IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 2235

FINDING INTO DEATH WITH INQUEST[1]

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

Inquest into the Death of: WALDEMAR ARIEL[2] OGON

Delivered On:	27 May 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank VIC 3006
Hearing Date:	11 February 2014
Finding Of:	AUDREY JAMIESON, CORONER
Appearances:	Mr Michael Regos on behalf of Mercy Health
Counsel Assisting	Senior Constable Greig McFarlane, Police Coronial Support Unit

[1] The Finding does not purport to refer to all aspects of the evidence obtained in the course of the Investigation. The material relied upon included statements and documents tendered in evidence together with the transcript of proceedings and submissions of legal representatives/counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

[2] Mr Ogon's middle name was recorded as "John" on the Statement of Identification completed by his brother Piotr Ogon. His middle name is recorded as "Ariel" on the Release Authority and Confirmation of Name document completed by his mother, Jadwiga Ogon. For consistency, I have adopted the name "Ariel" as Waldemar Ogon's middle name.

I, AUDREY JAMIESON, Coroner having investigated the death of WALDEMAR ARIEL OGON

AND having held an inquest in relation to this death on 11 February 2014

at the Coroners Court of Victoria sitting at Melbourne

find that the identity of the deceased was WALDEMAR ARIEL OGON

born on 23 February 1966

and the death occurred on 20 June 2011

at the Werribee Mercy Psychiatric Unit, Mercy Mental Health, 298 Princes Highway, Werribee VIC 3030

from:

1 (a) SPONTAENOUS LETHAL ARRHYTHMIA

1 (b) FOCAL MYOCARDIAL FIBROSIS

in the following circumstances:

1. A mandatory inquest into the death of Mr Ogon was held on 11 February 2014, pursuant to section 52(2)(b) of the *Coroners Act 2008* (Vic) ('the Act'), as Mr Ogon was, immediately before death, a patient detained in a designated mental health service within the meaning of the *Mental Health Act 1986* (Vic).[3] At approximately 7.35am on 20 June 2011, Mr Ogon was located deceased in his bed by a nursing staff member at Werribee Mercy Psychiatric High Dependency Unit.

BACKGROUND AND CIRCUMSTANCES

2. Mr Ogon was born on 23 February 1966 and was 45 years of age at the time of his death. He was divorced and had two children to his marriage. He was in recipient of a disability support pension and resided at Maribyrnong with his parents, with whom he maintained a close and loving relationship. He had two siblings, Margaret Rato and Piotr Ogon.

3. Mr Ogon had a documented mental health history of bipolar affective disorder and alcohol abuse. He had been admitted to Mercy Mental Health in 2003, 2005, 2006, 2007, 2009 and 2011 in the context of non-compliance with his medications and relapses of his bipolar

[3] As it then was. See also *Coroners Act 2008* (Vic) s 52(2)(b); *Coroners Act 2008* (Vic) s 3(i), definition of 'person placed in custody of care'.

affective disorder. On each admission, Mr Ogon was documented to present with persecutory and grandiose delusions, and was noted to be irritable, hostile and aggressive which, on occasion, required Mr Ogon to undergo mechanical restraint or seclusion. He was most often nursed in the High Dependency Unit ('HDU') until his behaviour settled, before being transferred to the Low Dependency Unit ('LDU'). Mr Ogon's last admission in 2009 occurred in the context of non-compliance with medication leading to a manic relapse. Following this admission Mr Ogon was discharged on a Community Treatment Order and was prescribed lithium, olanzapine and chlorpromazine.[4]

4. On 6 June 2011, Mr Ogon's sister Margaret Rato contacted the Mercy Health Community Treatment Program ('CTP') with concerns that Mr Ogon was non-compliant with his medication, acting strangely and going out late in the evening to drink alcohol, behaviours that were known to be early signs of relapse of Mr Ogon's illness. Over the following days, Mr Ogon admitted to being non-compliant with his medication, was undertaking risk-taking activities such as drink driving, had persecutory and grandiose delusions and was acting in an aggressive manner. On 9 June 2011, the CTP referred Mr Ogon for triage alert and attempted to contact him by telephone. On 10 June 2011, Mr Ogon was transported by police to Mercy Mental Health under section 10 of the *Mental Health Act 1986* (Vic), in the context of appearing acutely psychotic, assaulting his mother and threatening his family. Mr Ogon was assessed by the on-call Psychiatric Registrar and was involuntarily admitted to the Werribee Mercy Psychiatric HDU.

5. Upon admission, an initial physical examination was attempted with 'further assessment not possible as the patient is un-accepting' recorded by the on-call Psychiatric Registrar. All requisite medical and nursing seclusion reviews, including basic observations, were completed.

