IN THE CORONERS COURT
OF VICTORIA
AT SOUTHBANK

Court Reference: COR 2010 001287

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of ALEXANDER CODY

Delivered On:	21 February 2013
Delivered At:	Melbourne
Hearing Dates:	15/02/2013
Findings of:	Iain T West, Deputy State Coroner
Representation:	Ms Ingrid Nunnink G4S Health Service
Police Coronial Support Unit	L/S/C John Kennedy

I, Iain Treloar West, Deputy State Coroner, having investigated the death of ALEXANDER IGNATIUS CODY

AND having held an inquest in relation to this death on 15/02/2013

at the Melbourne Coroners Court

find that the identity of the deceased was ALEXANDER IGNATIUS CODY

born 25 February 1917

and the death occurred on 3 April 2010

at MAROONDAH HOSPITAL, RINGWOOD RD, RINGWOOD EAST 3135 VIC

from:

1a INTRACRANIAL HAEMORRHAGE IN THE SETTING OF OVER-WARFARINISATION

in the following circumstances:

1. Mr Alexander Cody was aged 93 years at the time of his death and resided at Lionsbrae Hostel, a residential aged care facility in Ringwood East, where he had been admitted in September, 2009, following a stroke. His medical history included mitral valve repair, depression, subtotal colectomy for transverse colon cancer, osteoarthritis, atrial fibrilation, hypertension, peripheral vascular disease and a stroke. Mr Cody suffered the stroke in July 2009 and was treated thereafter, with Warfarin anticoagulant medication.

2. On the 20th March 2010 at approximately 10.00 pm, Mr Cody was found on the floor of his bedroom after having an unwitnessed fall whilst getting changed. He stated that he struck his head on the wall and television cabinet and he sustained skin tears to his limbs for which staff administered first aid. The registered nurse on duty took a set of neurological observations and did not notice any change in his cognitive state. Mr Cody remained conscious and alert and reported the incident clearly and dispayed no loss of motor strength, dizziness or nausea. Nevertheless, an ambulance was called due to the head strike and being administered Warfarin medication. A non-emergency ambulance officer attended to Mr Cody shortly before midnight and after assessment and speaking to staff, it was decided he did not need to be transported to hospital, as no injury could be identified other than the minor skin tears. Mr Cody had a Glasgow Coma Score of 15 and was subsequently monitored half hourly overnight, with staff reporting that he was comfortable during the night.

3. During the morning of the 21st March, Mr Cody complained of a stiff neck and upon examination, staff found no briusing to the head or neck, nor other areas of pain. Nevertheless a locum doctor, Dr Syed Shabbir, was called in to review Mr Cody, with the examination taking place at 2.15 pm. The doctor diagnosed a 'sprain neck' and ordered medication, including panadiene forte for pain relief, which was subsequently administered by the nurse. Due to an error being written in the medication order, another locum, Dr Stephen Kay, attended the hostel at 10.50 pm, to rewrite the order. Dr Kay found Mr Cody to be alert, moving all four limbs and reporting no symptoms of pain. Observations were taken and found to be within acceptable limits and no major injuries were observed, with Dr Kay concluding that Mr Cody was medically stable. On the 22nd March, Mr Cody was seen by the physiotherapist at approximately 1.00 pm. He complained of pain in the posterior aspect of the neck and generalized body pain, but no dizziness, or radiating pain in the upper limbs. She recommendation a cervical spine Xray if pain increased.

4. On the morning of the 24th March, Mr Cody was observed to have right side coordination difficulties, with no power or strength in his right hand, nor normal weight bearing ability in his right leg. This was monitored and when checked again at 1.30 pm, with his daughter present, he was found to have normal strenght in both arms, but remained a little unsteady on his right leg. Mr Cody's general practitioner for the past five months, Dr Jerry Yang, saw him and signed an incident report form, stating there were no further orders.(Whilst there is conflicting evidence of the doctor attending Mr Cody at this time, the weight of evidence satifies me that he did). Mr Cody had a blood test undertaken on the morning of the 26th March for his INR reading (international normaization ratio), and afterwards attended the Eye and Ear Hospital in East Melbourne, for a specialist appointment. Later in the day Dorevitch pathology informed hostel staff that his INR was 10, and instructed that they withhold the daily dose of Warfarin, and to administer 5 mg tablet Vitamin K as a reversing agent. This was done at 6.00 pm following his return from the hospital,

5. Staff found Mr Cody on the morning of the 27th March with an altered conscious state, slurred speech, right hemiplegia and having vomited. Ambulance attendeance was requested at 8.15 am and Mr Cody was transported to Maroondah Hospital, where he was admitted with unequal pupils and a Glasgow Coma Score of 13. Investigations included a CT scan of the brain which showed a left intracerebral haemorrhage and subdural haemorrhage, and imaging of the cervical spine showed a fractured C2 vertebra with minimal displacement. Mr Cody was subsequently transferred to the ward from the emergency department and his elevated INR was reversed with intravenous Vitamin K, Prothrombin X and fresh frozen plasma. In consultation with family, Mr Cody was managed conservatively and as his condition continued to deteriorate over subsequent days, he was treated palliatively with morphine. Alexander Cody died on the 3rd April 2010 at approximately 11.00 am.

