IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 5807

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of FIKRI MEMEDOVSKI

Delivered On:	25 October 2012
Delivered At:	Melbourne
Hearing Dates:	15 May 2012
Findings of:	Coroner Heather Spooner
Representation:	Mr John Snowden, Southern Health
Counsel Assisting the Coroner:	Ms Jacqui Hawkins, Principal In-House Solicitor, Coroners Court of Victoria

I, HEATHER SPOONER, Coroner having investigated the death of FIKRI MEMEDOVSKI

AND having held an inquest in relation to this death on 15 May 2012
at MELBOURNE
find that the identity of the deceased was FIKRI MEMEDOVSKI
born on 20 November 1979
and the death occurred on 23 November 2009
at Dandenong Hospital, 135 David Street, Dandenong, Victoria 3175
from:

1 (a) HEROIN OVERDOSE

in the following circumstances:

1. Mr Memedovski was aged 30 years of age when he died on 23 November 2009. He was of Macedonian background and was married to Klotilda Memedovksi. They had four children together.

2. Mr Memedovski had a past medical history that included schizophrenia, intravenous drug use, heroin and polysubstance abuse, hepatitis C and anti social personality traits.

3. The death of Mr Memedovski was reported to the coroner by the Registrar of Births Deaths and Marriages (BDM) shortly after his death and subsequently a coronial investigation was directed to be conducted into the circumstances surrounding the death.

Brief chronology and circumstances

4. In 1999, Mr Memedovski arrived in Australia from Albania with his young wife. Mr Memedovski had used cannabis in Albania and soon after his arrival to Australia was again smoking and later started abusing polysubstances, including heroin.

5. Mr Memedovski had many emergency admissions connected to drug abuse and to unintentional overdose throughout his time in Australia. Between 2001 and 2009, Mr Memedovski was regularly admitted to various hospitals for psychiatric care and treatment of drug overdoses.

6. On 4 August 2009, Mr James Rugboohur, a registered psychiatric nurse who had been Mr Memedovski's case worker from the Dandenong Community Care Team since January 2008

made arrangements for Mr Memedovski to be admitted to hospital however he later absconded.

7. On 6 August 2009 members of Victoria Police returned Mr Memedovski to the Dandenong Hospital, Emergency Department (ED).

8. On 7 August 2009, Mr Memedovski was admitted to Dandenong Area Mental Health Services as an involuntary patient and remained there until 23 October 2009. On that day, he was discharged on a Community Treatment Order (CTO) to the Crisis Team for management.

9. On 4 November 2009[1] he was subsequently transferred to the Dandenong Community Care Team.

10. On 6 November 2009, Mr Memedovski's case manager contacted him and found him to be calm and Mr Memedovski denied any depression or substance abuse.

11. On 13 November 2009, Mr Memedovski's case manager spoke to him and advised he was going on leave. Mr Memedovski declined the assistance of another clinician while his case manager was away however he was aware of available services to contact if required.

12. On 19 November 2009, Mr Memedovski visited the home of a friend in a drug affected state. When Mr Memedovski's condition deteriorated, his friend took him to the Dandenong Hospital and dropped him off at the ED, where Mr Memedovski remained until his demise.

13. Mr Memedovski was diagnosed with anoxic brain damage secondary to cardiopulmonary arrest. He was non-responsive and mechanically ventilated. The family were informed that Mr Memedovski's prognosis was poor.

14. On 23 November 2009, his clinical status deteriorated and Mr Memedovski subsequently died.

15. Dr Dennis Lee, ICU Registrar of Dandenong Hospital did not report Mr Memedovski's death to the Coroners Court of Victoria (CCOV), instead, he wrote a death certificate and stated in his opinion the cause of death was:

    1a. *Cerebellar tonsillar herniation*

    1b. *Cerebral oedema*

    1c. *Hypoxic brain injury*

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[1] Statement of Mr James Rugboohur Inquest brief at page 11

1d. *Respiratory arrest, heroin overdose.*

16. The death certificate was then provided to the Registrar of BDM.

17. After review of the death certificate by the Registrar of BDM, the death of Mr Memedovski was reported to the CCOV for further investigation as a reportable death.

Legislative requirements of reportable deaths

18. A reportable death as defined by section 4(2)(a) of the *Coroners Act 2008* (Vic) (Coroners Act) and includes "*a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury*".

19. A death is also reportable if the deceased was a "*person who immediately before death was a patient within the meaning of the Mental Health Act 1986*".[2]

20. The Coroners Act provides that "*a registered medical practitioner who is present at or after the death of a person must report the death without delay to a coroner if the death is a reportable death*".[3] It is an offence not to report a reportable death.

