IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2007 3703

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: PAUL BERNARD FINCK

Delivered On:	26 February 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Dates:	26 and 27 October 2011
Findings of:	AUDREY JAMIESON
Representation:	Ms D Foy of Counsel on behalf of Eastern Health
Police Coronial Support Unit	Leading Senior Constable Greig McFarlane

I, AUDREY JAMIESON, Coroner, having investigated the death of PAUL BERNARD FINCK

AND having held an inquest in relation to this death on 26 October 2011
at MELBOURNE
find that the identity of the deceased was PAUL BERNARD FINCK
born on 1 September 1960
and the death occurred on 19 September 2007
at Maroondah Hospital, Davey Drive, Ringwood East, 3135
from:

1 (a) PULMONARY THROMBOEMBOLISM
1 (b) DEEP VEIN THROMBOSIS

in the following circumstances:

1. On 26 October 2011, a mandatory inquest under section 52(2)(b) of the *Coroners Act 2008* (Vic)[1] began into the death of Mr Paul Bernard Finck, because immediately before his death, Mr Finck was "a person placed in....care" as it is defined in the Act, in that prior to his death, Mr Finck was a patient in an approved mental health service within the meaning of the *Mental Health Act 1986* (Vic) (the Mental Health Act).[2]

2. On 15 September 2007, Mr Finck was admitted as an involuntary patient to the Psychiatric unit of Maroondah Hospital after walking barefoot to his Aunt's home some considerable distance away. Whilst in the Psychiatric unit, Mr Finck was assessed and was placed under observation. On 19 September 2007, at approximately 7.45pm, staff found Mr Finck collapsed in his ensuite. Cardiopulmonary resuscitation (CPR) was performed, however, Mr Finck was unable to be revived.

BACKGROUND CIRCUMSTANCES

3. Mr Paul Finck, 47 years of age at the time of his death, resided in Nunawading with two housemates and was in receipt of a Disability Support Pension.

4. Mr Finck had a history of mental health issues after being diagnosed with Schizophrenia in his late teens/early twenties. He had previously been admitted to the Eastern Health Mental Health Service in October/November 2002 following separation from his then

[1] See below discussion under the heading of "Jurisdiction" for further explanation.

[2] As it then was.

wife. Since 2002, he had been managed by his General Practitioner (GP) and private Psychiatrist. It was noted that he had good support from family and community workers.

SURROUNDING CIRCUMSTANCES

5. On 14 September 2007, Mr Finck arrived at his Aunt's house in Mulgrave. It is believed that he had walked all the way from his house in Nunawading. Mr Finck stated that he had walked all night. He was barefoot and said that he had lost his shoes and consequently received injuries to the balls of his feet.

6. He was described as disorientated upon his arrival. His Aunt rang his mother, who came and collected him.

7. Mr Finck was taken by his mother to the Emergency Department (ED) at Maroondah Hospital at 12.37pm on 15 September 2007. Dr Ambreen Memon consulted with him and noted that he had missed his medication (Abilify/Aripiprazole) over the last three days. She noted that he had walked up to 26km as he was feeling upset. She also noted that he looked confused, had a vacant stare and his speech was slow with a blunt affect.

8. Dressings were applied to his feet and a referral was made for Psychiatric assessment by a Registered Psychiatric Nurse. Mr Finck was then admitted to Maroondah Hospital, West Ward on 15 September 2007 as an involuntary Psychiatric patient for Schizophrenia and psychotic episodes. On admission, he was found to be febrile and tachycardic. Abnormalities were seen in his Thyroid Function Tests and he was possibly experiencing urinary retention.

9. Mr Finck's brother reported him to be in a Catatonic state initially upon admission.[3] Hospital staff found his lack of engagement a barrier to assessing his psychotic symptoms.[4]

10. Mr Finck received both medical and Psychiatric care whilst in the West Ward's High Dependency Unit (HDU). He was referred to the Endocrinology unit, and a range of clinical tests were ordered including an ECG, blood cultures, urine samples, nuclear thyroid scan, chest X-ray and a bladder scan. He was commenced on oral antibiotics on 17 September 2007.

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[3] Transcript p. 9

[4] Statement of Psychiatrist Dr Ashu Gandhi, undated, coronial brief of evidence p. 16.

