IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 003502

FINDING INTO DEATH WITH INQUEST

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

Inquest into the death of David John McLEOD

Delivered on:	23 December 2014
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing dates:	17 October 2014
Findings of:	Coroner Paresa Antoniadis SPANOS
Assisting the Coroner:	Sergeant Sharon Wade, Police Coronial Support Unit.

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of DAVID JOHN McLEOD
and having held an inquest in relation to this death on 17 October 2014
in the Coroners Court of Victoria at Melbourne

find that the identity of the deceased was DAVID JOHN McLEOD
born on 28 September 1953
and that the death occurred on 26 August 2012
at the St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria 3065

from:

I (a) CARDIOMEGALY AND SEVERE SINGLE VESSEL CORONARY ARTERY ATHEROSCLEROSIS IN A MAN WITH SCHIZOAFFECTIVE DISORDER

in the following circumstances:

1. David John McLeod was a 58-year-old single man who was born in Melbourne, the youngest and only male of four siblings. Mr McLeod had a mild intellectual disability and, as a teenager, was diagnosed with Schizoaffective Disorder.
2. According to family reports, as a consequence of his cognitive impairment and mental illness, Mr McLeod had been in one form of state care or another since adulthood.[1] Despite this, Mr McLeod's family maintained meaningful relationships with him and ensured that he participated in important family celebrations. Mr McLeod was particularly close to two of his sisters: Janet and Margaret. His sister Janet visited on a near weekly basis, in addition to communicating with him by telephone.[2]
3. Mr McLeod received treatment for Schizoaffective Disorder as an involuntary patient.[3] He was subject to a Community Treatment Order [CTO] pursuant to section 14 of the *Mental Health Act* 1986 [MH Act] that required him to receive treatment for his mental illness in the community. Mr McLeod had a poor history of compliance with the treatment regime specified in the CTO leading to periodic deterioration in his mental health. There seemed to be a pattern of episodes of mania, in the context of poor compliance with medication, leading to revocation of his CTO and his admission to psychiatric facilities until his mental health had sufficiently stabilised to allow him to return to the community for treatment on a CTO once

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[1] Coronial Brief of Evidence, page 7, (Statement of Janet Metherall).

[2] Coronial Brief of Evidence, page 7, (Statement of Janet Metherall) and Transcript page 24.

[3] St Vincent's Hospital clinical records maintained in relation to Mr McLeod.

again. Mr McLeod was involuntarily admitted to psychiatric units on at least six occasions between 2005 and 2007. His penultimate admission to St Vincent's Mental Health occurred in 2010.

4. For the five years prior to his death, Mr McLeod lived at Prague House which is an adult aged care residential facility with 24-hour per day staff presence, operated under the auspices of the St Vincent's Hospital.[4] Whilst at Prague House, Mr McLeod participated in a number of community based recreational programs.[5] In addition, Mr McLeod was able to pursue his passion for music, to write songs and play his guitar.

5. The support Mr McLeod received while living at Prague House enabled him to achieve a lengthy period of well-managed physical health and relative stability of mental health. Mr McLeod's history of physical illnesses included diet-controlled type 2 diabetes, cellulitis (bacterial skin infection) of his lower limbs, chronic obstructive airways disease [COAD], hypothyroidism, and hypercholesterolaemia (high cholesterol). Mr McLeod was a heavy smoker. He also suffered from Crohn's disease (inflammatory bowel disease), prostatic hypertrophy (enlarged prostate) and chronic urinary incontinence for which a transurethral resection of his prostate [TURP] was performed in April 2012.[6] Mr McLeod's physical health was regularly reviewed during his residence at Prague House.

6. Throughout his residence at Prague House, Mr McLeod was subject to a CTO and a mental health treatment regime consisting of depot antipsychotic medication (zuclopenthixol decanoate) and psychiatric review of his mental health managed by the St Vincent's Mental Health Service Continuing Care Team based at the Hawthorn Clinic.[7] At the Hawthorn Clinic, Mr McLeod was case managed by Sheryll Bird and under the care of psychiatrist Dr Ajit Selvendra.[8]

7. Throughout August 2012, the staff at Prague House had observed deterioration in Mr McLeod's mental state. He presented as increasingly disorganised with a labile mood, unsettled and preoccupied, and sleeping poorly.[9]

8. On 21 August 2012, Mr McLeod left Prague House and did not advise staff of his intended destination. Mr McLeod missed an appointment that morning at the Hawthorn Clinic but presented there in the afternoon. Upon review by Dr Selvendra, Mr McLeod was observed to

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[4] Exhibit C.