21. Further, it is also an offence pursuant to section 37(4) of the *Births Deaths and Marriages Registration Act* (Vic) 1996 for a medical practitioner to complete a death certificate when they are required to report the death to a coroner.

22. The Registrar of Births Deaths and Marriages (BDM) identified that Mr Memedovski's death was reportable due to the reference in the cause of death to 1d) *respiratory arrest, heroin overdose* which indicated that a contributing cause of the death was external to Mr Memedovski, that is, the cause of death was unnatural.

23. In addition, Mr Memedovski was on a CTO at the time of his death, which meant the death was also reportable pursuant to section 4(2)(d) of the Coroners Act.

The BDM Review

24. When a potentially reportable cause of death is recorded on a death certificate, the Registrar of BDM refers the death certificate to the coroner. The coroner then commences an investigation into the death. These investigations are referred to as BDM Reviews.

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[2] *Coroners Act* 2008 (Vic), section 4(2)(d).

[3] *Coroners Act* 2008 (Vic), section 10(1).

25. As part of the BDM Review the coroner meets with pathologists/clinicians from the Victorian Institute of Forensic Medicine (VIFM) to examine the death certificate and determine whether further investigation of the death is required.

26. If further investigation is deemed appropriate the hospital, medical and nursing home records may be obtained and reviewed. In some cases the coroner may direct a police investigation, a Health and Medical Investigation Team referral[4] or request statements from the treating practitioners to examine and clarify the circumstances of the death and why the death was not reported.

27. The coroner convenes regular case management meetings with a forensic pathologist and/or a clinician. The circumstances of particular cases are reviewed and the suggested cause of death is formulated as accurately as possible without the benefit of a post mortem examination being performed on the body of a deceased person.

28. The coroner may direct that a death certificate be amended to reflect the outcome of the BDM review and then make a finding in relation to the death.[5]

29. In this case, Mr Memedovski's death was referred to the Coroners Court of Victoria (CCoV) and a BDM Review was conducted. As part of the investigation into the death of Mr Memedovski, further information and evidence was sought including a statement from Dr Subhash Arora, an Intensive Care Consultant from the Dandenong Hospital for an explanation as to the circumstances surrounding Mr Memedovski's death. Dr Aurora stated:

> *"[Mr Memedovski's] clinical status continued to deteriorate with worsening hypotension and acute renal shut down. He developed cardio-respiratory arrest and was declared dead at 2145 on 23.11.2009 by the ICU registrar, Dr Dennis Lee. Cause of his death was multi-organ failure, secondary to severe anoxic brain damage, due to prolonged cardio-pulmonary arrest which was most likely a result of drug overdose. Dr Lee did not inform the Coroner as he thought that the cause of death was clearly due to severe anoxic damage from prolonged cardio-respiratory arrest. The police had been informed by the Emergency Department team to*

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[4] The role of the Health and Medical Investigation Team (HMIT) is to assist the Coroner's investigation into the nature and extent of deaths, which occurred during the provision of healthcare and identify potential system factors in healthcare related deaths. HMIT personnel comprise practising Physicians and Clinical Research Nurses who draw on their medical, nursing and research experience, skills and knowledge, to independently evaluate clinical evidence for the investigation of reportable healthcare deaths and to assist in identifying remediable factors that may assist in prevention and risk management in health services settings.

[5] Transcript of proceedings, Tuesday 15 May 2012, at page 2.

investigate the exact circumstances of his presentation and to follow up on any necessary legal investigation." [6]

30. The BDM Review concluded that the death certificate of Mr Memedovski should be modified to state the cause of death as 1(a) "*Heroin Overdose.*" Associate Professor David Ranson, Deputy Director of VIFM who was part of the BDM Review of Mr Memedovski's death supported this reformulation of the cause of death.

Inquest

31. The circumstances surrounding the death of Mr Memodovski did not require a mandatory inquest be conducted pursuant to section 52(2) of the Coroners Act. Although the death of a person on a CTO is reportable, this death did not satisfy the requirement of section 52(2)(b) that "*the deceased was, immediately before death, a person placed in care or custody*", as defined in section 4 of the Coroners Act.

32. A coroner may however hold an inquest into any death they are investigating.[7] Indeed, coroners have an 'absolute discretion' whether or not to conduct an inquest, however this discretion must be exercised in a manner consistent with the preamble and purposes of the Coroners Act. One of the purposes of the Coroners Act is to require the reporting of certain deaths. Given that the medical practitioner in this case did not report the death as required, I made a decision to conduct an inquest to highlight the legal obligations of medical practitioners with respect to reporting deaths to the coroner.