6. No autopsy was performed in this case as the coroner, in consultation with Dr Melissa Baker, Forensic Pathologist with the Victorian Institute of Forensic Medicine, directed that no autopsy was required. Dr Baker performed an external examination of Mr Cody at the mortuary, reviewed the circumstances of his death, the medical deposition and clinical notes, the post mortem CT scan and provided a written report of her findings. Dr Baker reported that in all the circumstnces a reasonable cause of death appeared to be intracranial haemorrhage in the setting of over Warfarinisation.

COMMENTS

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

7. The inquest highlighted a number of concerns regarding Mr Cody's care and management, both before and after his fall. It is not the role of the coroner to apportion blame, but to review the circumstances surrounding a death and to make recommendations in an attempt to reduce the number of preventable deaths.

a. INR

In the period leading up to his fall, Mr Cody had his INR levels regularly checked by Dorevitch Pathology, with this occurring on average every 5 to 6 days. However, no testing was undertaken between the 5th March and the day of his fall, a period of 14 days and when next tested on the 24th March, the reading as described by one medical witness was, 'deranged'. No evidence was available at the inquest to explain this change of routine, with hostel staff indicating that the pathology service was responsible for arranging testing and that the hostel did not monitor the attendance of their residents. Hence, there was nothing in place to trigger a reminder for testing if there was an omission to do so by the pathology service. Similarly, there was no procedure in place for alerting the service to a change in a resident's circumstances or medication regime, where such change may adversely affect the INR balance. The inquest heard that Naproxen, an anti-inflammatory (which is also used to treat pain), was prescribed following the fall, with the evidence

indicating that it can increase the Warfarin effect, by further thinning the blood. Neither this change of medication, nor the fall with head strike, was reported to the pathology service.

b. Ambulance transfer

The hostel appropriately had in place a protocol for ambulance attendance in circumstances of a resident falling and suffering a head strike when on Warfarin. I am satisfied that the request for a non-emergency ambulance was appropriate, given it was made by a Division 1 Registered Nurse who had also undertaken an assessment of Mr Cody. I am further satisfied that the decision not to transfer to hospital was reasonable, as the examining ambulance officer noted that the observations were 'unremarkable'. The assessing officer, whilst currently a non-emergency transport crew member, had 30 years prior experience as a qualified Ambulance Officer with Ambulance Victoria. In addition, the decision not to transfer was made following consultation and discussion with nursing staff. It is also significant that the medical officers, who later attended Mr Cody, did not see a need to transfer him to hospital. The inquest was told that G4S, the provider of non-emergency transportation services, has amended their patient transport procedures such that if there is doubt about patient transfer, the crew member, via the dispatcher, is to discuss the event with the Metropolitan Ambulance Service duty clinician.

c. Locum service and general practitioner

There is no evidence to find that either of the attending locum doctors failed to exercise appropriate care and management of Mr Cody. The locum service covered medical needs at the hostel at weekends, hence their attendance on the 21st March. The family is critical of their father's general practitioner, Dr Yang, believing that he should have monitored their father more frequently, especially following his fall. Dr Yang stated, however, that he routinely attended the hostel once a week and if required, attended at the end of a working day, after his clinic commitments. On his regular visits, he only saw a resident if there were medical issues brought to his attention by nursing staff. Dr Yang was not made aware of Mr Cody's fall, with it coming to his attention only after receiving the locum's report on the 22nd March. He was subsequently made aware of the locum's prescription for Naproxen and decided not to interfere, as the dispensing period was short term. The evidence does not support a finding that Dr Yang failed to pay sufficient attention to Mr Cody's needs, despite the fact that there appears to have been very few consultations in his 5 months residential period. The paucity of consultations needs to be considered, however, in the setting of Mr Cody being a relatively fit and healthy 93 year old.

RECOMMENDATIONS

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

8. a. That Lionsbrae Hostel add to their head injury post fall management checklist, 'for INR review', when the resident is on anticoagulation medication.

b. That Lionsbrae Hostel have available both observation charts and neurological charts for staff to record their post fall findings and to put in place protocols to ensure the findings are recorded.

c. For residents on anticoagulation, Lionsbrae Hostel to put in place a mechanism for reporting falls and/or a resident's change of medication regime, to the INR pathology service in order that consideration can be given to rescheduling testing.

d. That Lionsbrae Hostel gives consideration to developing a means by which an alert is raised if a resident's INR testing routine is not followed, or appears to fall outside the established pattern.

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

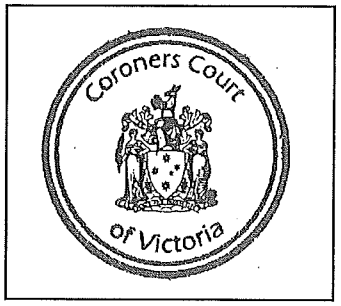
Family of Mr Cody

Manager, Lionsbrae Hostel

General Manager, G4S Health Services Australia Pty Ltd

Manager, Dorevitch Pathology

Signature:



Iain T West

Date: 21 February 2013