[5] Coronial Brief of Evidence page 155, (St Vincent's Mental Health Progress Notes).

[6] Exhibit C.

[7] Ibid.

[8] Ibid.

[9] Coronial Brief of Evidence pages 155-157 (St Vincent's Melbourne Progress Notes, Prague House).

have an unstable mood (alternating between being anxious, crying and having an elevated mood), limited organization, planning, judgement and insight, and with a plan to leave Prague House.[10] In the context of information provided by staff at Prague House, Dr Selvendra considered Mr McLeod's presentation, to suggest a manic relapse and degree of deterioration in his mental health sufficient to revoke his CTO.

9. On the afternoon of 21 August 2012, Mr McLeod's CTO was revoked and he was admitted to St Vincent's Psychiatric Inpatient Unit [the Inpatient Unit]. Mr McLeod's mental state was comprehensively re-assessed upon entry to the Inpatient Unit.

10. In the evening of his admission to the Inpatient Unit, Dr Bailey examined Mr McLeod physically. Albeit Mr McLeod denied physical symptoms when questioned systematically, his blood test results indicated that he was suffering from an infection. Mr McLeod was prescribed a broad-spectrum antibiotic (augmentin duo forte) and this was administered along with his usual medications.[11]

11. On 22 August 2012, Mr McLeod was reviewed by Consultant Psychiatrist, Dr Unadak and his Registrar, Dr Robb. Mr McLeod again denied physical symptoms and when examined showed no signs of active cellulitis and no peripheral oedema, though the appearance of his limbs was consistent with chronic venous insufficiency. He presented with raised a respiratory rate which was attributed to COAD. A chest x-ray and an electrocardiogram [ECG] were both reported as normal. Mr McLeod reported no deterioration in urinary incontinence and nothing in his presentation indicated that his urinary tract was the cause of his infection. Nonetheless, nursing staff attempted to obtain a diagnostic mid-stream urine sample for analysis, but were unable to do so due to Mr McLeod's incontinence.[12]

12. Whilst in the Inpatient Unit, Mr McLeod was subject to visual observation by nursing staff every 15 minutes. Nursing notes indicate that Mr McLeod was irritable upon admission but soon settled, and slept well on his first night in the unit following the administration of medication. However, Mr McLeod remained wakeful, barely sleeping, on each of the following nights (that is overnight on 22, 23, 24 and 25 August 2012) despite being administered sleeping tablets most nights.

13. Nurses noted that Mr McLeod was generally talkative and co-operative, although he left the unit without permission on 23 August 2012. He was returned to the unit by a member of the public on the same day. Mr McLeod demonstrated some tangential thinking and disorganisation, but that his lability of mood was improving over time. Mr McLeod

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[10] Coronial Brief of Evidence page 160-161, (St Vincent's Community Mental Health Progress Notes).

[11] Exhibit C, Lithium was not administered because blood testing of lithium levels had not been completed.

[12] Exhibit D.

experienced shortness of breath on exertion, requiring the assistance of a wheelchair when returning to the unit after his chest x-ray, and was troubled by his urinary incontinence. He was eating and drinking well

14. On 24 August 2012 Dr Robb conducted a further physical review of Mr McLeod, though this was not contemporaneously recorded in the patient notes. Dr Robb's assessment was that Mr McLeod's mental state was stabilising and his physical health also appeared to be improving. Repeat blood tests were ordered but testing was delayed owing to difficulty in drawing a blood sample.[13]

15. On 26 August 2012, just before 7.30am, a patient informed nursing staff that Mr McLeod had collapsed, falling to the ground in the bricked courtyard of the Inpatient Unit, and that he may have had a seizure. Nursing staff responded promptly. Nurses found Mr McLeod on the ground and observed that he was bleeding from an injury to his nose. Initially, Mr McLeod was breathing and had a pulse, but a short time later his respiration and pulse ceased. Nurse Sharma called a "Code Blue" (medical emergency) and commenced cardiopulmonary resuscitation [CPR].[14]

