slipping when she and Ms DHUNGNA lifted Mr EPSIMOS onto the bed. Her evidence is that this lift was difficult and took some effort. Her reasoning for placing him back on the bed was to ensure he was comfortable.

Sabita Dhunga's version

Ms DHUNGA's version was inconsistent and disjointed. She gave evidence that Ms GOCK lifted Mr EPSIMOS onto the bed by herself. She stated that she could not press the emergency button as she could not get to it due to the lifter blocking access, and she referred to the room as a "very congested room".[9] Because of the presence of the lifter and the shower chair, she did not go near Mr EPSIMOS. She said Ms GOCK was trying to lift Mr EPSIMOS onto the bed and asking her for help, but she did not help.

In contradiction to this, she stated that Ms GOCK had managed to get Mr EPSIMOS back onto the bed as soon as she entered the room. Her evidence was that Mr EPSIMOS was already on the bed before she could press the emergency buzzer. While at different points she offered both the difficulty in reaching the buzzer and the speed of Ms GOCK putting Mr Epsimos back on the bed as reasons for her not pressing the emergency buzzer, neither explanation is credible.

According to Sabita DHUNGA's diagram of the room, moving the shower chair out of the way would have required minimal effort.[10] The chair is wheeled, and Kasaya GOCK gave evidence that she intended to wheel Mr EPSIMOS to the shower in the chair. Emmanuel MASIH indicated in his diagram and evidence that the lifter, when he attended, was not in the spot Sabita indicated.[11] MASIH recalls the lifter being near the doorway and its position, if MASIH is correct, would not have hindered Sabita DHUNGA accessing the emergency buzzer. The position of the lifter in

[9] Evidence given at inquest on 12/9/16
[10] Tab 25 Exhibit 1, Police Brief of Evidence
[11] Tab 26 Exhibit 1, Police Brief of Evidence

MASIH's diagram is consistent with Kasaya GOCK's version that she put the lifter just inside the doorway.

Sabita DHUNGA also stated that when she had suggested to Kasaya GOCK that they call a registered nurse, Ms GOCK had told her to wait. On this point, the two versions are consistent.

Mr Epsimos is moved back on to his bed

After moving Mr EPSIMOS onto the bed, Kasaya GOCK left the room and verbally informed enrolled nurse Effie NICHOLAS of what occurred. NICHOLAS was a short distance from the room, but was only a few metres from the nurses' station where Emmanuel MASIH and Yevlin YESUDASAN were.

Kasaya GOCK gave evidence that verbally notifying the registered nurse or enrolled nurse was just as effective as pressing the buzzer. However, she also admitted that the nursing station might not have been manned which would have resulted in a delay. Indeed, her verbal notification to enrolled nurse Effie NICHOLAS resulted in a delay because when NICHOLAS attended she determined that the registered nurses were required. Pressing the buzzer would have resulted in the attendance of these registered nurses in the first instance.

It would seem that pressing the emergency buzzer also allows for prompt medical intervention. Given the time spent cleaning the blood and lifting Mr EPSIMOS onto the bed for reasons of comfort, prompt medical attention did not seem to be foremost in the mind of Kasaya GOCK. Indeed, one explanation for her informing only Effie NICHOLAS is that Ms NICHOLAS was the most junior of the enrolled and registered nurses. Also, it was Sabita DHUNGA's evidence that the assistants in nursing are overseen by the registered nurses, so notifying Ms NICHOLAS meant she was effectively avoiding her more senior supervisors. It is difficult to understand why she has chosen to inform the least qualified of those nurses available. It may be that Ms GOCK's actions were with a view to minimising the graphic appearance of the scene and in notifying an assistant in nursing colleague, Ms GOCK may have been hesitant to fully disclose the event to the senior nurses.

Her explanation for moving Mr EPSIMOS after the fall, both in her statement and in her oral evidence, was that she wanted to make Mr EPSIMOS "comfortable". She appears to have suffered a considerable lack of judgement in deciding to lift a recently fallen patient back into bed without consulting any registered or enrolled nurses in accordance with the policy.

Kasaya GOCK's version is that she asks Sabita DHUNGA not to press the emergency buzzer. This makes more sense logically than Sabita DHUNGA's version, as there did not appear to be sufficient physical impediments preventing

Sabita DHUNGA from pressing the buzzer and it is unlikely Kasaya GOCK lifted Mr EPSIMOS back into bed too quickly for Sabita DHUNGA to press the buzzer.