Purpose of the inquest

33. The purpose of holding an inquest is to make a finding (if possible) in relation to:

    a. the identity of the deceased; and

    b. the cause of death; and

    c. the circumstances in which the death occurred.[8]

34. In addition, a coroner may comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice.

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[6] Statement from Dr Subhash Arora, Inquest brief at page 23.

[7] *Coroners Act* 2008 (Vic), section 52(1).

[8] *Coroners Act* 2008 (Vic), section 67(1).

35. In this case the identity of Mr Memedovski and the circumstances of his death were not in dispute, however, there were issues around Mr Memedovski's cause of death that required further investigation.

36. The main purpose of the inquest into the death of Mr Memedovski was to examine the understanding of the medical profession's obligations with respect to reporting deaths to the coroner. The inquest further sought to examine how best to generate awareness amongst medical professionals of their statutory obligations to report certain deaths and the importance of the coroners investigation.

Expert evidence at inquest

37. At the inquest held on 15 May 2012 Associate Professor David Ranson[9] and Dr Sandra Neate[10] provided me with statements and were called to give concurrent evidence to assist me with my enquiries in relation to the level of knowledge surrounding medicals practitioners' obligations to report certain deaths and the way in which doctors write death certificates.[11]

Mr Memedovski's cause of death

38. At inquest Associate Professor Ranson was asked to comment on the cause of death written on Mr Memedovski's death certificate and after studying the death certificate he stated that:

> "*the underlying cause of death is clearly not a natural process, it is a chemical trauma process and unnatural process caused by an extrinsic toxic substance, namely heroin, and that alone would make it a reportable death*".[12]

39. In addition, Dr Neate commented that:

> "*Essentially one can put a variety of processes or diseases and conditions into a death certificate but essentially its looking for diseases and conditions causing death and one could argue that a hypoxic brain injury or cerebral herniation is only very loosely linked to a disease or a condition and a fundamental underlying principle here is that this person has died of the affects of a heroin overdose, and I believe that keeping things*

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[9] Associate Professor Ranson is a Senior Forensic Pathologist and Deputy Director of the Victorian Institute of Forensic Medicine who conducts the BDM Reviews.

[10] Doctor Sandra Neate is a specialist medical practitioner in the field of emergency medicine and conducts BDM reviews.

[11] Concurrent evidence is the evidence of witnesses who are invited to participate in a professional discussion in the witness box as well as being questioned by the coroner, counsel assisting and any other interested party about a particular issue. [This may also sometimes be referred to as "hot tubbing"].

[12] Transcript of proceedings, Tuesday 15 May 2012, at page 9.

simple, keeping things direct, provides the best clarity in communication of what really happened."[13]

40. More simply put Dr Neate stated:

> "*what was it that sadly led to the death of [Mr Memedovski?, ..[W]as[it] the heroin overdose that resulted in him stopping breathing and all the subsequent things that they have described there are pathological consequences of that event so its the complexity that they understand on a day to day basis but which confuses the issue when you're reading a death certificate.*"[14]

State of knowledge of medical practitioners' obligations to report certain deaths

41. Dr Neate was asked to comment on the state of knowledge of medical practitioner's obligation to report certain deaths and she confirmed that "*medical practitioners appear to have knowledge deficits with respect to how to complete a death certificate accurately and what constitutes a reportable death as described in the Coroners Act.*"[15]

Possible reasons as to why doctors do not report deaths to the coroner

42. Associate Professor Ranson and Dr Neate were asked to provide possible reasons that could explain why medical practitioners do not report reportable deaths to the CCOV and they provided a number of possible reasons. One such example was given that some doctors have a misconception that a death is not reportable because the death is not suspicious.[16] Associate Professor Ranson succinctly stated that "*I think it is a concern that doctors and the community still feel that the coroner's role is about [investigating] suspicious deaths*".[17]

43. Another example given was that sometimes the medical practitioner who certifies death is not the same as the medical practitioner who originally admits the patient, or the medical practitioner may not remember the original reason for admission. Where this happens, the reportable nature of the death may not be immediately evident.[18]

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[13] Transcript of proceedings, Tuesday 15 May 2012, at page 10.

[14] Transcript of proceedings, Tuesday 15 May 2012, at page 11.

[15] Transcript of proceedings, Tuesday 15 May 2012, at page 2.

[16] Transcript of proceedings, Tuesday 15 May 2012, at page 18.

[17] Transcript of proceedings, Tuesday 15 May 2012, at page 19.

[18] Statement of Associate Professor Ranson, page 12.