11. On 18 September 2007, Consultant Psychiatrist Dr Ashu Gandhi advised that Mr Finck's antipsychotic medication should be ceased,[5] that his vital signs should be regularly monitored, and that he should be transferred to the ED if his condition deteriorated.[6] Mr Finck was also reviewed by Endocrinologist Resident Dr Xiang Loh in the morning, who determined the differential diagnoses to include infection, thyrotoxicity, hyperthyroidism, urinary retention and neuroleptic malignant syndrome (NMS).[7]

12. In the afternoon of 18 September 2007, Mr Finck was reviewed by the Medical Registrar who considered it was likely he was suffering from a urinary tract infection causing retention and fever, with the rise in Creatine Kinase (CK) noted in his blood resulted attributed to walking 26kms. It was thought that it was unlikely that he was suffering from NMS.[8]

13. On 19 September 2007, Mr Finck was reviewed by Dr Gandhi in the morning and was reported to have passed urine, with stable vital signs, and was observed to be generally settling down,[9] with mildly increased engagement, although still in an apparent catatonic state.

14. At approximately 11.30am on Wednesday 19 September 2007, Mr Finck was transferred from the HDU to the Low Dependency Unit (LDU). Mr Finck also complained of epigastric pain later that day. As a result, Psychiatric Registrar Dr David Harms requested Mr Finck to be reviewed by the Psychiatric Registrar, Dr Piyumali de Silva, that evening.

15. At approximately 7.30pm, Dr de Silva walked to the West Ward nurses' station. On her way, she observed Mr Finck in his room sitting upright in a lounge chair facing the corridor.

16. Dr de Silva then spent some time reading his history and speaking with the Nursing staff about Mr Finck and other patients on the ward. Nurse Fiona Lankford alerted Dr de

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[5] Due to the possibility of Mr Finck having neuroleptic malignant syndrome; transcript p. 62 and 135.

[6] Statement of Dr Ashu Gandhi, undated, coronial brief of evidence p. 16.

[7] Statement of Dr Xiang Ho dated 26 October 2010, coronial brief of evidence p.18E.

[8] Statement of Medical Director of Maroondah Hospital Dr Peter Sloan dated 24 August 2010, coronial brief of evidence, p. 18G.

[9] Statement of Dr Ashu Gandhi, undated, coronial brief of evidence p. 16, although Dr Gandhi notes that a record of this was not located.

Silva to the abdominal pain as well as mild tachycardia and hypertension that she had observed just before Dr de Silva's arrival.

17. At approximately 7.43pm, Dr de Silva and Nurse Lankford entered Mr Finck's room. He was not in his bedroom and was located in the ensuite, collapsed on the ground between the toilet and the wall.

18. Dr de Silva attended to him, and she thought that she detected a weak pulse that stopped almost immediately. Nurse Lankford called a 'code blue', with the code blue response team arriving within two minutes. Prior to their arrival, Dr de Silva removed Mr Finck from the wedged position that she located him in, cleared debris from his mouth, applied oxygen and commenced manual ventilation.

19. Once the code blue response team arrived, full resuscitation efforts were employed including intubation, defibrillation and the administration of adrenaline. However, they were unable to restore spontaneous circulation and the decision was made to cease resuscitation efforts at 8.14pm, upon which time Mr Finck was formally pronounced deceased.

INVESTIGATIONS

Identity

20. The identity of Paul Bernard Finck was without dispute and required no further investigation.

The medical investigation

21. On 25 September 2007, Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine performed an autopsy on the body of Mr Finck, reviewed a post mortem CT scan and the Victoria Police Report of Death, Form 83. Anatomical findings included one abrasion on the right upper forearm and another abrasion overlying the right portion of the face, between the right eye and right ear. Dr Parsons also indentified deep venous thromboses in the left and right calves and a large saddle pulmonary embolism in Mr Finck's lungs. Dr Parsons noted that Mr Finck had been running a fever in the days prior to his death and was dehydrated, which she opined may have increased his risk of pulmonary thromboembolism.

22. Toxicological analysis of Mr Finck's blood revealed the presence of diazepam, its metabolite nordiazepam and olanzapine at therapeutic levels.