BUPA Incident Management Policy

The policy of not moving the patient and calling a registered nurse seems to have been common knowledge to all staff. There was no evidence of a training deficit. According to Kasaya GOCK, her decision to move Mr EPSIMOS back onto the bed before contacting an enrolled nurse or pressing the emergency buzzer was a decision she made after being reminded by Sabita DHUNGA that they should call a registered nurse. In evidence, Kasaya GOCK said that Sabita DHUNGA said to her, "Shall we call the RN?" to which Kasaya GOCK replied, "No. Let's make him comfortable."[12]

Both Emmanuel MASIH and Evlin YESUDASAN are experienced registered nurses. Both gave evidence that they had dealt with numerous falls at the BUPA facility and at previous health facilities where they had worked. MASIH stated they dealt with the "situation on a daily basis".[13]

MASIH could not recall any incidents where the fallen patient had been moved prior to the attendance of an enrolled nurse or a registered nurse. Emmanuel MASIH was also adamant that it was bad practice to raise a bed and leave a patient unattended and at risk of falls.

All the available evidence suggests that policy is usually followed at BUPA Bexley in relation to falls notification. It was Kasaya GOCK's response on this occasion that was outside of the normal practice. Kasaya GOCK gave evidence that she had never encountered this particular situation before and she panicked.

I do not accept that panic was behind her failure to comply with proper notification policy. She gave evidence that she had operated the emergency buzzer on previous occasions and it seems that the gravity of the situation as she described it should have immediately informed her that pressing the buzzer was necessary. She thought to ask Sabita DHUNGA to assist moving the patient to the bed after Sabita DHUNGA suggested the correct course of action. She then commenced wiping up the blood on the floor. These latter two actions required a degree of coherent thought, including the assessment of the blood as a hazard.

Whatever the circumstances of the fall, Kasaya GOCK breached the policy that related to the emergency buzzer and to the notification of an enrolled or registered nurse. I am unable to determine whether this was because she was in a state of

[12] Tab 23 Exhibit 1, Police Brief of Evidence
[13] Evidence given at inquest on 13/9/16

panic or because she feared the response and involvement of more experienced senior staff.

I do not accept the evidence of Sabita DHUNGNA that Kasaya GOCK lifted Savvas EPSIMOS by herself or that Sabita DHUNGNA did not have the time or the opportunity to press the emergency buzzer. Kasaya GOCK is a woman in her mid-fifties, and the deceased weighed 56 kg. For her to lift Mr EPISMOS off the floor with no assistance would have been difficult. Kasaya GOCK's version is simply more plausible. Kasaya GLOCK said it took some time to get Mr EPSIMOS back onto the bed, as opposed to Sabita DHUNGNA who said that it was a quick process.

In my view Sabita DHUNGNA was untruthful when she said that she did not assist Kasaya GOCK to lift Mr EPSIMOS and in her reasons for not pressing the buzzer. It may be that she was reluctant to tell the truth because she did not wish to admit that she had breached policy by lifting the deceased before an enrolled or registered nurse was notified. This, of course, places her credibility in general in question.

Mr Epsimos's ability to move himself

There were different versions provided regarding the degree of movement Mr EPSIMOS had. The general impression I obtained from the witnesses was that Mr EPSIMOS had an extremely limited degree of side to side movement.

Dr Payda was Mr EPSIMOS's GP. He did recall that Mr EPSIMOS could move his limbs but could not recall how much strength he had. He last saw Mr EPSIMOS on the 5 December 2014. Dr Payda expressed the opinion that based on his knowledge of treating Mr EPSIMOS, it was "quite possible" he had fallen out of bed under his own efforts. He said: "I have dealt with demented people before and people are able to do things like that where we don't expect them to and for some reason they either slip out, fall, or get out of the bed."[14]

Emmanuel MASIH stated that he had previously seen Savvas EPSIMOS slide down the bed and had seen him display a limited degree of side to side movement. He was of the opinion Mr EPSIMOS could have slid off the bed on his own. MASIH stated that he had seen Savvas EPSIMOS move from the middle of the bed to the left or the right side, but could not recall specific incidents. At the time, he did not think he would go that far and fall on the floor. He referred to the movement as "moving slightly".[15] He quantified this as about 2 centimetres of movement from the middle of the bed. MASIH said that Mr EPSIMOS had sufficient strength in his arms that he could feed himself.

