IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 4274

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: GEOFFREY POWER

Finding Of:	AUDREY JAMIESON, CORONER
Hearing Date:	16 February 2016
Counsel Assisting:	Senior Constable King Taylor, Police Coronial Support Unit
Appearances:	Mr Mark O'Sullivan, for Cabrini Health
Delivered On:	17 February 2016
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank Melbourne 3006

I, AUDREY JAMIESON, Coroner having investigated the death of **GEOFFREY POWER**

AND having held an inquest in relation to this death on 16 February 2016

at MELBOURNE

find that the identity of the deceased was **GEOFFREY POWER**

born on 6 September 1958

and the death occurred on 10 October 2012

at the Cabrini Hospital, 181-183 Wattletree Rd, Malvern, 3144

from:

1 (A) COMPLICATIONS OF CERVICAL SPINAL STENOSIS TREATED WITH CERVICAL LAMINECTOMY AND FUSION IN A MAN WITH PERINATAL HYPOXIC/ISCHEMIC BRAIN INJURY

in the following circumstances:

1. On 16 February 2016, a mandatory inquest under section 52(2)(b) of the *Coroners Act 2008* (Vic) (the Act) was held into the death of Mr Geoffrey Power, because immediately before his death, Geoffrey was "a person placed in....care" as it is defined in the Act. Geoffrey was a person under the control, care and custody of the Secretary to the Department of Human Services (DHS).[1]

BACKGROUND AND CIRCUMSTANCES

2. Mr Geoffrey Power was 54 years of age at the time of his death. His medical history included hypertension, epilepsy and a perinatal hypoxic/ischaemic brain injury. He suffered a severe intellectual disability and blindness as a result. His communication was nonverbal and he lived in a group home in Chadstone operated by DHS.

3. Geoffrey walked approximately 50 minutes per day, which provided him with significant sensory stimulation and his exercise regime was accordingly extremely important to his wellbeing.

[1] I note that the DHS is now known as the Department of Health and Human Services (DHHS).

4. In 2011, Geoffrey's ability to walk began to decline, and his mother Mrs Beryl Power consulted neurologist Dr Andrew Churchyard in November 2011 to discuss the decline in his mobility.

5. In December 2011, Geoffrey underwent magnetic resonance imaging (MRI) of the brain and cervical spine, which showed a diffuse cervical level compression of his spine, which had progressed since his previous MRI in 2003.

6. In late January 2012, Dr Churchyard referred Geoffrey to neurosurgeon Mr Myron Rogers to assess whether surgery was indicated.

7. On 15 February 2012, Geoffrey was reviewed by Mr Rogers. He told Geoffrey and his mother that from a technical perspective, the appropriate surgery was a posterior decompression: laminectomy over several segments. Mr Rogers explained the potential risks of surgery to Geoffrey and his mother.

8. On 28 August 2012, Geoffrey was admitted to Cabrini Hospital, and underwent a post cervical decompression, internal fixation and postero-lateral bone graft performed by Mr Rogers that day.

9. As Geoffrey became more awake following surgery, he began to place his hand behind his head to feel the dressing from the surgery which also held in a drainage tube; while doing this he pulled the drainage tube completely out.

10. Over the following few days the suture line began discharging pus and serous fluid and according to the nurses, Geoffrey was requiring more regular dressing changes than was usual for this type of surgery.

11. On 3 September 2012, Geoffrey was discharged into the care of his mother. On 6 September 2012, he returned to Cabrini Hospital to have the staples removed, and a fresh dressing reapplied. He returned home.

12. On 7 September 2012, Geoffrey's wound was weeping considerably and he was taken by ambulance to Cabrini Hospital and subsequently admitted after blood tests revealed he had an infection. Geoffrey was treated with intravenous antibiotics in hospital for ten days. During this time, Consultant Physician Dr Leon Chapman suggested that Geoffrey should have a computed tomography (CT) scan of the wound; Mr Rogers apparently rejected this suggestion.

13. On 18 September 2012, Geoffrey was discharged home with a six-week course of oral antibiotics. Tests and x-rays conducted prior to his discharge from hospital cleared him of an infection.

14. In the following days, Geoffrey was unable to sleep at night and he seemed unable to place pressure on the wound site by lying on his back. In addition, his mother noted that he was crying, apparently from pain and distress.