23. Dr Parsons ascribed the cause of Mr Finck's death to pulmonary thromboembolism and deep vein thrombosis.

Victoria Police

24. The circumstances of Mr Finck's death were subject to investigation by Victoria Police. A coronial brief of evidence was submitted to the Court in August 2008, containing statements from Mr Noel Finck, and from past and present employees of Eastern Health including Nurse Lankford, Dr M Hashim, Dr de Silva, Dr Gandhi, Dr Ambreem Memon, Dr Xiang Hua Loh, Dr Peter Sloan and Dr Vinod Aiyappan.

Clinical Liaison Service

25. The Clinical Liaison Service[10] reviewed the circumstances of Mr Finck's death on behalf of the Coroner in relation to the issue of whether it was reasonable and appropriate in the circumstances for Mr Finck to have been admitted to the Psychiatric ward rather than a medical ward.

26. It was noted that if Mr Finck had been treated in a medical ward rather than a Psychiatric ward, he was likely to have been cared for by a Division 1 Nurse rather than a Division 2 Nurse, as Nurse Lankford was.[11]

27. It was also suggested that because of the abnormalities in Mr Finck's observations detected by Ms Lankford at 4.30pm on 19 September 2007, his medical management should have been reviewed at that stage rather than at 7.30pm when Dr de Silva was available.

Issues identified for further exploration

28. The main issue identified was whether Mr Finck should have been treated in a medical ward with input from Psychiatric staff or whether he should have been treated in a Psychiatric ward with input from medical staff, and if the latter was appropriate, whether

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[10] The Clinical Liaison Service (CLS), now known as the Health and Medical Investigation Team (HMIT) is a unique initiative of the Coroners Court of Victoria and the Victorian Institute of Forensic Medicine (VIFM) to improve patient safety. HMIT is staffed by practising Physicians and Nurses who are independent of the health professionals or institutions involved. They assist the Coroner's investigation of deaths occurring in a healthcare setting by evaluating the clinical management and care provided and identifying areas of improvement similar deaths may be avoided in the future.

[11] Nurse Lankford gave evidence that there are only five patients in the HDU at any time, and two Nurses; transcript, p. 27. Dr Peter Sloan gave evidence that there is generally a combination of Division 1 and Division 2 Nurses on all wards; transcript p. 91, and that the Nurse to patient ratio on a medical ward is 1:4 (as opposed to 1:2.5 in the Psychiatric unit), transcript, p. 108.

his medical management as a Psychiatric patient was adequate and appropriate in the circumstances.

29. A Directions Hearing was held in March 2011 at which Interested Parties were informed of the issues identified by the investigation into the death of Mr Finck.

INQUEST

Jurisdiction

30. At the time of Mr Finck's death, the *Coroners Act 1985* (Vic) (the Old Act) applied. From 1 November 2009, the *Coroners Act 2008* (Vic) (the Act) has applied to the finalisation of investigations into deaths that occurred prior to the new Act commencement.[12] In the preamble to the Act, the role of the coronial system in Victoria is stated to involve the independent investigation of deaths for the purpose of finding the causes of those deaths and to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice. Reference to preventable deaths and public health and safety are mentioned in other sections of the Act.[13]

31. Section 67 of the Act describes the ambit of the Coroner's findings in relation to a death investigation. A Coroner is required to find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.[14] The 'cause of death' generally relates to the *medical cause of death* and the 'circumstances' relates to the *context* in which the death occurred.

Evidence at Inquest

32. *Viva voce* evidence was obtained from the following witnesses at Inquest:

    a. Mr Noel Finck;

    b. Ms Fiona Lankford, enrolled Psychiatric Nurse, Maroondah Hospital;

    c. Dr Piyumali de Silva, Psychiatric Registrar at Maroondah Hospital at the time of Mr Finck's death;

    d. Dr Peter Sloan, Director of Medical Services, Maroondah Hospital;

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[12] Section 119 and Schedule 1 – *Coroners Act 2008*.

[13] See for example, sections 67(3), 72 (1) and (2).

[14] Section 67(1).

e. Dr Ashu Gandhi, Consultant Psychiatrist, Eastern Health; and

f. Dr Xiang Hua Loh, Endocrinology Resident at Maroondah Hospital at the time of Mr Finck's death.

