IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 001075

FINDING INTO DEATH WITH INQUEST

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

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**MARGARET SMITH**
Delivered on:	**19 AUGUST 2016**
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	**19 AUGUST 2016**
Counsel assisting the Coroner:	**Ms Rebecca Johnston-Ryan**

HIS HONOUR:

BACKGROUND

1 Margaret Smith was 91 years old at the time of her death. She is survived by her children Alan and Anne, with whom she maintained close and loving relationships.

2 A coronial brief was provided by Victoria Police to this Court. At my request, the Coroners Prevention Unit[1] reviewed the medical and mental health management and care of Mrs Smith at Latrobe Regional Hospital. I have also used this information to assist my finding.

3 At inquest, a summary was read into evidence by Coroner's Legal Officer, Rebecca Johnston-Ryan. I am satisfied that the summary accurately reflects the evidence.

THE PURPOSE OF A CORONIAL INVESTIGATION

4 Mrs Smith's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as her death occurred in Victoria, and immediately before death she was a patient within the meaning of the *Mental Health Act 2014* (Vic) (*Mental Health Act*).[2] Consequently, this matter is a mandatory inquest.[3]

5 The jurisdiction of the Coroners Court of Victoria is inquisitorial[4]. The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

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[1] A specialist service for coroners created to strengthen their prevention role and provide them with expert assistance. Hereafter referred to as 'CPU'. The role of the CPU is to assist coroners investigating deaths, particularly deaths which occur in a healthcare setting. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are independent of the health professionals and institutions under consideration. The CPU professionals draw on their medical, nursing and research experience to evaluate the clinical management and care provided in particular cases by reviewing the brief of evidence, medical records, the autopsy report and any particular concerns which have been raised.

[2] Section 3, definition of 'Reportable death', *Coroners Act 2008.*

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

[4] Section 89(4) *Coroners Act 2008.*

6 It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

7 The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

8 For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

9 The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

10 Coroners are also empowered:

(a) to report to the Attorney-General on a death;

(b) 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

(c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

11 All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[6] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

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[5] *Keown v Kahn* (1999) 1 VR 69.
[6] (1938) 60 CLR 336.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

12 Mrs Smith was visually identified by her son Mr Alan Smith on 5 March 2015. Identity is not disputed and requires no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

13 On 8 March 2015, Dr Yeliena Baber, Forensic Pathologist, Victorian Institute of Forensic Medicine (VIFM), conducted an inspection of Mrs Smith's body and provided a written report, dated 24 March 2015, concluding a reasonable cause of death to be 'Unascertained'. I accept her opinion.

14 The external examination showed findings consistent with the clinical history. Examination of the post-mortem Computed Tomography (CT) scan showed a large pneumoperitoneum, bilateral pleural effusions, increased lung markings, calcified coronary arteries and aorta and cerebral atrophy. Dr Baber noted that the cause of death was unclear, particularly in the context of the pneumoperitoneum. It was noted that Mrs Smith's next of kin strongly objected to autopsy, and it was subsequently decided that an autopsy not be performed.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

15 Mrs Smith presented to the Latrobe Regional Hospital Emergency Department on 26 December 2014 following a fall involving a head strike. No significant acute injuries were identified, but the medical record noted that Mrs Smith had an unsteady gait and was generally weak. Mrs Smith was admitted to the Tanjil Ward for further medical management.[7]

16 On 30 December 2014, Mrs Smith was transferred to the Nicholson Geriatric Evaluation Management (GEM) Unit, following recommendation by physiotherapist J. Lai the previous day. On 6 January 2015, the Clinical Liaison Psychiatry team received a referral for psychiatric assessment of Mrs Smith in the context of a possible depressive illness. Mrs Smith

[7] Coronial brief, statement of Dr Brij Kishore, dated 6 August 2015, 1.

was reviewed by Consultant Psychiatrist Dr Brij Kishore that day, who recommended ceasing lithium medication and commencing venlafaxine[8] after determining that Mrs Smith appeared to be suffering from moderate depression on a background of Recurrent Depressive Disorder. On 14 January 2015, Mrs Smith's medication was changed to sertraline[9], and the sertraline dosage was titrated upward. Dr Kishore elected not to recommence Mrs Smith on lithium, as there was no evidence of bipolar disorder. By 2 February 2015, Mrs Smith had shown no improvement in her depressive state. Dr Kishore recommenced the lithium at a lower dose in an effort to augment the effect of the sertraline.[10]