6. From 10 June 2011 to 15 June 2011, Mr Ogon presented as argumentative, hostile and threatening, and was nursed in the HDU and in seclusion. On 11 June 2011, he was assessed as having a relapse of his bipolar affective disorder and his involuntary status was upheld. Throughout this period, he was administered olanzapine 10mg and diazepam 10mg orally, and benztropine 2mg and zuclopenthixol acetate 75mg-100mg by intramuscular injection, when prescribed, after assessments by the on-call Consultant Psychiatrist or Psychiatric Registrar. Staff monitored Mr Ogon throughout his admission and when noted to be sedated,

[4] Statement of Dr Amy Rooke, Consultant Psychiatrist at Werribee Mercy Psychiatric Unit, dated 26 September 2011, Coronial brief, 25; Mercy Health Medical records of Waldemar Ogon.

his routine medications were given orally and PRN[5] medications were reduced. On 16 June 2011, Dr Sujaritha Thomas requested a full set of biochemistry, including an electrocardiograph, however the request slip records that Mr Ogon 'refused' these investigation on 17 and 18 June 2011. From 16 June 2011, Mr Ogon largely resided in the HDU and would occasionally move to the LDU until incidents or behavioural concerns compelled his transfer back to the HDU. Throughout Mr Ogon's admission, he refused to allow blood tests to be taken and on 19 June 2011, he refused to have a blood test or physical observations taken.[6] Over the course of the day, he required one dose of PRN diazepam 10mg, one dose of PRN quetiapine 100mg, one dose of PRN temazepam 20mg to assist with sleep that evening and paracetamol 1g.[7]

7. At approximately 11.30pm on 19 June 2011, Mr Ogon awoke and at 11.40pm was given his medication comprising temazepam 20mg and PRN quetiapine 100mg, for sleep inducement. At this time, Registered Psychiatric Nurse ('RPN') Kerryn Evans observed Mr Ogon's legs to be swollen and his right leg to be red 'down the front of the calf area'. Mr Ogon made no reference to feeling unwell and did not look unwell. RPN Evans asked if he was experiencing any pain and he responded that he was not. She requested that he go to bed so that he could put his legs up, and she conveyed her observations to the Nurse in Charge, RPN Claire Jenkins, for review in the morning by the medical team.[8] Mr Ogon retired to bed at approximately 12.00am and was to be observed at fifteen-minute intervals by staff on duty. RPN Evans stated that Mr Ogon slept well throughout the night and was audibly breathing on the majority of observation rounds.[9]

8. RPN Louise Field undertook visual observations between 6.30am and 7.00am on 20 June 2011 and observed Mr Ogon to be audibly breathing and to have changed sleeping positions. She did not record her observations on the visual observations chart and instead documented her observations on a photocopy of the chart, which she later intended to transcribe onto the original chart after hand-over was completed. However, this transcription did not occur.[10]

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[5] PRN is pro re nata, which means as required.
[6] Statement of Dr Amy Rooke, above n 4, 25; Mercy Health Medical records of Waldemar Ogon.
[7] Statement of Dr Amy Rooke, above n 4, 34.
[8] Exhibit 5, statement of Kerryn Evans, registered psychiatric nurse at Werribee Mercy Psychiatric Unit, dated 6 December 2011, Coronial brief, 44.
[9] Ibid 45.
[10] Statement of Louise Field, registered psychiatric nurse at Werribee Mercy Psychiatric Unit, dated 22 November 2011, Coronial brief, 40.

9. RPN Evans undertook visual observations of Mr Ogon at 7.15am and 7.25am in the company of RPN Anne Partanen. RPN Evans subsequently returned to Mr Ogon's room after reflecting that he had been unusually quiet and not snoring as he normally did. RPN Evans stood over Mr Ogon for approximately 5-10 seconds and observed him to breathe. Satisfied that he was asleep, RPN Evans left his room and continued her observations of other patients with RPN Partanen. These observations were not recorded, as the primary visual observation sheet was taken by the shift leader RPN Jenkins for document compilation prior to handover.[11]

10. At approximately 7.35am, RPN Partanen went into Mr Ogon's room in an attempt to wake him so that blood samples could be taken. Mr Ogon was observed to be lying on his right side. RPN Partanen attempted to wake him by saying his name. When Mr Ogon did not respond, she called his name again, with a raised voice, touched his face and shook him gently by his shoulders. Due to Mr Ogon's unresponsive state, RPN Partanen opened his eyes and observed that his pupils were dilated and unresponsive to light. She could not palpate a pulse and did not observe any respiratory effort. She consequently yelled 'Code Blue' from the room door, returned to Mr Ogon and continued to attempt to wake him, while observing that his face and neck were 'very cold to touch' and his lips were 'cyanotic'.[12]

11. RPN Bridget Cunningham arrived and assisted RPN Partanen in an attempt to elicit a response from Mr Ogon. They attempted to turn him onto his back, however 'it proved to be very difficult as his extremities were stiff, i.e. [they] could not straighten his arms and legs'. Cardiopulmonary resuscitation ('CPR') was commenced at approximately 7.40am (defibrillation pads were applied to Mr Ogon's chest, he was manually ventilated and chest compressions were commenced), however Mr Ogon did not respond. At 8.10am, CPR was ceased and Mr Ogon was declared deceased.[13]

POST MORTEM EXAMINATION AND REPORT

12. A post mortem examination was undertaken by Dr Malcolm Dodd, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr Dodd reported[14] that the

[11] Exhibit 5, statement of Kerryn Evans, above n 8, 44-45.
[12] Statement of Anne Partanen, registered psychiatric nurse at Werribee Mercy Psychiatric Unit, dated 6 September 2011, Coronial brief, 23.
[13] Ibid 24.
[14] Exhibit 1, Medical Examiner's Report of Dr Malcolm Dodd dated 19 August 2011.

external examination showed changes of early decomposition, but was otherwise unremarkable.