16. The Code Blue Team [the Team] arrived approximately three minutes later bearing the Resuscitation Trolley, which contained an Automatic External Defibrillator.[15] At the time of the Team's arrival, Mr McLeod was not breathing and had no cardiac output. A cardiac monitor was attached but throughout the Code Blue there was never a cardiac rhythm suitable for defibrillation.[16] Advanced resuscitation methods were employed by the Team, both in the courtyard, and in the Emergency Department [ED] where Mr McLeod was transferred at 7.50am for ongoing resuscitation and further evaluation.

17. After 40 minutes of extensive resuscitation, Mr McLeod showed no improvement and the specialist emergency physician on duty decided to cease resuscitation. Mr McLeod was pronounced deceased at 8.10am on 26 August 2012,[17] and as was appropriate, his death was reported to the Coroner.

18. Apart from a jurisdictional nexus with the State of Victoria, reportable deaths are, generally, deaths that appeared to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury. However, some deaths are reportable irrespective of the nature of the death, based on the status of the person immediately before

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[13] Exhibit D.

[14] Coronial Brief of Evidence, page 12, (Statement of Nurse K. Sharma).

[15] Coronial Brief of Evidence, page 12, (Statement of Nurse K. Sharma).

[16] Coronial Brief of Evidence, page 16, (Statement of Dr G. Phillips).

[17] Coronial Brief of Evidence, page 18, (Statement of Dr G. Phillips).

death. Mr McLeod's death was reportable as he was a *person placed in custody or care*[18] pursuant to the provisions of the MH Act. This is one of the ways in which the *Coroners Act 2008* recognises that people in the control, care or custody of the State are vulnerable, and affords them the protection of the independent scrutiny and accountability of a coronial investigation.

19. Another protection is the requirement for mandatory inquests. While there is a discretionary power to hold an inquest in relation to any death a coroner is investigating,[19] this was a mandatory or statutorily prescribed inquest as Mr McLeod was, immediately before death, a person placed in custody or care.[20]

20. The purpose of a coronial investigation of a *reportable death*[21] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[22] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[23]

21. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[24] Coroners are also empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or

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[18] See section 3 for the definition of a "person placed in custody or care" and section 4(2)(c) of the definition of "reportable death".

[19] Section 52(1) provides that a coroner may hold an inquest into any death that the coroner is investigating.

[20] Section 52(2) and the definition of "person placed in custody or care" in section 3.

[21] The *Coroners Act* 2008 [The Act], like its predecessor the *Coroners Act 1985*, 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 in section 4 includes deaths that appear *to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury* and the *death of a person who immediately before death was a patient within the meaning of the Mental Health Act 1986".*

[22] Section 67(1) of the *Coroners Act 2008.* All references which follow are to the provisions of this Act, unless otherwise stipulated.

[23] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[24] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

safety or the administration of justice.[25] These are effectively the vehicles by which the prevention role may be advanced.[26]

22. This finding is based on the totality of the material the product of the coronial investigation of Mr McLeod's death. That is the brief of evidence compiled by First Constable Byron Smith from Fitzroy Police, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them. All of this material, together with the inquest transcript, will remain on the coronial file.[27] In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

23. In relation to Mr McLeod's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. His identity and the date and place of death were not at issue. I find, as a matter of formality, that David John McLeod born on 28 September1953, aged 58, late of Prague House, 253 Cotham Road in Kew, died at St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria 3065 on 26 August 2012.

24. I find that at the time of his death Mr McLeod was a "person placed in custody or care" as defined in section 3[28] of the *Coroners Act* 2008 because he was an involuntary patient at St Vincent's Hospital psychiatric unit.

25. The medical cause of Mr McLeod's death was not contentious. On 29 August 2012, Dr Linda E. Iles from the Victorian Institute of Forensic Medicine (VIFM) conducted a post-mortem examination of Mr McLeod's body, including the analysis of post-mortem CT scans (PMCT).[29] Dr Iles also reviewed the circumstances of the death as reported by the police to the coroner when preparing a report of her findings.