Concerns of Mr Finck's family

33. Mr Noel Finck, on behalf of his family raised concerns regarding whether his brother's apparent sedation and consequent immobilisation could have contributed to the development of DVT.

Events prior to Mr Finck's admission to Maroondah Hospital

34. Mr Noel Finck described his brother as a fairly fit man, despite his stocky appearance, that used walking as his primary mode of transport.

35. Mr Noel Finck also described how his brother had spent several days in the secure area of the same Psychiatric ward approximately five years prior to his death. Mr Noel Finck described that this admission occurred in the context of excess alcohol consumption following the break-up of his marriage.

36. Mr Noel Finck stated that his brother appeared happy living with his housemates, but noted that they had observed some unusual behaviour from his leading up to the night that he walked to his Aunt's home. It is possible that Mr Finck ceased taking his psychotropic medication around this time.

37. Mr Noel Finck in his statement to the Court stated that his brother "struggled occasionally with mental health issues throughout his life but had been fine for 5 years and many years before that occurrence."[15]

38. Various estimates were heard in respect of how far Mr Finck walked overnight, however it was clearly a significant distance, part of which he spent barefoot for an uncertain reason.

Medical care received while in Maroondah Hospital

39. Upon admission to Maroondah Hospital, Mr Finck was recommenced on his usual medication, Aripripazole 15mg daily. It was noted that he was rigid, especially in his upper limbs. Medical records describe him as appearing perplexed, with poverty of

[15] Statement of Mr Noel Finck dated 18 July 2008, coronial brief of evidence, p. 18.

thoughts and blunted affect. Mr Noel Finck described him as almost catatonic.[16] His psychotic symptoms were listed as auditory hallucinations, diminished speech and facial expression, fearfulness, bizarre thoughts and behaviour, including unusual body posture, slowing of movements, noting his episode of walking tens of kilometres barefoot.[17]

40. In the morning of 18 September 2007, Mr Finck was reviewed by the Endocrinology House Medical Officer who requested a review by the medical Registrar, Dr Vinod Aiyappan, who reviewed him at 12.00pm. He noted that if Mr Finck's urea and electrolytes results worsened or the CK levels rose, Mr Finck could be transferred to a medical ward after discussion with medical staff. Dr de Silva noted that Mr Finck's blood tests results proceeded to improve.[18]

41. By the time that Mr Finck was transferred to the LDU on 19 September 2007, he was still requiring full nursing care and 15 minute visual observations.[19] He had been placed on a fluid balance chart.

42. When Nurse Lankford took Mr Finck's observations at 4.30pm, she was concerned about tachycardia and hypertension.[20] She immediately asked Dr Harms to review Mr Finck.

43. At the commencement of her shift, Nurse Lankford placed Mr Finck in a position within in his room where he was viewable from the Nurse's station.[21] Nurse Lankford gave evidence that as an enrolled Nurse, it was her responsibility to communicate any concerns regarding her patients to the unit doctor, and that it was "above her head" to call in a physician from another unit, and not her responsibility to escalate situations.[22]

44. Dr de Silva was rostered on an "after-hours" shift that day, with her shift commencing at 5.30pm. According to her statement, she spent the first hour of her shift completing paperwork in her office. At approximately 6.30pm, she was approached by Dr Harms and asked to review Mr Finck. Her evidence states that Dr Harms requested her to

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[16] Transcript p. 9.

[17] Statement of Dr Piyumali de Silva, coronial brief of evidence, p. 13.

[18] Transcript, p. 60.

[19] Transcript, p. 22, 41 and 44.

[20] Nurse Lankford was particularly concerned with the diastolic blood pressure reading of 120mmHg; transcript p.23 and 32.

[21] Transcript, p. 31.

[22] Transcript, p. 36-38.

assess Mr Finck at approximately 7.30pm. He also advised her of Mr Finck's room number.

45. At approximately 7.30pm, Dr de Silva walked past Mr Finck's room. She noticed him sitting upright in a chair, facing the corridor. She continued to the Nursing station where she reviewed his history and spoke to Nursing staff about Mr Finck and other patients on the ward. Nurse Lankford alerted Dr de Silva to Mr Finck's complaints of epigastric pain as well as mild tachycardia and hypertension that she had noted only a few minutes earlier. Dr de Silva and Nurse Lankford then collected their monitoring equipment and entered Mr Finck's room.[23] Their evidence indicates that they entered his room between 7.43 and 7.45pm.