13. Internal examination showed mild cardiac enlargement that in the context of Mr Ogon's physique would fall into the normal range of heart weight. The heart appeared somewhat rounded and showed evidence of biventricular dilatation, which Dr Dodd noted may be in part due to post mortem change. Macroscopically, the heart appeared otherwise unremarkable and the coronary artery tree was patent throughout. The cardiac muscles showed no apparent changes although autolysis was noted. In view of Mr Ogon's age, a cardiac conduction study was performed. Sections sampled from the region of the atrioventricular node and sinus artery showed dense mature paucicellular fibrous tissue with some narrowing of the sinus artery lumen.

14. Internal examination also identified an enlarged liver with moderate fatty degeneration. The lungs showed congestion and oedema, which Dr Dodd considered a nonspecific finding. No other significant naturally occurring disease was identified.

15. Toxicological analysis of body fluids indentified Olanzapine, the benzodiazepines[15] Temazepam, Diazepam and its metabolite Nordiazepam, Quetiapine, Zuclopentixol and a trace amount of paracetamol. The levels of these medications did not exceed the expected normal therapeutic range.

16. Dr Dodd reported that as far as can be ascertained, there is no evidence to suggest that Mr Ogon's death was due to anything other than natural causes.

17. Dr Dodd ascribed the cause of Mr Ogon's death to spontaneous lethal arrhythmia in the context of focal myocardial fibrosis, with incidental findings of 1) hepatomegaly (marked fatty degeneration of the liver); and 2) Mild fibrofatty replacement of the pancreas.

PURPOSE OF THE CORONIAL INVESTIGATION

18. The primary purpose of the coronial investigation of a reportable death[16] is to ascertain, if possible, the identity of the deceased, the cause of death (interpreted as the medical cause of death) and the circumstances in which the death occurred.[17]

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[15] Please note: Error in medical examiners report that states 'Benzydamines' instead of 'benzodiazepines'.
[16] Section 4 of the *Coroners Act 2008* (Vic) requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death includes all deaths that appear 'to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury. Mr Ogon's death falls within this definition.
[17] *Coroners Act 2008* (Vic) s 67.

19. Coroners are also empowered to report to the Attorney-General on a death they have investigated. Coroners can comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[18] This is referred to as the 'prevention role' of the coroner.

20. I note that historically, under the *Coroners Act 1985* (Vic), a Coroner was obliged to make a finding regarding person/s or other entities who had "contributed" to the death. In 1999, the 1985 Act was amended to remove this obligation. The absence of this obligation was preserved in the *Coroners Act 2008* (Vic), and is supported by the common law, which maintains that it is not part of a Coroner's role to lay or apportion blame.[19] However, the removal of this obligation does not preclude a Coroner from making a finding of contribution, in appropriate cases. The *Briginshaw*[20] standard of proof is applicable to findings of fact in this Court. As Dixon J espoused:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proof, indefinite testimony or indirect inferences.[21]

THE EVIDENCE

21. This finding is based on all the investigation material comprising the coronial brief of evidence, all material obtained after the provision of the brief, the statements and evidence of those witnesses who appeared at the Inquest and any documents tendered through them, other documents tendered through counsel, and submissions made by counsel.

22. The following witnesses gave *viva voce* evidence at the Inquest:

    a) Dr Malcolm Dodd, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine;

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[18] *Coroners Act 2008* (Vic) ss 72(1), 72(2) and 67(3).
[19] *Keown v Kahn* (1999) VR 69:, 76 per Calloway JA.
[20] *Briginshaw v Briginshaw* [1938] 60 CLR 33.
[21] Ibid, at [362]-[363].

b) Claire Jenkins, Registered Psychiatric Nurse;

c) Kerryn Evans, Registered Psychiatric Nurse; and

d) Natasha Stresnjak, Registered Psychiatric Nurse.

ISSUES INVESTIGATED AT INQUEST

23. At the commencement of the Inquest, it was evident that most of the facts surrounding Mr Ogon's death were known and without dispute, including his identity, the medical cause of his death and aspects of the circumstances of his death, including the place of his death.

24. Issues were identified regarding the care provided to Mr Ogon that required further exploration at Inquest, including:

a. the time of Mr Ogon's death; and

b. the nature and recording of the observations made overnight on 19 to 20 June 2011.