15. On 22 September 2012, Geoffrey was taken back to Cabrini Hospital with an apparent ruptured cyst at the lower wound edge. Blood tests confirmed an infection. Geoffrey was discharged home and advised to continue with oral antibiotics.

16. On 24 September 2012, Mrs Power called '000' and requested an ambulance. Geoffrey was taken by ambulance to Cabrini Hospital as he was still in pain and unable to lie on his back. Geoffrey was admitted to the Intensive Care Unit (ICU) with a diagnosis of pneumonia and a collapsed right lung.

17. On 4 October 2012, a CT of the cervical spine was performed. Mr Xenos, an adult and paediatric neurosurgeon, noted that the CT scan showed suggestion of a fluid collection consistent with possibly localised infection in the inferior aspect of the wound.

18. On 6 October 2012, Geoffrey was taken to theatre by Mr Xenos. The abscess was surgically drained and a bronchoscopy performed to determine if Geoffrey had incurred pulmonary aspiration.

19. Geoffrey remained in ICU from the 6-8 October 2012 and was transferred to the coronary care unit (CCU) on 8 October 2012. Geoffrey remained unwell with progressive difficulty breathing, and suffered an arrest on 10 October 2012 from which he did not recover.

20. Geoffrey's death was a reportable death under the Act. An extensive investigation into his death has been conducted.

FORENSIC PATHOLOGIST EXAMINATION AND EVIDENCE

21. Dr Jacqueline Lee, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination on the body of Geoffrey. Dr Lee also reviewed the Victoria Police Report of Death Form 83, medical deposition from Cabrini Hospital, medical records from Cabrini Hospital and a post mortem CT scan, and ascribed the cause of his death to complications of cervical spinal stenosis treated with cervical laminectomy and fusion in a man with perinatal hypoxic/ischaemic brain injury.

FAMILY CONCERNS

22. I received a letter from Mrs Power dated 4 November 2012, which outlined a number of concerns, including that:

    a. more appropriate post-operative safe guards should have been put in place to prevent Geoffrey from removing the drainage tube from the surgical site;

    b. the surgical site should have been inspected more regularly post-operatively by surgeon Mr Rogers;

    c. a CT scan of the surgical site should have been carried out in a more timely manner.

CORONER'S PREVENTION UNIT AND EXPERT OPINION

23. In response to Mrs Power's concerns, I asked the Coroner's Prevention Unit (CPU)[2] to investigate the circumstances of Geoffrey's death on my behalf.

24. An expert opinion dated 20 July 2014 was received from neurosurgeon, Associate Professor Graeme Brazenor. He noted that Geoffrey was a difficult patient to care for due to his disabilities. Associate Professor Brazenor also said that he believed that the cervical operation was indicated and was the appropriate procedure and that the pros and cons of the operation were discussed adequately with Mrs Power by multiple doctors before the operation proceeded.

25. Whilst Associate Professor Brazenor agreed with Mrs Power that it would have been advantageous for Geoffrey's upper limbs to be mechanically restrained in the postoperative period, it was his opinion that this "simply is not done in this day and age" due to human rights legislation.[3]

26. However, Associate Professor Brazenor pointed out that the fact Geoffrey pulled out his drain tube had no effect on his clinical course or the likelihood of him incurring a wound infection.

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[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

[3] Expert opinion from Associate Professor Brazenor dated 20 July 2014.

27. Associate Professor Brazenor supplied a graph showing how Geoffrey's markers of infection (white cell count (WCC) and C-reactive protein (CRP)) continued to diminish and reach normal levels.

28. Associate Professor Brazenor agreed with the decision made by Mr Xenos and the other doctors looking after Geoffrey that a wound exploration was a 'last ditch' measure which was entirely justified in an attempt to prevent further progression in Geoffrey's downhill course. No serious retained locus of infection was found and it is Associate Professor Brazenor's opinion, based on Mr Xenos' description of what he found at operation that the infection would have continued to resolve completely with prolonged administration of antibiotics.

29. Associate Professor Brazenor said that the care Geoffrey received in regards to the wound infection was satisfactory and accords with normal standards and usual management.

30. Associate Professor Brazenor also supplied a supplementary report dated 6 October 2015.

FURTHER INVESTIGATION

31. A number of matters I considered required further investigation were communicated to Cabrini on 14 May 2015 and to which Cabrini responded on 22 June 2015.