46. Dr Peter Sloan, the director of medical services at Maroondah Hospital in his statement to the Court addressed hospital policy regarding care of complex medical patients admitted under psychiatric care. He stated;

> *"When a patient is to be admitted to hospital and has both medical and psychiatric diagnoses then a judgement is made between the psychiatry service and the medical unit as to the appropriate location of the patient in the hospital. The patient may be admitted to an acute medical bed with support from the psychiatry service or to a psychiatry bed with support from the medical unit."*

47. Dr Gandhi gave evidence at Inquest in relation to Mr Finck's treatment whilst an involuntary patient. He stated that he would be guided by medical staff on issues of medical treatment. He also noted that it was not unusual for patients to come to the Psychiatric ward and sit or lay in one place for an extended period.

48. Dr de Silva stated in evidence that 50% of the Psychiatric patients she is asked to review require assessment/treatment for medical issues,[24] and that she considers it her responsibility "to manage both medical and psychiatric issues".[25]

49. Dr Sloan concluded that Mr Finck received "appropriate care and appropriate assessment by duly qualified medical staff".[26]

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[23] Nurse Lankford stated that she had not taken other vital sign observations from 4.30pm until this time; transcript, p.25, and that Mr Finck required four hourly vital signs observations; transcript, p. 28 and 29.

[24] Transcript, p. 52-53.

[25] Transcript, p. 60.

Sedation

50. Dr Gandhi was asked in evidence whether Mr Finck was sedated for the first few days upon his admission to the Psychiatric unit, or whether his apparent catatonic state was rather part of his presentation. Dr Gandhi explained that Mr Finck's presentation was a result of a combination of factors, including him having travelled a long distance, a possible infection and the possibility that some of the medications provided in hospital may have affected his sedation level. Dr Gandhi stated that his presenting illness itself possibly had features of a person who was sedated.[27]

51. Dr Gandhi gave evidence that some of the prescribed medication (diazepam, temazepam and olanzapine) was to treat Mr Finck's agitation rather than to sedate him.[28] Dr Gandhi was also of the view that these medications were prescribed at relatively low doses.[29] According to Dr Gandhi, the other medication, Aripiprazole (abilify), that Mr Finck was prescribed and had been taking for some time previously, was unlikely to result in sedation.

52. Dr Gandhi stated that Mr Finck was observed to be responding to internal stimulation, which can sometimes misrepresent as patients being sedated.[30] Dr Gandhi also explained that less severe catatonia, which he stated Mr Finck may have been experiencing, can sometime be misinterpreted as psychotic symptoms or sedation.[31]

Risk of DVT

53. Dr de Silva stated that she would be concerned about a DVT developing in a patient who is bedbound for more than 24 hours.[32] She noted that although the risk of DVT raises when someone is dehydrated,[33] it was her impression that Mr Finck was mobilising, and accordingly would not have considered that DVT prophylaxis was indicated.[34] Dr de

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[26] Transcript, p. 110.

[27] Transcript, p. 125.

[28] Transcript, p. 133-134.

[29] Transcript, p. 125, and 134.

[30] Transcript, p. 125.

[31] Transcript, p. 138.

[32] Transcript, p. 55-56.

[33] Transcript, p. 56.

[34] Transcript, p. 57.

Silva did not consider that it was clinically indicated to provide Mr Finck with intravenous fluid rehydration, as he was drinking reasonable volumes, and his blood test results were improving.[35]

54. Dr Sloan similarly stated that Mr Finck would not have been categorised as a patient with "significant immobility", as he was toileting himself independently, therefore he considered the risk of immobility associated with DVT development would not apply to Mr Finck's situation.[36]

55. Dr de Silva conceded that DVT might be more difficult to diagnose in a Psychiatric setting where a patient is possibly not engaging sufficiently to communicate any relevant symptoms,[37] however conceded that there would be no difference in his capacity to discriminate between calf pain and epigastric pain.[38]