Time of Mr Ogon's death

25. RPN Field undertook visual observations between 6.30am and 7.00am on 20 June 2011 and observed Mr Ogon to be audibly breathing and to have changed sleeping positions.[22] RPN Evans gave evidence that during the 7.25am round of visual observations, after observing Mr Ogon with RPN Partanen, she was unsure about Mr Ogon's condition and decided to go back and "take a closer look at him".[23] She stood over Mr Ogon, within hand's reach,[24] for approximately 5-10 seconds and observed him to breathe.[25] At approximately 7.35am RPN Partanen entered Mr Ogon's room and observed that he was unresponsive, his face and neck were very cold to touch and his lips were cyanotic. When she and RPN Cunningham attempted to turn Mr Ogon onto his back, 'it proved to be very difficult as his extremities were stiff, i.e. [they] could not straighten his arms and legs'.[26] Mercy Mental Health Inpatient Unit Manager RPN Stresnjak corroborated this evidence, stating that when she assisted with the Code Blue call, she attempted to roll Mr Ogon to check his airway, however she had great difficulty as his body was very rigid, was 'like trying to turn a plank', and his skin was cyanosed and cool to touch.[27]

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[22] Statement of Louise Field, above n 10, 40.
[23] Exhibit 5.
[24] Inquest transcript, 62.
[25] Exhibit 5, statement of Kerryn Evans, above n 8, 44-45.
[26] Statement of Anne Partanen, above n 12, 23.
[27] Inquest transcript, 81-4

26. Dr Dodd gave evidence that, 'in this regard, a person being alive at 7.25am and being found dead approximately 10 minutes later would not realistically have any demonstrable temperature changes to the touch, and rigidity would not yet be established' and that 'when a body is noted to be cold and rigid the post mortem interval is somewhere between eight and thirty six hours'.[28] Dr Dodd stated that post mortem rigidity changes 'can be hastened by covering of blankets, which tends to conserve body temperature to some degree, so it tends to speed up the changes of onset of rigidity', and that the time frame of slightly less that 8 hours post-death would not concern him if Mr Ogon had been in a warm environment or if he was covered with blankets.[29] Dr Dodd gave evidence that:

a. when the body is noted to be warm and flaccid, the post mortem interval is less than three hours;

b. when the body is noted to be warm and rigid, the post mortem interval is between three and eight hours,

c. when the body is noted to be cold and rigid, the post mortem interval is between eight and thirty six hours; and

d. when the body is cold and flaccid (rigor has passed), the post mortem interval is deemed to be in excess of thirty six hours.[30]

27. Dr Dodd stated that if the body is actually distinctly not just cool but cold to the touch then it is probably at the extreme end of that scale, however Dr Dodd noted that rigidity is the most important factor, as the feeling of 'cold to touch' could just be reflective of the ambient environment.[31] He gave evidence that it is not possible for someone to be absolutely deemed alive and ten minutes later is noted to be cold and rigid, and that rigidity takes place from about three hours onwards post mortem.[32]

28. Dr Dodd noted that arrhythmias, by their very nature occur as a sudden onset event, and a person can die 'very very quickly' from an arrhythmia. He considered that if Mr Ogon been alive at 7.25am and had an arrhythmia, he could be dead at 7.35am, but this would still not explain why ten minutes later he was found to be 'cold and rigid'.[33] Dr Dodd gave evidence

[28] Inquest transcript, 11.
[29] Ibid, 13, 14.
[30] Ibid, 11.
[31] Ibid, 18-19.
[32] Ibid, 14-15.
[33] Ibid, 20-21.

that after death, very rarely, there might be what could be perceived as a respiratory sound which might be heard as a sigh, but there would certainly be no chest movements.[34]

29. After hearing Dr Dodd's evidence, RPN Evans gave the following evidence when asked about whether she observed Mr Ogon to breathe at the 7.25am observation round: 'Yeah. Well, what appeared to be a breath. After hearing from Dr Dodd it could have been an exhale, it could have been – you know, he may have been dead but it didn't indicate that to me.'[35] She gave evidence that she is positive that Mr Ogon was alive at 7.15am.[36]

30. I am satisfied based on the evidence obtained from Dr Dodd that Mr Ogon died prior to the observations undertaken by RPNs Field and Evans from 6.30am. RPN Partanen gave evidence that at 7.25am, Mr Ogon's face and neck were very cold to touch, and that his extremities, including his arms and legs, were stiff and could not be straightened. This evidence is consistent with the evidence given by Dr Dodd that post mortem rigidity takes place from approximately three hours onwards, and that a time frame of slightly less that 8 hours post-death would not concern him if Mr Ogon had been in a warm environment, or if he was covered with blankets. I accept RPN Evans' evidence regarding her visual observations of Mr Ogon, to the extent that I am satisfied that she believed that Mr Ogon was sleeping and may have mistaken a post-death respiratory sound for Mr Ogon taking a breath.

The nature and recording of visual observations, and those made overnight on 19 to 20 June 2011.