26. Among Dr Iles' anatomical findings were severe single vessel coronary artery atherosclerosis, mild cardiomegaly (heart enlargement), chronic pericarditis (inflammation of the lining around the heart), abrasion and bruising to the frontal scalp, CPR-related rib fractures, an elevation of C-reactive protein considered indicative of inflammatory conditions and that the

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[25] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[26] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[27] From the commencement of the *Coroners Act 2008* [the Act], that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

[28] See section 3 of the Act, and in particular, subsection (i) of the definition relating to persons placed in custody or care.

[29] Exhibit A.

bladder contained a small amount of slightly turbid (cloudy) urine.[30] Dr Iles attributed the cause of Mr McLeod's death to Cardiomegaly and severe single vessel coronary artery atherosclerosis in a man with schizoaffective disorder.[31] Post-mortem toxicological analysis detected therapeutic levels of medications prescribed to Mr McLeod (risperidone, olanzapine, zuxlopenthixol and paracetamol).[32]

27. The adequacy of the clinical management and care provided to Mr McLeod in relation to his physical health whilst an involuntary patient at St Vincent's Psychiatric Inpatient Unit was the primary focus of the coronial investigation of his death.

28. Although no concerns about clinical management and care were stated in the police report of Mr McLeod's death, there was a troubling lack of clarity in Mr McLeod's medical records in relation to urological issues. Accordingly, the investigation and inquest examined the following issues and whether or not these caused or contributed to Mr McLeod's death:

    a. Whether relevant information about Mr McLeod's current and historical physical health was available to, and appropriately utilised by, medical staff at the Inpatient Unit;

    b. Whether Mr McLeod's urinary incontinence had resolved following his TURP surgery and, if so, whether the incontinence noted in patient progress notes maintained during his admission at the Inpatient Unit was therefore a new symptom requiring specific investigation in light of his recent mental state deterioration and a diagnosed infection.

29. St Vincent's Hospital maintained electronic and hard copies of Mr McLeod's health records, inclusive of medical and surgical consultations and treatment, inpatient and community-based mental health treatment, and progress notes from allied facilities such as Prague House.[33] While allied facility staff could access Mr McLeod's entire St Vincent's Hospital electronic records irrespective of their origin, medical staff involved in Mr McLeod's psychiatric admission commencing 21 August 2012, relied – as a matter of practice – on a hard copy synopsis of his medical and psychiatric history compiled from the electronic records by the admitting registrar.[34] Psychiatric, medical and nursing staff added to this hard copy medical record [Hard Copy Record] during the course of Mr McLeod's admission to the Inpatient Unit. A copy of this record was provided to the Court.

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[30] Exhibits A and B and Transcript pages 4-9.

[31] Exhibit A.

[32] Ibid.

[33] Transcript page 12.

[34] Transcript page 15.

30. Mr McLeod's Hard Copy Record contained a summary of an Outpatient Urology review that occurred three months after his laser TURP surgery. This document noted that "initially post-op" Mr McLeod had reported some pain on urination and "symptoms suggestive of stress urinary incontinence" but that by July 2012, both of those issues had "resolved" and Mr McLeod was "happy with the result of the operation".[35] In contrast, that part of the Hard Copy Record created during Mr McLeod's last admission to the Inpatient Unit suggested that staff understood Mr McLeod to have chronic – that is, continuing and current – urinary incontinence and so managed his incontinence rather than viewing it as an emergent symptom or as a condition requiring treatment.

31. Dr Unadkat, Mr McLeod's treating psychiatrist, gave evidence at inquest during which he stated that ordinarily staff from Prague House would accompany a resident on their admission to the Inpatient Unit in order to provide a verbal handover of the patient's current condition(s).[36] Mr McLeod was not accompanied to the Inpatient Unit by Prague House staff given the circumstances of his admission.