56. Dr de Silva noted that it may have been challenging to nurse Mr Finck in a medical ward, due to his unpredictability, possible wandering behaviour, and the less frequent visual observations generally provided to medical unit patients.[39] Dr Sloan however stated, that while he did not have a "great feel" for Mr Finck's mental health status, it was possible to have nursed him on the medical ward, that if (Psychiatric) patients are required to be on a medical ward, then "we provide them with additional nursing staff".[40] Dr Sloan however stated that there was nothing in Mr Finck's presentation that suggested he should have been treated in a medical ward.[41]

57. Dr de Silva did not consider Mr Finck's blood test results would indicate that a DVT was present,[42] nor did she consider there could be a relationship between his reported epigastric pain and the DVT.[43] Dr de Silva stated that there was no indication that Mr

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[35] Transcript, p. 60.

[36] Transcript, p. 101 and 116 where Dr Sloan also notes Mr Finck's relatively young age in reference to known risk factors.

[37] Transcript, p. 58

[38] Transcript, p. 68.

[39] Transcript, p. 58-59.

[40] Transcript, p. 97.

[41] Transcript, p. 97-98.

[42] Transcript, p. 67. Dr Sloan concurred; transcript p. 108.

[43] Transcript, p. 68.

Finck was going to develop a DVT from the diagnostic results or observations.[44] Dr Sloan stated that tachycardia is not a symptom of DVT.[45]

58. Dr de Silva stated that a DVT can sometimes lead to a sudden, catastrophic event without warning signs,[46] a view confirmed by Dr Sloan, who stated that a pulmonary embolism from DVT can occur without any warning.[47]

59. Dr Sloan noted that Mr Finck's blood test results, specifically the neutrophilia, changes in his CK and urea levels are all consistent with muscle breakdown due to overexertion. Dr Sloan explained that muscle breakdown, referred to as rhabdomyolysis, carries with it an opposite risk to clotting/DVT formation, rather the risk of disseminated intravascular coagulation (DIC), a coagulation defect where patients bleed rather than clot.[48]

60. In the whole of the circumstances, Dr Sloan stated that Mr Finck did not fit into the any of the thromboprophylaxis risk groups, therefore he would not have been investigated for DVT formation or provided with prophylaxis therapy.[49]

61. Dr Gandhi stated that he had not experienced an association between sedation of Psychiatric patients and DVT formation.[50]

Incident Review

62. I note that a serious incident review was undertaken by Maroondah Hospital in respect of Mr Finck's management. A number of recommendations were made following that review. For completeness, they include;[51]

    1. *It is recommended that all Mental Health patients have a baseline set of clinical observations and a physical assessment on arrival to the Emergency*

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[44] Transcript, p. 75.

[45] Transcript, p. 103. Dr Sloan went further and stated he considered the tachycardia was related to Mr Finck being thyrotoxic (p. 118).

[46] Transcript, p. 75.

[47] Transcript, p. 97.

[48] Transcript, p. 113-114.

[49] Transcript, p. 114.

[50] Transcript, p. 128.

[51] Although Ms Foy on behalf of Eastern Health initially canvassed an intention to make a submission pursuant to section 115(3) of the Act (transcript p. 4) and mentioned certain aspects of the report that highlighted Eastern Health's intention that it remain an internal document and not be distributed (transcript p. 83-86), no formal application was made with respect to the document provided to the Court, during the Inquest or at the conclusion of the Inquest, when the document was specifically discussed.

Department. This is to be documented in the clients notes Emergency Management Form MH/162.

***Action**: Dr Peter Archer Maroondah Hospital Director Emergency Medicine to provide information and education to all Emergency Medical staff as to the above requirements for Mental Health clients on admissions to the Maroondah Hospital Emergency Department.*

2. *As per Eastern Health Mental Health Service policy all patients are to have documented physical assessment and observations attended on admission to inpatient units. These observations and assessments are to be recorded on MH222 Chart.*

***Action**: Dr Paul Katz Associate Professor Eastern Health Mental Health Service to disseminate this information to all Mental Health clinicians in the Service.*

3. *All clients are to have a documented Clinical Risk Assessment and Management form **MREH 205.2** completed on admission and the Clinical Risk Review form **MREH 205.1** updated each shift as per Eastern Health Mental Service Policy.*

***Action**: Mental Health Services Acute Operations Manager Mark Thornett to reinforce to all clinicians the importance of adherence to Eastern Health Policy for Clinical Risk Assessment and Review in relation to admission and management of all inpatient clients.*

63. Dr Sloan stated that the recommendation in relation to the physical examination of mental health patients has been adopted, that it essentially stated the policy that existed beforehand, which has now been reaffirmed.[52] Dr Sloan opined that the adoption of this recommendation would not have impacted on Mr Finck's outcome.[53] He also said that there was nothing in his presentation to indicate that a DVT was likely,[54] and that Mr Finck did not meet any of the accepted hospital guidelines for DVT prophylaxis.[55]

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[52] Transcript, p. 94-95.