31. RPN Louise Field undertook visual observations between 6.30am and 7.00am on 20 June 2011 and observed Mr Ogon to be 'audibly breathing' and to have 'changed sleeping positions'. She did not record her observations on the visual observations chart and instead documented her observations on a photocopy of the chart, which she later intended to transcribe onto the original chart after hand-over. However, this transcription did not occur, as she intended to do it after handover following the conclusion of her shift but was not able to access the original observation chart, as it was ordinarily retained by the Nurse in Charge when giving handover.[37]

[34] Inquest transcript, 17.
[35] Ibid, 68.
[36] Ibid, 67.
[37] Statement of Louise Field, above n 10, 40.

32. RPN Evans undertook visual observations of Mr Ogon at 7.15am and 7.25am in the company of RPN Anne Partanen, who, according to RPN Evans "was satisfied there was nothing untoward" about Mr Ogon but RPN Evans was "unsure" and decided to go back and take a closer look at him.[38] The initial reason for doing so was that Mr Ogon 'more often snored when he slept', and was 'particularly quiet'.[39] RPN Evans stood over him for approximately 5-10 seconds and observed him to breathe. Satisfied that he was asleep, she left his room and continued her observations of other patients with RPN Partanen. These observations were not recorded, as the visual observation sheet was taken for document compilation prior to handover.[40] It remains unknown which other nurses undertook visual observations of Mr Ogon overnight on 19 to 20 June 2011,[41] and the visual observation checklist used at the time of Mr Ogon's death does not identify the nurses who undertook observations, or the exact times that the observations were undertaken. The whereabouts of the original of the night shift checklist remains unknown, and a copy was tendered to the Court which records Mr Ogon's arousal score as 'zero' from 12.15am to 6.30am.[42]

33. As Nurse in Charge on the evening of 19 June 2011, RPN Jenkins gave evidence that due to feeling ill, she began to prepare for handover to the morning staff earlier than usual and placed all of the documents, including the original HDU and LDU 'sleep charts',[43] in a pile and left them in the handover room, which was her usual practice. She stated that towards the end of the shift photocopies are made to assist staff in recording their progress notes, and a copy is usually taken to handover, with the original staying at the nursing station. RPN Jenkins believes that on this occasion, a copy was kept at the nurses station, instead of the original, and the checks were recorded on the copy. She is unable to say whether on this occasion the original or a copy were retained, or if they were all shredded,[44] but that there would usually be three copies, used as a reference for people writing their notes, and that those records would be transferred to the original and the copies would usually get shredded.[45] There was a period when the original was also shredded, but a process was developed of keeping the original, however she cannot recall when this process began.[46]

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[38] Exhibit 5.
[39] Exhibit 5, statement of Kerryn Evans, above n 8, 45.
[40] Ibid 44-45; Exhibit 5.
[41] Inquest transcript, 27, 60,
[42] Exhibit 4, night shift checklist for Waldemar Ogon, dated 19 June 2011, Coronial brief, 72.
[43] Formally referred to as the 'night shift checklist'.
[44] Inquest transcript, 25-6.
[45] Ibid, 32-3.
[46] Ibid, 38.

RPN Jenkins stated that at the 10.00pm check, the sleep charts would not be carried around with the nurses performing the checks, because staff did not feel the need once it was established who the patients were and what room they were in. By that stage, the nurses relied upon their memory.[47]

34. RPN Jenkins gave evidence that in relation to the checks performed, she would expect the nurses to first check whether the patient is in their room, and then 'look for some sign of life' such as coughing or snoring, in circumstances where they are not awake. She expects the check to continue until the nurse is satisfied that the person is alive.[48] She does not think that each patient's breathing needs to be checked if there is snoring and movement, but if there are no observed sounds or movement, respirations will be checked. She has no reason to think that on this occasion, the checks were not done and to the best of her knowledge, they were done.[49] RPN Jenkins stated that the only time she performs a 'clinical observation' is if there has been a significant issue and there has been a recommendation by the doctor or a nurse-initiated recommendation that something should be done overnight.[50] She gave evidence that most often nurses will check the patient from the door, and that they try not to enter the room if they can see from the door, because they do not want to startle the patient. Until hearing evidence at this Inquest, she was unaware that there is a hospital policy in relation to how a check should take place, and has never seen the policy.[51]

35. RPN Evans gave evidence that she is not able to tell who performed the checks on the evening of 19-20 June 2011. She stated that when undertaking visual observations, she would not necessarily go into the patients' room, because most of the beds are very close to the door, and that she would check that there was some sign of life. If the patient appeared asleep with no movement, she would look for an objective marker of respiration, such as breathing, coughing, snoring or movement and that she gets as close as she needs to confirm that they are breathing. Until hearing evidence at this Inquest, she was also unaware that there is a hospital policy in relation to visual checks.[52] She is aware that the Werribee Mercy Hospital maintains a database of policies, but stated that it is quite possible that a policy has been updated or changed and that nobody would bring it to the staff's attention, or that the definition of 'visual observation' has been put in place but nobody has informed the