17 As Mrs Smith was not suffering from any acute medical issues, she was transferred to Macalister Ward acute psychogeriatric inpatient unit on 3 February 2015. On 4 February 2015, following the sudden development of acute renal impairment and a metabolic acidosis, Mrs Smith was transferred to Tyers Unit medical ward. The sudden acute renal impairment and metabolic acidosis were suspected to be due to Mrs Smith's reduced oral intake. Mrs Smith's lithium was ceased at this time due to the risk of lithium toxicity in the context of the renal and metabolic impairment.[11]

18 Mrs Smith's blood results improved following intravenous (IV) fluid treatment and she became medically stable once again, looking well and appearing more alert. Despite this, Mrs Smith continued to be severely depressed and regularly refused oral intake. On 17 February 2015, following a four week regimen of sertraline, Mrs Smith's medication was replaced by mirtazapine[12]. At this time, Mrs Smith's daughter, Ms Anne Ross, agreed to trialling electroconvulsive therapy (ECT), after Dr Kishore explained the potential benefits of the therapy for treatment of severe depression which was resistant to drug therapy. Due to Mrs Smith's increasingly severe depression, Dr Kishore considered that Mrs Smith no longer had the capacity to provide informed consent to the ECT, and so she was made a compulsory patient on a Temporary Treatment Order under the *Mental Health Act*. On 19 February 2015 the Mental Health Tribunal subsequently approved 12 ECT treatments over a six-week period.[13]

19 The initial ECT sessions undertaken by Mrs Smith produced a non-sustained improvement in her alertness and communication. She developed pneumonia and then a urinary tract infection,

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[8] A serotonin/noradrenaline reuptake inhibitor anti-depressant medication.
[9] A selective serotonin reuptake inhibitor anti-depressant medication.
[10] Above n 8, 2-3.
[11] Above n 8, 3.
[12] Mirtazapine is indicated for the treatment of depression.
[13] Above n 8, 3-4.

which were treated with several oral and IV antibiotics over subsequent weeks. Mrs Smith's renal impairment returned and worsened along with multiple electrolyte derangements, and her infections proved somewhat refractory to treatment. Mrs Smith's conscious state gradually worsened, potentially exacerbated by a delirium that may have been precipitated by the persistent infections. At a family meeting on 4 March 2015, during a period of greater lucidity Mrs Smith expressed her wishes for no further medical intervention. [14] Mrs Smith's final ECT session took place on 4 March 2015, and active medical management was planned to continue until 6 March 2015, at which time palliation was to be considered.

20 On 5 March 2015 at 12:55a.m., Mrs Smith developed abdominal pain and nausea. She was administered paracetamol and an anti-nausea IV medication. A short time later, Mrs Smith complained of chest pain and abdomen pain. Notes made at 1:30a.m. regarding a review by night shift medical officer Dr Oo describe Mrs Smith's pain as originating in the epigastric region or possibly the lower central chest. Dr Oo noted that Mrs Smith was not distressed, and aside from a mild tachycardia[15], she had unremarkable vital signs and a normal electrocardiogram[16] (ECG).[17] Testing and investigations were performed, and medications administered to treat reflux and angina[18] largely resolved Mrs Smith's discomfort.

21 During the morning of 5 March 2015, Mrs Smith was alert, took her medication but refused breakfast, and chatted with nursing staff. At 10:00a.m. Mrs Smith was sighted by nursing staff. At approximately 10:45a.m., Registered Nurse Natasha Campbell attended Mrs Smith to check her vital signs and found her unresponsive. Mrs Smith's daughter, Ms Ross, was in attendance, and advised Nurse Campbell that Mrs Smith had been similarly unresponsive for approximately 30 minutes. A Medical Emergency Team (MET) call[19] was initiated. Mrs Smith was assessed as having no pulse, fixed and dilated pupils, and in line with Mrs Smith's explicit wishes the previous day no resuscitation was attempted.[20] Mrs Smith was declared deceased at 11:20a.m.

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[14] Coronial brief, statement of Dr David Miao, dated 28 July 2015, 2.
[15] An elevated heart rate.
[16] An ECG is a non-invasive investigation of the electrical conduction pathway of the heart.
[17] Coronial brief, statement of Dr Hnin Cherry Oo, dated 28 July 2015, 1-2.
[18] Angina is pain or discomfort that occurs when the heart does not receive sufficient blood and/or oxygen.
[19] A MET call is an urgent call for assistance, facilitating rapid medical review and management of an unwell or deteriorating patient.
[20] Coronial brief, statement of Natasha Campbell, dated 30 July 2015, 1-3.

Assessment of medical care

22 At my request, the CPU conducted a review and assessment of the medical and mental health care received by Mrs Smith at Latrobe Regional Hospital prior to her death.