32. On 13 October 2015, Cabrini were asked to respond to the following further concerns relating to the:

    a. communication between Cabrini staff regarding Geoffrey's pre-morbid function;

    b. capacity of Cabrini to adequately manage Geoffrey's post-operative needs;

    c. clinical reasoning behind the decision to not place restraints on Geoffrey postoperatively; and

    d. apparent lack of postoperative orders relating to the drain tube.

33. Cabrini was also asked to obtain a statement from the Director of Nursing in response to Associate Professor Brazenor's supplementary report dated 6 October 2015. The statement was to include what pre and postoperative information nursing staff expect from treating surgeons, when a patient with a disability is admitted and when a patient returns to the ward postoperatively with a drain tube in place.

PRE-ADMISSION ASSESSMENT AND DOCUMENTATION OF CARE NEEDS

34. Mr Rogers requested that a meeting occur before Geoffrey was admitted between Mr Jerry Ward, nurse unit manager at Cabrini and Mrs Power. This meeting occurred on 22 August 2012. Mr Wayne Hargraves from the DHS also met with Mr Ward to discuss Geoffrey's postoperative support needs. Documentation of this meeting could not be located in the medical record.

35. In a letter dated 5 November 2015, Dr Simon Woods, Executive Director of Cabrini Malvern, acknowledged that this meeting was not documented, and that it would have been desirable to have recorded this meeting in a formal pre-operative planning document. However, Dr Woods also pointed out that Cabrini's current admission process facilitates this through the 'About Me' assessment tool.

36. Dr Woods stated he doubts whether documentation of the 22 August 2012 meeting would have altered the course of events given that Nurse Ward was subsequently acutely involved in Geoffrey's care and was ultimately responsible for his day to day nursing. Nurse Ward also made the initial admission notes which detailed Geoffrey's care needs.

37. Dr Woods highlighted that the 22 August 2012 meeting was in addition to Cabrini's pre-admission process at the time.

38. In addition to the 22 August 2012 meeting, Division 1 Registered Nurse Joanne Crystal had a pre-admission telephone interview with Mrs Power on 27 August 2012. Nurse Crystal documented Geoffrey's medical history, non-verbal communication and aspects of his personal care and mobility needs. Nurse Crystal completed a documented risk screen and cognitive assessment.

39. Nurse Ward documented Geoffrey's medical and social history at the time of his admission on 28 August 2012.

40. It was not apparent that Mr Rogers had documented any instructions for post-operative care of the surgical wound or drain tubes. However, I find that these concerns are somewhat mitigated by Associate Professor Brazenor's opinion that the self-removal of the drain tubes by Geoffrey had no effect on his clinical course or the likelihood of him incurring a wound infection, and also by the content of Dr Wood's letter and an accompanying statement of Director of Nursing Ms Anne Zandegu dated 5 November 2015.

USE OF RESTRAINTS

41. Cabrini Health supplied the Court with a copy of their restraint policy dated 30 July 2012, which was in place at the time of Geoffrey's admission. The policy outlines that restraints should be used as a last resort, and only when potential benefits are greater than potential harm and that only the minimal amount of restraint should be employed.

42. It appears that Cabrini Health had a robust restraint policy in 2012 which appears to be in accordance with *The Disability Act 2006*, *The Charter of Human Rights and Responsibilities Act 2006* and recommendations of the Office of the Public Advocate.

43. Mr Rogers considered that restraints were not required to facilitate essential treatment and that Geoffrey was not at significant risk of harming himself, therefore Cabrini's policy appears to have been adhered to.

44. At the Directions Hearing on 14 December 2015, Mr Mark O'Sullivan advised that Cabrini has taken on board the comments and suggestions made by Mrs Power and has made changes to its policy. Mr O'Sullivan said that Cabrini is in the process of changing its restraints policy so that the family are consulted at the outset. He advised that this change has been approved and is in the process of being formulated into a written policy. I have since been forwarded a copy of the policy that was last reviewed on 18 March 2015. I note that this policy includes that "the decision to restrain a patient must be discussed with the patient and their family or carer as soon as practical, and where possible, prior to the application of restraint."