[47] Inquest transcript, 46.
[48] Ibid 28.
[49] Ibid, 36-7.
[50] Ibid, 41.
[51] Ibid, 29.
[52] Ibid, 60.

nurses.[53] RPN Evans' observations were not recorded, as the visual observation sheet was taken for document compilation prior to handover.[54] She stated that prior to the 7.15 check, she would have checked Mr Ogon at some time, but could not confirm when or how often.[55] RPN Evans acknowledged that there is a lack of rigour in Mr Ogon's observations that does not enable a definitive picture about what was occurring overnight.[56]

36. Inpatient Unit Manager RPN Stresnjak gave evidence that her rationale behind visual observations of psychiatric patients is to ensure the visual sightings of patients at intervals determined by the most recent risk assessment completed. She stated that a thorough risk assessment, together with visual observations, aims to reduce incidents and ensure staff and patient safety. She gave evidence that once nursing handovers are completed, the night shift checklist photocopies are shredded,[57] and acknowledged that at the time of Mr Ogon's death, a new risk and visual assessment tool was being developed, and all procedures relating to risks were being reviewed.[58]

37. RPN Stesnjak's expectation from a night shift staff member undertaking observations is that they would sight the patient at the relevant interval and, as per protocol, would engage the patient as required. If the patient appeared to be asleep, she would expect the nurse to observe respiratory activity as per procedure.[59] However, she acknowledged that at the time of Mr Ogon's death, she does not believe there was a definition in the procedure regarding what constituted an observation if somebody appeared to be asleep, except for the arousal scale of 'zero' to reflect 'sleep'.[60]

IMPROVEMENTS TO THE DELIVERY OF HEALTH SERVICES

38. I acknowledge that at the time of Mr Ogon's death, Mercy Mental Health was in the process of developing a new risk and visual assessment tool and all procedures relating to risks were being reviewed.[61] I am satisfied that Mercy Mental Health undertook a systems review after Mr Ogon's death, and in response to identified shortcomings have instituted the following changes:

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[53] Inquest transcript, 61.
[54] Exhibit 5, statement of Kerryn Evans, above n 8, 44-45.
[55] Inquest transcript, 67.
[56] Ibid, 74.
[57] Ibid, 86.
[58] Ibid, 77.
[59] Ibid, 87.
[60] Ibid, 94-5.
[61] Ibid, 77.

a. The implementation[62] of a new Inpatient Risk Assessment and Visual Observation Form,[63] which has implemented the following changes:

   i. a more streamlined document incorporating both risk assessment and visual observation on the same form. This is said to allow staff to review the patient's most current risk at a glance;[64]

   ii. a section on the form that allows staff members to link together the level of the patient's arousal to the need of nursing intervention. For example, scores of two and above on the arousal scale for two consecutive sightings should elicit a prompt to the contact nurse to undertake an intervention and a review of the risk assessment;[65]

   iii. a section on the form identifying the staff that are giving and receiving handover;

   iv. a section on the form where a staff member undertaking a visual observation is required to fill in the exact time that the visual observation was undertaken and initial and print their name;

   v. a description of arousal level 'zero'; and

   vi. a section on the form that allows the contact nurse to document risk management strategies for all clients, which is said to assist staff to review, at a glance, strategies which have assisted during the previous shift.

b. The implementation[66] of a Psychiatric Inpatient Risk Assessment and Visual Observations Procedure, that includes:

   i. a definition for 'visual observation'; that is 'observing a client, their activity level, and check for breathing if the client appears to be sleeping'. This outlines the expectation of observations around patients breathing activity, and was made as a direct result of Mr Ogon's death;[67]

[62] Implemented in July 2012; Inquest transcript, 76.
[63] Exhibit 6, Inpatient Risk Assessment & Visual Observation Form, Coronial brief, 58-9.
[64] Inquest transcript, 76.
[65] Ibid.
[66] Implemented in July 2012.
[67] Exhibit 7, statement of Natasha Stresnjak, registered psychiatric nurse at Werribee Mercy Psychiatric Unit, Undated, Coronial brief, 51-2.

ii. an outline of the frequency of visual observations and definitions of low, medium, high, HDU observations and specialling; and

iii. a new structured handover process, in which incoming and outgoing shift leaders (or their delegate) must complete a round of the unit together and ensure all clients are present and perform visual observations pursuant to the procedure.[68]

c. Implementation of a new Mental Health Risk Assessment and Management Planning Procedure, an evidence-based framework around the risk assessment process at Mercy Mental Health.[69]

d. Implementation of a policy that requires the HDU area to be staffed by two nursing staff at all times. This policy change was made as a direct result of Mr Ogon's death.[70]

e. Implementation of a policy that one nurse is allocated the responsibility of visual observations for one hour at a time,[71] although RPN Stresnjak acknowledged that in the HDU, visual observations would always be undertaken by two nurses, for safety reasons.[72]

f. Implementation of a procedure relating to night shift visual observations that requires night shift, staff to take all risk assessment and visual observation tools with them on a clipboard around the ward to locate the clients and document visual observations directly onto the sheet. RPN Stresnjak gave evidence that the basis for this procedure is to reduce the risk of human error associated with transcribing information, as previously occurred.[73] Although concerns were raised at Inquest by a member of staff that this procedure may create privacy issues in relation to carrying around patients' personal and medical information,[74] RPN Stresnjak gave evidence that she disagreed with that notion, as the information would be contained within a file or on a clipboard that would be in the possession of nursing staff undertaking visual observations, and that after visual observations are completed the folder and