[53] Transcript, p. 95.

[54] Transcript, p. 95.

[55] Transcript, p. 95-96.

64. Dr Gandhi stated that, based on discussions he has had with the Nurse Unit Manager of the Psychiatric unit, clinical risk assessments are completed upon admission, and clinical risk reviews upon the change of each shift (three times per day), whereas at the time of Mr Finck's death, the reviews were completed daily.[56]

Submissions

65. Oral submissions were received from Ms Deborah Foy of Counsel on behalf of Eastern Health on the final day of the Inquest. Ms Foy submitted that the medical care provided to Mr Finck was of an adequate standard and that he was appropriately followed up and reviewed by at least two medical practitioners every day during his admission.[57] Ms Foy submitted that a very thorough process of differential diagnoses was undertaken by all medical practitioners with respect to Mr Finck's symptoms.[58]

66. Ms Foy submitted that Mr Finck's tragic clinical course was not diagnosable; there was no history which would have prompted hospital staff to consider that he had a DVT.[59] Ms Foy submitted that there is no evidence that suggests that moving Mr Finck to a medical ward would have been able to prevent his death, and that it is probable that he received more nursing care in the HDU than he might have on a medical ward.[60]

67. Ms Foy therefore submitted that there should be no criticism directed to the medical or nursing staff involved in Mr Finck's care.[61]

FINDINGS

While I accept that the medications prescribed to Mr Finck whilst an inpatient at the Psychiatric unit can have a slight sedating effect,[62] I do not accept that Mr Finck was purposely sedated by staff at Eastern Health and that any perceived sedation was more likely to be mild catatonic symptoms linked to Mr Finck's acute psychotic episode. I accept that any medication prescribed to him during his admission, at relatively low doses, was provided to treat agitation rather then to promote

[56] Transcript, p. 142-143.

[57] Transcript, p. 165.

[58] Transcript, p. 167.

[59] Transcript, p. 165.

[60] Transcript, p. 166.

[61] Transcript, p. 166.

[62] Transcript, p. 134.

sedation. I also accept on the weight of the evidence that Mr Finck's objective sedated appearance was likely an organic part of his presenting illness.

I am satisfied that Mr Finck's clinical presentation prior to his death was not due to pulmonary embolism/deep vein thrombosis and that this condition could not have been predicted on the evidence available to medical staff at that time. I accordingly find that it was appropriate to treat Mr Finck in the West Ward Psychiatric unit with regular and appropriate monitoring by medical doctors. I also find that the medical management of Mr Finck, an involuntary Psychiatric patient, was reasonable and appropriate in the circumstances.

Accordingly, I make no adverse findings against any Eastern Health staff involved in his care.

The investigation into Mr Finck's death did not identify evidence that the outcome would have been different if Mr Finck had been transferred to a medical ward.

I am satisfied that the recommendations made by and implemented at Eastern Health followed a proper review of the circumstances of Mr Finck's death, and are, although not overwhelmingly specific, restorative in nature.

I accept and adopt the medical cause of death as identified by Dr Sarah Parson and find that Paul Bernard Fink died from natural causes, being pulmonary thromboembolism and deep vein thrombosis.

I direct that these Findings be published on the internet.

I direct that a copy of this finding be provided to the following:
Mrs Loretta Finck
Mr Noel Finck
Ms Sue Allen, Chief Counsel, Eastern Health
Dr Paul Katz, Eastern Health
Ms Deborah Ellis of Counsel
Dr Mark Oakley Browne, Office of the Chief Psychiatrist
Police Coronial Support Unit
Leading Senior Constable Allan Langley

Signature:

AUDREY JAMIESON
CORONER
Date: **26 February 2015**