CAPACITY OF CABRINI HOSPITAL TO ADEQUATELY MANAGE GEOFFREY'S POST-OPERATIVE NEEDS

45. Following the 22 August 2012 meeting, Cabrini had been reassured there would be a family member or carer present with Geoffrey throughout his admission. However, the exact nature of this role and what was expected of this family member or carer was not entirely clear, whether it was just for familiarisation and orientation or whether Cabrini expected those present to play a more active role in terms of his personal activities of daily living or supervising him to prevent him from taking out his drain tubes.

46. At the Directions Hearing on 14 December 2015, Mr O'Sullivan clarified that one of the main purposes of having a carer in the room with Geoffrey was to have someone familiar

with him in the room, to provide some sort of reassurance to him in an unfamiliar place with strangers. It was not expected that that they would provide nursing care; it was expected that nurses would take care of the activities of daily living. However, if, for example, the carers or Geoffrey indicated a preference to use a carer to do these tasks, the nurse would supervise that process. It was not the expectation that the nursing staff would delegate all those tasks to the carers. Another function of the carer was to provide some sort of supervision in case Geoffrey had needs or required nursing attention.

47. In a letter dated 5 November 2015, Cabrini considered it had adequate resources to manage Geoffrey. Cabrini facilitated 24 hour care for Geoffrey in a single room. If at any time it was deemed clinically necessary for Geoffrey to have a 'special nurse' or personal care attendant, this could have been promptly arranged.

VILLAMANTA'S SUBMISSIONS

48. Following a Form 31 Application for Leave to Appear as an Interested Party dated 22 June 2015, I granted Villamanta Interested Party status on the basis of them having been Geoffrey's former legal representative and not on the basis of Villamanta being a specialist community legal centre.

49. Villamanta provided extensive submissions on 16 September 2015 and requested that I consider, amongst other things, making wide–ranging recommendations regarding:

    a. professional and healthcare standards and statements of rights which exist for all individuals who use Victoria healthcare services; and

    b. human rights protections for people with disabilities and their carers which create specific obligations on health care providers to provide appropriate and suitable care for people with disabilities.

RESTORATIVE MEASURES

50. Since Geoffrey's death, Cabrini have taken steps to identify areas for improvement in its process and has implemented the following measures:

    a. Revision of the Malvern pre-admission process and admission policy to specifically develop a protocol to arrange pre-operative planning and assessment of patients with

extra care needs. The protocol requires the allocations coordinator to contact the patient or Next of Kin to ascertain their extra needs and develop a plan. The allocations coordinator then communicates with the Nurse Unit Manager, and together they organise a plan to provide appropriate accommodation and care.

b. Development of the 'About Me' assessment tool to obtain relevant information for the patient and family necessary to provide for extra care needs to the patient. Cabrini's policy is that patients with extra care needs (or their Next of Kins) are required to complete the 'About Me' assessment tool pre-operatively. If a pre-admission meeting is arranged with a patient with extra care needs or their family, the information obtained during this meeting is documented in the 'About Me' assessment tool.

JURISDICTIONAL LIMITATIONS OF THE CORONERS ACT 2008

51. In making this finding, I have referred to the purposes of the Act, specifically that which is to contribute to the reduction of the number of preventable deaths through the findings of the investigations of deaths and the making of recommendations.

52. I have also referred to the Supreme Court decision of *Harmsworth v The State Coroner* [1989] VR 989 in which Justice Nathan held that the (State) Coroner's power of investigation arises from a particular death, and his/her enquiry must be relevant to the death or fire. It was held that the power to comment arises as a consequence to make findings and is not free-ranging. It must be comment on any matter connected with the death. The (State) Coroner may not enquire for the sole or dominant reason of making comment or recommendation. Justice Nathan said:

> *An inquest into particular deaths in a prison, is not and should not be permitted to become an investigation into prisons in which deaths may occur. A comment on the particular deaths may be pertinent, especially so if the prison facilities were found to be inadequate. It could even be that a comment could have general application, and so much is envisaged by the Act which gives commentary and recommendatory powers in matters of public safety. But the power to comment is incidental and subordinate to the mandatory power to make findings relating to how the deaths occurred their causes.....* (page 996)

53. I have also referred to section 8 of the Act (relating to subsection (b) that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death) and section 9 (that the coronial system should operate in a fair and efficient manner).

54. In consideration of the above matters related to the jurisdictional limitations of the Act, I advised Villamanta at the Directions Hearing on 14 December 2015, that while their submissions were worthy of greater exploration, in Geoffrey's case, I did not intend to make broad, wide-ranging statements or recommendations about caring for people with disabilities in hospitals.