[68] Ibid 52.
[69] Ibid.
[70] Ibid 52; Inquest transcript, 100.
[71] Exhibit 7, statement of Natasha Stresnjak, above n 69, 53.
[72] Inquest transcript, 100.
[73] Ibid, 89-91.
[74] Ibid, 40-1, 43, 46.

clipboard should be placed back in the nurses station.[75] She did not see it to be a 'huge' risk, as nursing staff are equipped with Ascom phones[76] and can utilise them by pressing a single red button, which will elicit a prompt response from staff on the ward and elsewhere within the hospital.[77]

g. The new risk assessment and visual observation form is no longer copied/transcribed, or shredded after the end of the shift,[78] and all staff use the original form, which is now kept on file as a record.[79]

39. RPN Stresnjak stated that she was 'quite concerned' that staff gave evidence during the Inquest that they either had not heard about, or were not familiar with, the new risk assessment and visual observation tool, as its introduction required all staff to attend an implementation training package. She stated that the hospital has a 'Prompt System' which she described as 'quite easy to use'. She stated that if staff typed 'visual observations' into the Prompt System, the new risk assessment and visual observation tool would be quite easy to locate. She is of the belief that emails were sent out about Prompt establishment, communicating that the new process was going ahead. She acknowledged that a training day or something similar could be arranged to inform staff about the new risk assessment and visual observation tool.[80]

FINDINGS

1. I find that the identity of the deceased is Waldemar Ariel Ogon.

2. I acknowledge the inherent difficulties faced by health clinicians in managing and treating individuals with a mental illness.

3. The night shift checklist that was used by nursing staff at the time of Mr Ogon's death was somewhat ambiguous, due to not adequately defining what was meant by an arousal level of 'zero' and not defining what constitutes a 'visual observation'. In coronial matters where the circumstances surrounding a death are associated with medical management, the standard of communication and documentation invariably comes under scrutiny. In many circumstances, the absences, inadequacies or inaccuracies of recordings of observations become the focus of enquiry and a significant issue at Inquest, so that the deceased patient's

[75] Inquest transcript, 99.
[76] A smartphone for healthcare services that enables voice traffic, alarm and message handling.
[77] Inquest transcript, 104.
[78] Ibid, 52.
[79] Ibid, 33-4, 85.
[80] Ibid, 87-8.

clinical course can be factually understood. The Office of the Chief Psychiatrist's *Chief Psychiatrist's Investigation of Inpatient Deaths 2008-2010* states:

> In a dynamic and highly pressured environment, it is most important that there is clear communication, documented decision-making and regular review and monitoring of the level and type of nursing observations required.[81]

To make a recommendation that healthcare professionals be more diligent with their documentation would be somewhat banal but as in other matters,[82] I again make the comment that clinicians be reminded that their documentation is a means of communication between treating healthcare professionals, is a legal document and should act as an *aid memoir*.

4. I find that I cannot reconcile the evidence heard at Inquest with the visual observations recorded on the night shift checklist. I cannot exclude the possibility that the checks were not undertaken. It is also possible that they were in fact undertaken but it is unknown who undertook the visual observations or when. It is similarly possible that nursing staff *believed* that they were undertaken and retrospectively filled in the night shift checklist. The whereabouts of the original night shift checklist is unknown, and the evidence suggests that it is more likely than not that it was shredded by mistake, leaving only a copy of the checklist that does not identify the staff members who undertook the visual observations or the exact time that the visual observations were undertaken. It is therefore difficult to reconcile the evidence, such as that of Dr Dodd, RPN Stresnjak and RPN Partanen, with a document that does not indicate anything other than that Mr Ogon was sleeping.