32. Dr Unadkat conceded both that the document about the TURP surgery suggested Mr McLeod's urinary incontinence had resolved post-operatively, and that the balance of the Hard Copy Record was indicative of the opposite.[37] He agreed that acute onset or re-emergence of, or deterioration in, urinary incontinence were factors clinically relevant to a patient's physical and mental health.[38] Dr Unadkat testified that in Mc McLeod's case, a change to, or worsening of, urinary (in)continence may have indicated the source of his infection and/or the increased disorganisation associated with a deteriorating mental state.[39] Dr Unadkat stated that the Inpatient Unit received "no report of deterioration in [Mr McLeod's] urinary incontinence".[40]

33. Several of Dr Unadkat's answers at inquest indicated that he could not state with any certainty whether or not Mr McLeod's incontinence pre-dated his admission to the Inpatient Unit or whether reliable information about this had been "lost".[41] It was evident from Dr Unadkat's testimony that Mr McLeod's Hard Copy Record did little to clarify the issue.

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[35] Coronial Brief of Evidence pages 75 and 76 (Correspondence between Dr P. Satasivam, urology registrar, and Dr P. Wright, Mr McLeod's general practitioner dated 11 Jul 2012).

[36] Transcript page 16.

[37] Transcript page 15.

[38] Transcript page 18, 22 and 23.

[39] Transcript page 20

[40] Exhibit D, page 3, and see, for instance, Transcript pages 15, 17 and 18.

[41] Transcript page 18.

34. Mr McLeod's sister, Janet Metherall, attended the inquest and provided definitive evidence, based on her near-weekly visits to her brother since 2009, that he was incontinent of urine before his TURP operation and remained so after it.[42]

35. While St Vincent's Hospital has a policy in relation to the medical review of patients of the Inpatient Unit at the time of their admission, namely the "Acute Inpatient Service Admission Guidelines,"[43] the frequency of the medical review of psychiatric patients thereafter is left to the treating doctors' clinical judgement.[44] Mr McLeod's physical health was examined by clinicians on 21, 22 and 24 August 2012 and, as a result, additional testing – repeated blood tests, a chest x-ray, an ECG, and an attempt to obtain a mid-stream urine sample – was conducted. It is clear from both the treatment plan developed at admission[45] and the investigations subsequently undertaken by medical staff to identify the source of Mr McLeod's infection, that Mr McLeod's physical health was appropriately managed.[46]

36. Dr Iles gave evidence at inquest elaborating on the contents of her post-mortem examination report and a supplementary report prepared at my request.[47] Dr Iles testified that Mr McLeod had suffered a "sudden cardiac event" and that his mildly enlarged heart would not necessarily have been visible on x-ray. Dr Iles could draw no firm conclusion about the relationship between the elevated C-reactive protein levels detected at autopsy and her anatomical findings (pericarditis and cellulitus). Similarly, Dr Iles conceded that while she could not definitively state whether or not Mr McLeod had a urinary tract infection [UTI] prior to death, she could not exclude the possibility in light of her post-mortem observations. She was able to state, however, that even if Mr McLeod had suffered a UTI peri-mortem, this condition was not causally related to his death.

37. In accordance with Dr Iles' advice, I find that Mr McLeod's death was attributable to cardiomegaly and severe single vessel coronary artery atherosclerosis in a man with schizoaffective disorder.

38. Based on the evidence before me, I am satisfied that the medical and psychiatric care provided to Mr McLeod while a patient at the Inpatient Unit was appropriate and consistent with the care delivered in the Victorian public health care system. The evidence does not support a

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[42] See generally, Transcript pages 23-25.

[43] See generally the Acute Inpatient Service Admission Guidelines (ratified in April 2011) appended to Dr Unadkat's statement (Exhibit D).

[44] Exhibit D.

[45] Coronial Brief of Evidence page 82.

[46] Coronial Brief of Evidence pages 81-147.

[47] See generally Exhibit B (Dr Iles' Supplementary Report dated 15 January 2014).

finding that there was any want of case or clinical management and care on the part of medical and nursing staff at St Vincent's Hospital, or that any such want of clinical management or care caused or contributed to his death.

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

Mr McLeod's family

St Vincent's Hospital

Chief Psychiatrist

First Constable Byron Smith 37358 of Fitzroy Police Station

Signature:

PARESA ANTONIADIS SPANOS

CORONER

Date: 23 December 2014