FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 2031/10

Inquest into the Death of NEIL CHARLES BETHUNE

Delivered On:	5th September, 2011
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne, Victoria 3000
Hearing Dates:	15th August, 2011
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Sergeant David DIMSEY, Police Coronial Support Unit, to assist the Coroner No other appearances.

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Section 67 of the ***Coroners Act 2008***

Court reference: 2031/10

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

Details of deceased:

Surname: BETHUNE
First name: NEIL
Address: 9 Salisbury Street
Balwyn, Victoria 3103

AND having held an inquest in relation to this death on 15th Augus, 2011
at Melbourne

find that the identity of the deceased was NEIL CHARLES BETHUNE also known as NEIL BETHUNE born on the 3rd April, 1927

and that death occurred on the 30th May, 2010

at Normanby House, St George's Hospital, 283 Cothan Road, Kew, Victoria 3101

from: 1(a) ISCHAEMIC HEART DISEASE
1(b) CORONARY ATHEROSCLEROSIS
2 CONTRIBUTORY FACTORS
CHRONIC OBSTRUCTIVE AIRWAYS DISEASE, DEMENTIA

in the following circumstances:

1. Mr Bethune was an eighty-three year old married man who resided with his wife Mary had been his primary carer for a number of years. Me Bethune had a past medical history which included Altzheimer's disease first diagnosed by Professsor David Ames in 2008, hypertension and cardiac disease for which he was reviewed six months before his death.

2. On 24 May 2010, Mr Behtune's daughter requested an assessment of her father by the St Vincent's Aged Psychiatric Assessment and Treatment Team (APATT) due to his self-neglect,

verbal aggression, safety concerns regarding his use of electrical appliances and general deterioration in functioning.

3. The assessment was undertaken at St Vincent's Hospital Emergency Department on 25th May 2010, by Dr Sally Chow, Psychiatric Registrar and APATT Clinician. Dr Chow recommended that Mr Bethune be made an involuntary patient under the Mental Health Act 1986, and in the absence of a bed at Normanby House, he was transferred to the Kingston Centre. Mr Bethune was commenced on a number of psycho-active medications - Oxazepam (a sedative/hypnotic drug of the benzodiazepine class), Risperidone (an antipsychotic) and additional Oxazepam, Midazolam and Temazepam on an "as required" basis.

4. On 27th May 2010, two days later, Professor O'Connor upheld Dr Chow's recommendation and changed Mr Bethune's anti-psychotic medication to Olanzapine. An electrocardiogram showed a "right bundle block" and a fast pulse at 87 beats per minute. Mr Bethune exhibited difficult behaviours whilst at the Kingston Centre, including wandering and restlessness at night rquiring sedation, and aggressive behaviours which required 3-4 staff members at a time to address.

5. A bed became available for Mr Bethune at Normanby House on 28th May 2010. Prior to transfer, Mr Bethune was administered 5mg Olanzapine to help staff manage his behaviours during the transfer. Whilst en route to Normanby House, Mr Bethune's conscious state altered with a Glasgow Coma Score (GCS, a universal measure of consciousness) first of 14, then 6, then 3. Mr Bethune was exhibiting no motor or verbal response but was still opening his eyes.

6. The ambulance diverted to Monash Medical Centre (MMC) where Mr Bethune seemed to have recovered by the time of arrival and was noted to have strong respiration, was flexing his legs, blinking and maintaining his own airway. He remained at MMC overnight while investigations were undertaken. An ECG again showed evidence of right bundle block, chest xrays showed no abnormalities, CT of the brain showed no acute changes and a full blood examination was satisfactory. Mr Bethune was discharged for transfer to Normanby House the following morning, 29 May 2010.

7. In his twenty four hours at Normanby House, there were no noted nursing care or behavioural issues. Nursing observations were within normal limits and Mr Bethune was alert and reactive, but confused and disoriented. He was on 15 minute visual observations. Overnight, Mr Bethune was observed to be sleeping and snoring heavily at 11.30pm, and again at 3.45am on 30 May 2010. At 3.49am the snoring stopped and one of the night duty nurses went to him immediately. Another nurse came to assist and together they undertook cardiopulmonary resuscitation. An ambulance paramedic arrived at 3.53am and confirmed that Mr Bethune had no pulse, was not breathing and that a three lead ECG showed "asystole". Medical staff arrived to confirm that Mr Bethune was deceased.

8. An autopsy was performed by Senior Forensic Pathologist Dr Shelley Robertson from the Victorian Institute of Forensic Medicine (VIFM). Dr Robertson reviewed the circumstances as reported by the police, noted marked coronary atherosclerosis and generalised atherosclerosis as

significant autopsy findings and formulated the cause of Mr Bethune's death as above. Dr Robertson commented in her report that Mr Bethune died from natural causes with evidence of ischaemic heart diease and marked coronary atherosclerosis, and underlying chronic obstructive airways disease.

9. As an involuntary psychiatric patient, Mr Bethune's death was reportable to the coroner irrespective of the cause of death. In this way, the Coroners Act 2008 extends some protection to those vulnerable people who are in the care of the state when they die by requiring a coronial investigation including an inquest into their deaths, thereby providing a degree of scrutiny and accountability of the care provided to them.[1] There is no suggestion in the material before me that any want of clinical care or management casued or contributed to Mr Bethune's death.

10. I find that Mr Bethune was a person in care, namely an invountary psychiatric patient, who died from natural causes, namely ischaemic heart disease secondary to coronary atherosclerosis, with chronic obstructive airways disease and dementia noted as contributory factors not direclty related to the cause or mechanism of death.

COMMENTS:

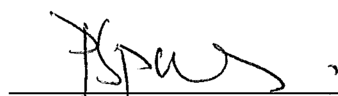
Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

1. The only issue raised by Mr Bethune's family, was the failure to advise them that he had taken ill during transfer from the Kingston Centre and Normanby House, and had without their knowledge spent the night at MMC. While there is no causal connection between this alleged failure and his death, it is understandable that the family feel aggrieved, as the failure to advise them coloured their decision not to visit him on his first day at Normanby House while he was still alive.

DISTRIBUTION LIST

The Bethune Family
Senior Constable Caroline Sorrell (#35147) c/o O.I.C. Boroondara Police
St Vincent's Health
Southern Health
Chief Psychiatrist

Signature:



Coroner: PARESA ANTONIADIS SPANOS
Date: 5th September 2011

1 See section 4(2)(d) of the *Coroners Act 2008* for the relevant part of the definition of a "reportable death" and section 52(2)(b) which mandates an inquest.