5. I acknowledge that the night shift checklist is no longer in use and I am satisfied that Mercy Mental Health has undertaken reasonable and appropriate steps to remedy the issues surrounding the nature and recording of visual observations, by implementing a new risk assessment and visual observation form in conjunction with new policies and procedures. Notably, the new Psychiatric Inpatient Risk Assessment and Visual Observations Procedure includes a definition of 'visual observations' that compels nursing staff to check for breathing if the patient appears to be sleeping, although I note it does not refer to the need to

[81] Chief psychiatrist, *Psychiatrist's Investigation of Inpatient Deaths 2008-2010*, 2012, Office of the Chief Psychiatrist, < http://health.vic.gov.au/chiefpsychiatrist/index.htm > as at 23 April 2015.
[82] Inquest into the death of Judith McDonald (COR 2005 3907); Inquest into the death of Mary Korzeniewski (COR 2004 4579) Inquest into the death of Maria Nigro (COR 2009 829).

observe visual respiratory chest movements, which importantly differentiates a breath from a post mortem respiratory sound.[83]

6. I am satisfied that Mr Ogon had died prior to the observations undertaken by RPN's Field and Evans from 6.30am. RPN Partanen gave evidence that at 7.25am, Mr Ogon's face and neck were very cold to touch, and that his extremities, including his arms and legs, were stiff and could not be straightened. This evidence, when considered in context of the evidence given by Dr Dodd, that post-death rigidity takes place from approximately three hours onwards, and that the time frame of slightly less that 8 hours post-death would not concern him if Mr Ogon had been in a warm environment, or if he was covered with blankets. Further, the evidence of RPN Partanen was corroborated by RPN Stresnjak's[84] who, after hearing the evidence of Dr Dodd, stated that she has no difficulty accepting his evidence in this respect.[85]

7. I accept RPN Evans' evidence regarding her visual observations of Mr Ogon, and I am satisfied that she believed that Mr Ogon was sleeping and may have mistaken a post mortem respiratory sound for Mr Ogon's normal respiratory efforts, but I cannot accept that he was alive at that time.

8. I find that there were shortcomings in the care provided to Mr Ogon, which I consider did not equate to the appropriate delivery of care required for involuntary psychiatric patients. At best, the visual observations were cursory and lacked rigour. However, I acknowledge the improvements made by Mercy Mental Health to the delivery of healthcare services, in response to such shortcomings.

9. I accept and adopt the medical cause of death as identified by Dr Malcolm Dodd and find that Waldemar Ariel Ogon died from natural causes, being a spontaneous lethal arrhythmia arising from focal myocardial fibrosis, and I further accept the evidence of Dr Dodd that spontaneous lethal arrhythmia, by its very nature, is often very sudden in onset.[86] Accordingly, it is not possible to make a finding that Mr Ogon's death could have been prevented.

[83] Inquest transcript, 17.
[84] Ibid, 82-4.
[85] Ibid, 84.
[86] Ibid, 20.

COMMENTS

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

1. While I acknowledge Mercy Mental Health's apparent remedial initiatives, the importance of the Office of the Chief Psychiatrist's *Chief Psychiatrist's Investigation of Inpatient Deaths 2008-2010* should not be overlooked. In particular, I note Recommendation 7 which states:

> That the Department of Health and health services ensure there is a clear and consistent process and documentation for nursing observations, and that any change in required observation level is made after suitable discussion and consideration. The frequency of observation over the night shift should be congruent with daytime observations unless otherwise decided and documented.[87]

2. I acknowledge that a physical examination, completed biochemistry and cardiac monitoring assessment may not have influenced the outcome of Mr Ogon's eventual death from a cardiac arrhythmia. It should not be forgotten, however, that the vulnerability of patients with a serious mental illness to cardiac, renal, hepatic and pancreatic medical conditions, is recognised and supported by the 2011 Victorian Ministerial Advisory Committee on Mental Health document, *Improving the physical health of people with severe mental illness report.*[88] Timely, basic medical screening for patients admitted to an acute inpatient mental health unit is a reasonable expectation and should be uncontroversial.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I make the following recommendations connected with this death:

1. With the aim of minimising risk and preventing like deaths, I recommend that Mercy Mental Health implement compulsory training (and ongoing refresher training) to inform staff about the new risk assessment and visual observation forms, policies and procedures implemented by Mercy Mental Health, and implement compulsory training about the Prompt system,

[87] Chief psychiatrist, *Psychiatrist's Investigation of Inpatient Deaths 2008-2010*, 2012, Office of the Chief Psychiatrist, < http://health.vic.gov.au/chiefpsychiatrist/index.htm > as at 1 May 2015.
[88] This document is part of the Victorian Government's *Because mental health matters: Victorian Mental Health Reform Strategy 2009-2019.*

including how to use it to access all current and future policies and procedures implemented by Mercy Mental Health.

2. With the aim of minimising risk and preventing like deaths, I recommend that Mercy Mental Health amend their definition of 'visual observation' so that it includes but is not limited to recording the patient's/client's activity level, and if the patient/client is assumed to be sleeping, that a notation of chest movements and/or other signs of respiration are recorded consistent with good clinical practice.

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

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

Mrs Jadwiga Ogon

Mr Michael Regos, DLA Piper Australia on behalf of Mercy Health

Dr Jack Bergman, Medical Director, Werribee Mercy Hospital

Dr Malcolm Dodd, Victorian Institute of Forensic Medicine

Police Coronial Support Unit

Dr Mark Oakley Browne, Chief Psychiatrist

Constable Adam Licastro

Signature:

AUDREY JAMIESON
CORONER
Date: **27 May 2015**