23 Two Latrobe Regional Hospital Not For Cardiopulmonary Resuscitation forms stipulating Mrs Smith's wishes to not receive cardiopulmonary resuscitation or cardiac defibrillation were completed during her admission. The first form was completed on 30 December 2014, and the second updated form was completed on 28 January 2015. The rationale provided for the decision was increased age and comorbidities.

24 On the basis of Dr Oo's medical assessment of Mrs Smith in the early hours of 5 March 2015, reflux or angina were reasonably considered as the likely precipitants. Appropriate tests, investigations, and medications were prescribed at this time, with planned follow up by the home medical team in the morning. The medications prescribed in the early morning of 5 March 2015 for Mrs Smith's epigastric and/or lower chest pain were oral Gastrogel[21], xylocaine[22], sub-lingual glyceryl trinitrate[23], intravenous ondansetron[24], and a minimal dose of 25 micrograms of subcutaneous fentanyl. Mrs Smith had no known drug allergies.

25 Repeat cardiac enzyme blood tests and an ECG would ordinarily be performed at six hours post chest pain onset, but they were not performed on the morning of 5 March 2015. It is unclear whether the tests were deemed unnecessary due to the unlikelihood of undertaking subsequent invasive cardiac investigations due to Mrs Smith's advanced age and chronic comorbidities, or whether the follow up review did not take place. No progress note documentation by the home medical team was found in the medical records for the morning of 5 March 2015.

Assessment of mental health care

26 Dr Kishore reasonably diagnosed Mrs Smith with moderate depression on a background of Recurrent Depressive Disorder. This diagnosis and the subsequent mental health treatment plan was supported by psychiatrist Dr Jacques Claassen.[25] The selection of psychoactive medications for Mrs Smith including trials of two antidepressants and the reintroduction of lithium were all within relevant prescribing and treatment guidelines.

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[21] Gastrogel is an antacid suspension medication.
[22] Xylocaine is a topical anaesthetic suspension medication.
[23] Glyceryl trinitrate is an anti-angina agent, used for the interim treatment of cardiac-related pain.
[24] Ondansetron is an anti-emetic/anti-nausea medication.
[25] Coronial brief, correspondence of Dr Jacques Claassen, dated 18 February 2015, 1-3.

27 The option of ECT was also appropriate and complied with the requirements of the *Mental Health Act*. ECT is recognised by the Department of Health and the Royal Australian and New Zealand College of Psychiatrists as an appropriate treatment for severe depression. The Chief Psychiatrist has produced an ECT manual that clearly stipulates the best practice standards required for ECT, and the legislative framework for the treatment. ECT has a strong evidence-base as an effective treatment for depressive episodes including bipolar depression, as well as evidence of efficacy for mania and psychosis. Further, ECT can produce a short-term reduction in suicidality[26].

28 Mrs Smith had her status under the *Mental Health Act* changed from voluntary to compulsory to enable the administration of ECT as she was not assessed as competent to consent and she met the criteria for compulsory treatment.[27] The Latrobe Regional Hospital complied with the requirements for a report and application to the Mental Health Tribunal, a second opinion from a Consultant Psychiatrist, and engagement with family.[28] The post-ECT monitoring of the effects and of any adverse side effects on cognition were within the guidelines that applied at the time of Mrs Smith's death.

FINDINGS

29 Having investigated the death of Mrs Smith, and having held an Inquest in relation to her death on 5 March 2015 at Latrobe Regional Hospital, make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

(a) that the identity of the deceased was Margaret Smith, born 22 June 1923; and

(b) that Margaret Smith died on 5 March 2015 at Latrobe Regional Hospital, Traralgon from an unascertained cause, in the circumstances described above.

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[26] Prudic, J & Sackeim, H, 'Electroconvulsive Therapy and suicide risk', *Journal of Clinical Psychiatry* (1999) 60(2), 104-110.

[27] Schedule 5 of the *Mental Health Act* requires all of the following treatment criteria are met: (a) the person has mental illness; (b) because the person has mental illness, the person needs immediate treatment to prevent (i) serious deterioration in the person's mental or physical health or (ii) serious harm to the person or another person; and (c) the immediate treatment will be provided to the person if the person is subject to a temporary treatment order and (d) there is no less restrictive means reasonably available to enable the person to be immediately treated.

[28] Victorian Government, department of Health and Human Services, 'Electroconvulsive Therapy', *Mental Health Act 2014 Handbook* (2014).

30 I find that the medical and mental health management and care provided by Latrobe Regional Hospital was reasonable and appropriate in the circumstances.

31 I convey my sincerest sympathy to Mrs Smith's family and friends.

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

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

(a) Mrs Smith's family, senior next of kin.

(b) Investigating Member, Victoria Police; and

(c) Interested Parties.

Signature:

Mr John Olle
CORONER
Date: 19 August 2016