44. In addition, where a family have expressed that they do not want an autopsy, medical practitioners may try to protect the family from any unnecessary angst and not appreciate the necessity of reporting the death to the coroner.[19] Associate Professor Ranson suggested that there was "*perhaps a paternalistic support process where a doctor is aware that a family are very, very reluctant about an autopsy or any further involvement with the deceased after death and therefore feels that they may be protecting them by not reporting a death to a coroner.*"[20]

45. This kind of misguided protective thinking unfortunately may have far-reaching consequences that will be discussed later in this finding.

Legal v medical issues

46. Navigating the medico-legal divide also appears to be problematic for medical professionals. Associate Professor Ranson indicated that some doctors "*find it very difficult to translate the legal language into a clinical, practical setting of their day to day work....the translation is truly difficult.*"[21] He later stated that "*the coroner has a very important role in assisting in public health but that role, I think is poorly understood out there in the medical community generally.*"[22]

47. Associate Professor Ranson further noted that:

> "*the biggest issue in some ways that underpins a lot of this is the misunderstanding that the coroner's role is very fundamentally a public health role and in many ways in these cases we as doctors need to see the coroner's role as being primarily there to support public health but if that clear focus was better understood then I think people would have a greater understanding of the benefits of reporting to a coroner.*"[23]

Research conducted by the Coroners Prevention Unit

48. The Coroners Prevention Unit (CPU)[24] was requested to conduct a study[25] which examined the frequency and nature of reportable deaths not reported to the coroner during the period 1

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[19] Transcript of proceedings, Tuesday 15 May 2012, at page 19.

[20] Transcript of proceedings, Tuesday 15 May 2012, at page 30.

[21] Transcript of proceedings, Tuesday 15 May 2012, at page 24.

[22] Transcript of proceedings, Tuesday 15 May 2012, at page 30.

[23] Transcript of proceedings, Tuesday 15 May 2012, at page 30.

[24] The Coroners Prevention Unit was established in 2008 to strengthen the prevention role of the Coroner. The CPU assists the Coroner with research on issues connected with deaths under investigation and in relation to the formulation of prevention-focussed recommendations, as well as assisting in monitoring of Coroners' recommendations.

July 2010 to 30 June 2011 to assist with this investigation. The purpose of this examination was to provide an evidence-base for the development of recommendations directed to medical practitioners on the circumstances under which deaths must be reported to the coroner to decrease the number of reportable deaths that are not reported.

49. The study found that between 2003 and 2011 inclusive, the Registrar of BDM reported 4,283 deaths to the CCOV. The annual frequency ranged from 143 in 2003 to 793 in 2008. Of these, 25.8% were determined to be deaths that should have been reported to the CCOV for investigation. Of the 656 deaths reported to the CCOV by the Registrar of BDM from 1 July 2010 to 30 June 2011, this study examined 320 deaths due to external causes that should have been reported to the coroner at the time of death.

50. Further analysis of these deaths showed that nearly all deaths resulted from falls. The three main injuries/complications resulting from the fall were fracture complicated by pneumonia, fracture only, and head injury. Of all fractures, 142 (74.7%) involved a fracture of the femur (including neck of femur) or pelvis. Of the head injuries, 81 (76.4%) were from subdural haematoma. Non-fall related causes of referral included choking, deaths with medical procedures recorded in the cause of death, intentional and unintentional poisoning and transport related deaths.

51. For each of the deaths, the place of death was recorded as either in hospital, residential care (low or high level care) or own residence. Region of death was divided geographically into metropolitan or regional. The majority of deaths (219, 68.4%) occurred in hospitals. When place of death and location were jointly considered, almost half the deaths (158, 49.4%) occurred at Melbourne based hospitals. In regional Victoria, the deaths were evenly distributed amongst the major regions.

52. In just under 50% of deaths, a major change to the cause of death was made following medical review. In only ten cases (3.1%) was no change made to the cause of death following review.

53. The CPU study found that some of the major problems with the framing of the causes of death included:

    a. failure to describe a pathological condition as the cause of death (e.g. pneumonia, acute myocardial infarction) rather than a mode of death (e.g. multi-organ failure, cardiac failure, cardiac arrest);

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[25] The CPU study will be available with this finding on the CCOV website.

b. failure to list the conditions in a causative sequence;

c. the inability to determine whether a condition caused the death or contributed to, but did not, cause death e.g. dementia contributed to the fall which caused the death; and

d. inclusion of multiple co-morbidities which were not related to the cause of death. Only 3% of death certificates were left unaltered suggesting a low frequency of accurate and correct completion of death certificates.