[14] Evidence given at inquest on 13/9/16
[15] Evidence given at inquest on 13/9/16

Mr EPSIMOS's son, John EPSIMOS was adamant in his evidence that his father did not have the physical capacity to roll himself out of bed. John EPSIMOS did however say that he rarely saw his father in bed.

Mr EPSIMOS had never fallen out of bed nor had he ever had a near miss. The level of his mobility was not definitively established. The Officer in Charge, Senior Constable NORVAL, gave evidence that the opinions of staff seemed to vary and his level of mobility was unclear. All witnesses ascribed a limited level of mobility to him. None of the witnesses, other than John EPSIMOS, were willing to say that he was incapable of falling out of the bed of his own accord. Mr EPSIMOS did not suffer complete paralysis; he had limited movement of his limbs. If his mobility were restricted by a physical disability such as quadriplegia, then only intervention by another party could have caused the fall. However, his lack of mobility appears to arise from multiple factors, including a suspected cerebro-vascular incident. It is possible that his level of mobility may have varied from day to day given the multiple medical conditions he suffered.

The use of crash mats

It was not dispute that Mr EPSIMOS had been recorded as a falls risk patient while at the BUPA facility. John EPSIMOS raised the concern that he had initially been assured by BUPA staff that crash mats would be in place in his father's room. The use of crash mats is aimed at minimising injury in the event of a fall by providing a soft padding on the floor. John also recalled that on some occasions he did see crash mats out. All witnesses appeared to accept that crash mats were not a permanent fixture of the room but could be stored under the bed or in the cupboard.

John's ability to give evidence about the crash mats within his father's room was limited because his attendance at BUPA was primarily during daylight hours. During these periods, his father was not in the bedroom, but usually in a wheelchair or other chair in a different area.

The BUPA clinical file does not indicate that crash mats were ever formally part of any care plan. Further evidence that crash mats did not form part of any care plan is provided in a note made by the Care Manager, Prerana BHATTARAI. The note is handwritten, dated the 9 December 2014. It amends the most recent care plan prepared by BUPA Bexley, dated the 1 October 2014. The note reads: Staff needs to place nonfalls mat on the [sic] both side of bed when I am on bed as I had incident of fall (A075914).[16]

[16] Exhibit 3

Prenana BHATTARA confirmed in her evidence that she made the note after the fall on the 8 December 2014 in direct response to the fall. [17] The care plans were situated on the wardrobes of the patient's rooms so all staff can view them.

Staffing levels

John EPSIMOS also raised concerns about staffing levels. He was of the opinion that the facility was understaffed. He said it was hard to get staff members to act upon a request because of the short staffing. At times, he said the family would have to wait 15 to 20 minutes for attention due to staff being with other residents. The delay was usually related to a request for Mr EPSIMOS being assisted in going to the toilet. Although the evidence falls short of showing that a staffing deficit exists, it was certainly the view of John EPSIMOS that the facility was understaffed. In evidence, Kasaya GOCK indicated that it was sometimes difficult to get the patients prepared for the day within the required timeframe.

The division of labour between the AINs does seem inefficient due to one staff member always being alone on a side of the floor requiring two-person assists. When Kasaya GOCK called out for assistance, it was only because Sabita DHUNGA was with a patient who could remain on the toilet unattended that she was able to respond. The majority of the patients on her side of the floor were two-person assists. Assuming that Kasaya GOCK had called out after getting all the equipment ready, she could have had to wait for a considerable period before Sabita or Monica became free. Sabita DHUNGA's version was that the common practice was to get all the equipment ready and then to call out. If no AIN was free on the side staffed with two AINs, the AIN by herself would have to wait. Although Sabita DHUNGA stated that this was quicker, the time saving would appear to be minimal or non-existent. On this occasion, at least two separate pieces of equipment needed to be obtained, and Kasaya GOCK said it took 2-3 minutes to get the lifter, and this was because other equipment was blocking it.

Mr Epsimos's injuries

The immediate circumstances leading up to Mr EPSIMOS's injuries are unclear. Dr Cordato's evidence was that that the injuries seemed to be consistent with a fall. He based this on having seen numerous patients who had sustained lacerations and subdural injuries after falls. In providing this opinion, Dr Cordato had viewed photographs of the physical layout of the room. There is no evidence to suggest that the injuries were the result of an assault or any other action other than a fall. I am satisfied that a fall caused the injuries that lead to Mr EPSIMOS's death.