FACTORS CAUSING OR CONTRIBUTING TO DEATH

55. Associate Professor Brazenor stated that the management of Geoffrey at Cabrini was satisfactory and accorded with normal standards and usual management. Geoffrey unfortunately developed an infection which was a known complication of surgery. Dr Lee has ascribed the cause of death as relating to complications of surgery. Associate Professor Brazenor commented that the pros and cons of surgery were adequately explained to Mrs Power prior to the surgery.

56. The investigation into Geoffrey's death has not identified any substantive evidence that would lead me to find that his death was preventable. In the absence of a full post mortem examination, making any link between aspects of Mr Power's care and his cause of death is not possible.

COMMENTS

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

1. In all the circumstances, I am satisfied that there would be no benefit from conducting a full inquest into Geoffrey's death or obtaining any further medical or other evidence, as neither would assist me to further understand the medical issues before me or the cause of Geoffrey's death which resulted from complications of cervical spinal stenosis treated with cervical laminectomy and fusion.

2. I accept Associate Professor Brazenor's opinion that the cervical operation was indicated and appropriate. I accept that the fact of Geoffrey pulling his drain tube out had no effect on

his clinical course or the likelihood of him incurring a wound infection and did not contribute to his death. Further, I accept Associate Professor Brazenor's opinion that the management of Geoffrey's wound infection was satisfactory and accords with normal standards and management. However, I do note that the tone of the expert opinion provided by Associate Professor Brazenor was unfortunate because aspects of the report could be interpreted as being dismissive of Mrs Power's concerns.

3. I acknowledge the distress caused to Mrs Power during the prolonged period of investigation following Geoffrey's death. In part this was due to the lack of clarity in relation to the care Geoffrey was meant to be afforded due to his disabilities. It is unfortunate that the passage of time has served to enhance Mrs Power's distress, but it was important to seek the appropriate advice and information from Geoffrey's treaters. A considerable amount has been done to try and reconcile this gap in information. While nothing has been identified in medical management that has led to Geoffrey's death, the communication provided by Cabrini Hospital was at times found wanting. There is much to be learned from the protracted nature of this process and the obvious impact on Mrs Power.

4. Some of Mrs Power's distress could have been alleviated if Cabrini Hospital had turned its mind to meeting with her earlier. Nevertheless, the recent invitation to do so and discuss ancillary issues and concerns that fall outside the jurisdiction of this Court will hopefully set an example where it becomes the norm for the hospital to meet with grieving families in a timely manner.

5. I also welcome Cabrini Hospital's willingness, expressed at the Directions Hearing, to consider articulating its expectations of family members or carers staying with a patient with a disability, in written form. I have since been forwarded a document entitled "Guidelines – Visiting patients at Cabrini Malvern" that was last reviewed on 28 November 2014. This document, inter alia, discusses the responsibility of carers to be respectful to patients, staff and visitors as well as to discuss wishes for extension of visiting hours and overnight accommodation. However, the document does not specifically delineate the carers' role in terms of seeking nursing attention or providing care. The provision of a document that incorporates these subjects would help provide some clarity that was absent in Geoffrey's case.

RECOMMENDATIONS

1. I am satisfied that the matters identified needing clarification have been addressed by Cabrini Hospital and do not necessitate the making of recommendations.

FINDING

I accept and adopt the medical cause of death as ascribed by Dr Jacqueline Lee and I find that Geoffrey Power, a man with perinatal hypoxic/ischaemic brain injury, died from complications of cervical spinal stenosis treated with cervical laminectomy and fusion.

AND I further find that there is no relationship between the cause of Geoffrey's death and the fact that he was "a person placed in care".

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

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

- Mrs Beryl Power
- Mr Mark O'Sullivan, Moray and Agnew Lawyers on behalf of Cabrini Health
- Ms Naomi Anderson, Villamanta Disability Rights Legal Service
- Senior Constable Georgia Herbert
- Dr Mary-Anne Lancaster, General Practitioner
- Ms Jennifer Radnell, Clinical Risk Manager, Cabrini Health
- Mr Shane Beaumont, Disability Services, Department of Health & Human Services

Signature:

AUDREY JAMIESON
CORONER
Date: **17 February 2016**