54. The CPU study concluded that:

> *"The ramifications of the failure to report a death to the coroner extend beyond the legal obligations of the medical practitioner. Five percent of deaths reported by the Registry of BDM required further investigation beyond that performed by the medical reviewers. The non-reporting of reportable deaths precludes the possibility of a complete investigation into the circumstances and cause of the death, including a potential medical examination of the deceased (autopsy). Such information may provide vital information to the family, treating practitioners and the coroner regarding the cause of death and potentially preventable aspects of the death. Reliable cause of death data is of importance to the health system and the community as it underpins patient management, hospital systems and disease prevention strategies in the wider community. It is likely that accurate completion of death certificates and the non-reporting of reportable deaths is an issue that may be addressed by further education of medical practitioners."*[26]

55. Unfortunately, medical practitioners do fail to report deaths that are reportable pursuant to the Coroners Act. This failure to report means that a coroner is not given an opportunity to conduct appropriate investigations, such as further post mortem medical examinations on a deceased like an autopsy and external examination. These types of medical examinations have a very important role to play in society in terms of providing an understanding to the family and the community of the exact cause of death. Failure to report also provides a missed opportunity to identify if there was any ability to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety. This is one of the fundamental purposes of the Coroners Act and the role of a coroners' investigation.

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[26] CPU Report, p13.

FINDING

After having conducted an investigation and inquest into the death of Mr Fikri Memodovski and having taken into consideration all of the evidence, I find that he unfortunately died at the Dandenong Hospital on 23 November 2009 from a Heroin Overdose, which was a reportable cause of death that should have been reported to the CCOV pursuant to the Coroners Act.

COMMENTS

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

1. The death of Mr Memodovski has highlighted the need for improved education and awareness within the medical profession about their reporting obligations to the Coroner.

2. The surveillance of death certificates by the Registrar of BDM is unusual in coronial jurisdictions. The process identifies part of the unquantified pool of non-reported reportable deaths as defined by the Coroners Act. Inaccurate completion of death certificates may result in a poor understanding by the family of the cause of their loved one's death, affect the accuracy of mortality data, particularly falls, and lead to unnecessary investigation of deaths or prevent an investigation of a death. [27] If there is doubt about whether a death is reportable – the medical professional should err on the side of caution and report.

3. The interaction between medical practitioners and the Initial Investigations Office of the CCoV involves a complex communication due to the medico-legal divide. To assist medical practitioners with their understanding of what is a reportable death, the CCoV has developed a guideline document entitled "*Medical practitioner enquiry to Coroner as to whether a death is reportable*". It is proposed that this document will be placed on the CCoV website for medical practitioners to refer possible reportable death enquiries to the coroner. The medical practitioner can answer the trigger questions in the document about the death and then the document will be given to a coroner to make a determination as to whether the death is reportable. This will ensure that the medical practitioners are fulfilling their legal obligations to report a death and the coroner will be provided with sufficient information to assist them in making a determination about whether the death is a reportable death. This pilot program is due to commence in November 2012.

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[27] CPU Report

RECOMMENDATIONS

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

Recommendation 1

1. Hospitals and health services should have appropriate programs, policies and procedures to ensure medical practitioners in their employ are educated and made aware of their legal obligations to report deaths that are reportable to a coroner. I therefore recommend that the Department of Health consider communicating this to all hospitals and health services in Victoria.

Recommendation 2

2. Medical practitioners should be reminded of their responsibility to understand their own personal legal obligations to report deaths that are reportable to the coroner. I therefore recommend that the Medical Board of Australia – Victorian Division consider communicating this to their members.

Recommendation 3

3. To improve the certification process for deaths meeting the definition of "reportable" in the *Coroners Act 2008* (Vic), I recommend the Registrar of BDM consider amending the guidelines on the medical certificate of the cause of death to draw specific attention to the two common key omissions – fractures and head injuries.

Recommendation 4

4. To minimise the possibility of medical practitioners failing to report a "reportable" death as defined in the Coroners Act, I recommend that the Department of Health consider communicating with hospitals and health services to implement a process of peer review of the medical cause of death by a senior medical practitioner prior to submission to the Registrar of BDM.

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

Secretary, Department of Health
50 Lonsdale Street
Melbourne Victoria 3000

Medical Board of Australia – Victorian Division
c/o Australian Health Practitioner Regulation Agency
GPO Box 9958
Melbourne VIC 3001

Registrar of Births, Deaths and Marriages
GPO Box 4332
Melbourne Victoria 3001

I direct a copy of the finding be provided to the following for their information only:

Mrs Memedovski
Dr Lee
Southern Health
Legal Counsel of Health Services

Signature:

HEATHER SPOONER
CORONER
Date: 25 October 2012