There is, however, the need to assess the various possibilities as to how Mr Epsimos fell out of bed. In my view there are three possibilities: he fell out of bed of his own

[17] Evidence provided at inquest on 13/9/16

accord; he fell as a result of manual handling by Ms GOCK acting alone; or he fell as a result of manual handling by Ms GOCK acting with Ms DHUNGNA.

Although there are a number of troubling aspects to the versions given by Ms GOCK and MS DHUNGA, there is insufficient evidence to indicate that Ms GOCK breached the manual handling policy and was in the room when he fell. Although some circumstances of the fall such as the bed position and the presence of the lifter lend weight to this proposition, I find, on balance, that no staff were present when Mr EPSIMOS fell.

Raising the bed

Kasaya GOCK offered no credible explanation as to why she chose to raise the bed and then leave Mr EPSIMOS unattended to obtain the lifter. She referred in a general sense to it being quicker and the room being small and furniture having to be moved.

I accept that it would be easier to push the lifter straight through under the bed if the bed was raised, however, there does not seem to be any reason why the lifter could not be in the room while the bed was raised.

According to MASIH, the lifter was near the doorway when he entered. It was not under the bed, but it was in the room. Kasaya GOCK said that no furniture had been moved by her therefore the lifter must be capable of being present in the room in a position away from the bed. In her evidence, Kasaya GOCK also said that she put the lifter through the door when she came back and that she didn't move it anywhere else. Therefore, the bed didn't have to be raised to fit the lifter in the room.

Her evidence in response to the question of whether raising the bed prior to getting the lifter was her usual practice seemed contradictory. She alternated between saying that she would usually have a second person in the room when the bed was being raised and saying that raising the bed and then leaving the room to get the lifter was her usual practice. One explanation for this confusion is simply that perhaps she had no firm practice.[18]

Another issue arose during the inquest regarding the size of the room and whether environmental aspects of the room contributed to the injuries or hindered treatment for the injuries. Sabita DGHUNGA stated that the room was very congested and prevented her pressing the buzzer or even accessing Mr EPSIMOS. However, I am of the view that she lacks sufficient credibility for this version to be accepted.

[18] Evidence provided at inquest on 13/9/16

As there were no witnesses to the fall and the blood was cleaned up, I am unable to find that the layout of the room or items in the room contributed to injuries or the treatment of Mr EPSIMOS.

Autopsy Report

A post mortem was conducted by Dr Liliana SCHWARTZ on 17 December 2014. In her report she found that the direct cause of Mr EPSIMOS's death was "complications of large right subdural haematoma".

Conclusion

In conclusion I am satisfied, on the balance of probabilities, that Mr EPSIMOS died as a result of a fall that occurred at Bexley BUPA at 741 Forest Rd, Bexley on 8 December 2014. There is insufficient evidence to speculate on the precise mechanics of the fall.

I find that the fall occurred while Assistant in Nursing Kasaya GOCK was absent from room 10. Ms GOCK had raised Mr EPSIMOS's bed prior to the fall occurring. The raised bed contributed to the severity of the fall. There were no crash mats present which also contributed to the severity of his injuries.

On the evidence before me, I am of the view that the staffing levels of the BUPA assistants in nursing should be reviewed. Similarly, consideration should be given to formally structuring the manner in which two-person assists are conducted, in particular, the raising/lowering of beds and the calling for a second staff member.

I would like to thank the Officer in Charge of the investigation, Senior Constable Christine NORVAL. I would also like to thank Coronial Advocate, Mr Durand WELSH for assisting me in this inquest.

Finally, I would like to thank John and Chris EPSIMOS for their participation in this inquest. I offer them my sincere condolences for the loss of their father, Sam.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The deceased person was Savvas Epsimos.

Date of death

He died on 12 December 2014.

Place of death

He died at St George Hospital, Kogarah.

Cause of death

The medical cause of his death was complications of large right subdural haematoma.

Manner of death

His death was a result of him falling out of bed when he was a resident at the BUPA Care Services at 741 Forest Rd, Bexley on the 8 December 2014.

I close this inquest.

Magistrate Teresa O'Sullivan
Deputy State Coroner

Date 20 October 2016