IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2015 4178

FINDING INTO DEATH WITH INQUEST

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

Deceased:	Yvonne Rose Vizard
Delivered On:	3 October 2018
Delivered At:	65 Kavanagh Street Southbank 3006
Hearing Dates:	28 August 2018
Findings of:	Caitlin English, Coroner
Police Coronial Support Unit:	Sergeant Tracy Weir

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I, CAITLIN ENGLISH, Coroner, having investigated the death of Yvonne Rose Vizard

AND having held an inquest in relation to this death on 28 August 2018

at Melbourne

find that the identity of the deceased was Yvonne Rose Vizard

born on 11 December 1942

and the death occurred on 18 August 2015

at 10 Peppercorn Place, Yarra Junction, Victoria

from:

I (a) Obstruction of the airways of the neck

in the following circumstances:

Background and chronology

1. On 18 August 2015 Yvonne Rose Vizard was found deceased in her home by her husband Ray Vizard.
2. Mrs Vizard was 72 years old at the time of her death. She had a medical history including hypertension, shoulder reconstruction, hypocholesteraemia, pancreatitis and a total hip replacement.[1] She was nonetheless active and was president of the Ladies Golf Committee at Gardiners Run.[2]
3. Mrs Vizard was married to Ray Vizard and together they had two adult daughters, Lea Rose and Sasha Portbury.[3]
4. On 21 May 2015 Mrs Vizard suffered a stroke while visiting Mrs Rose at her home in Clifton Hill. At around 9.00pm she became acutely aphasic, suffered right arm weakness and displayed a right facial droop.[4]
5. Mrs Vizard was immediately taken to the Epworth Emergency Department. She was found to have an acute left middle cerebral artery territory infarct with significant right hemiplegia.[5]

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[1] Medical records.
[2] Statement of Ray Vizard dated 23 January 2016, Coronial Brief p 12.
[3] Statement of Lea Rose dated 23 January 2016, Coronial Brief p 16.
[4] Statement of Lea Rose dated 23 January 2016, Coronial Brief p 18; Comments of Dr Andrew H Evans, Coronial Brief p 57.
[5] Comments of Dr Andrew H Evans, Coronial Brief p 57.

6. She was treated by Consultant Neurologist Dr Andrew H Evans with intravenous tissue plasminogen activator. This was modestly beneficial, and she recovered very quickly with regard to the hemiplegia. On the next day she had an MRI of the brain that showed a completed left superior branch MCA territory infarct without any haemorrhagic transformation.

7. After a week at the Epworth, on 28 May 2015 Mrs Vizard was transferred to Donvale Rehabilitation Hospital. She commenced a rehabilitation program including speech pathology, occupational therapy and physiotherapy.[6]

8. While at Donvale Rehabilitation Hospital Mrs Vizard received frequent reviews by her multidisciplinary team as well as nursing and medical staff. She had multiple episodes of overnight and weekend leave.[7]

9. On 27 June 2015, she was discharged home.[8]

10. On her discharge from Donvale she was referred to the Yarra Ranges Health Community Rehabilitation Program (CRP) and was a client of the CRP from 1 July 2015 onward.[9] She attended speech therapy once a week and started to re-engage with activities such as golf and bowls.

11. She was described as having speech pathology intervention due to moderate-severe expressive dysphasia[10] and moderate receptive dysphasia post-stroke.[11]

12. On 6 August 2015 Mrs Vizard consulted Dr Evans of the Epworth Hospital. He noted she was able to write short sentences and that she was keen to return to driving. He assessed her visual fields and completed a VicRoads Medical Report form.

13. Mrs Rose, who accompanied her mother to the consultation, noted Dr Evans told Mrs Vizard he thought she would not get much better, and she was distressed by this and required consolation afterwards.

14. During her recovery and upon her return home, all of Mrs Vizard's family members noted personality changes following the stroke. These included Mrs Vizard acting in a 'very young' manner, inappropriate laughter, eating different foods and drinks, reading different types of

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[6] Medical records.
[7] Medical records.
[8] Medical records.
[9] Comments of Erin Wilson (Eastern Health), Coronial Brief p 51.
[10] 'Dysphasia' means a condition in which a person has difficulty in speaking and putting words into the correct order.
[11] Coronial Brief p 51.

books and forgetting her words. She also expressed a fear to Mrs Rose that her husband may leave her.

15. On 17 August 2015 Mrs Vizard attended a former neighbour's funeral in Mornington. Mr Vizard described her as in good spirits.[12]

16. That evening, Mrs Vizard spoke by telephone to Mrs Rose, as well as to a friend, Gwenda Cook, and her sister Larraine Godkin, all of whom similarly described Mrs Vizard as in good spirits.[13]

Circumstances proximate to death

17. On the morning of 18 August 2015 Mrs Vizard was intending to play golf at 8.00am, however, due to rain she decided to stay home. Mr Vizard was to drive her to the golf club presentations later that day.'[14]

18. At around 10.00am Mr Vizard attended the Yarra Junction Gymnasium. He returned home at around 11.00am.[15] This was the first time he had left Mrs Vizard alone since she had returned home.[16]

19. Mr Vizard returned home and believed Mrs Vizard to be in the laundry and thought he heard her answer her phone. He heated up a can of soup for lunch and called out to Mrs Vizard when it was ready. He then may have nodded off for ten minutes. At approximately 12.30pm he went out to the shed to get a spade to weed around the back patio area.

20. As he entered the shed he found Mrs Vizard hanging by an electrical cord tied to the rooftop framework. He immediately called "000" and requested for ambulance to attend and then called Mrs Rose.

21. Ambulance attended but Mrs Vizard was deceased, unable to be revived.

22. Senior Constable Ray Cook of Victoria Police attended shortly after.[17] S/C Cook observed that an aluminium step ladder was located near where Mrs Vizard had been found. Mr Vizard

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[12] Statement of Ray Vizard dated 23 January 2016, Coronial Brief p 13.
[13] Statement of Lea Rose dated 23 January 2016, Coronial Brief pp 16-17.
[14] Statement of Ray Vizard dated 23 January 2016, Coronial Brief p 13.
[15] Statement of S/C Ray Cook dated 31 January 2016, Coronial Brief p 26; Statement of Ray Vizard dated 23 January 2016, Coronial Brief p 13.
[16] Statement of Ray Vizard dated 23 January 2016, Coronial Brief pp 13-14.
[17] Statement of S/C Ray Cook dated 31 January 2016, Coronial Brief p 25.

recalled that he had last seen the step ladder on the deck of the house 10 metres from the shed, and that he did not recall moving it to the shed at any time.[18]

23. No note from Mrs Vizard was found.

24. Mrs Vizard had no known mental health issues, however in 1996 she had attempted to self-harm in front of Mr Vizard on account of his relationship with another woman.[19]

25. In the week before Mrs Vizard's death, Mrs Rose thought she was stressed and suggested she see Mrs Rose's cousin Merri Hughes, a psychologist. Mrs Vizard did so, and Mrs Rose reports that Ms Hughes saw no sign of depression or suicidal thoughts.[20]

26. Mr Vizard states that '*Yvonne said at times she wished she was dead but I didn't take her remarks as serious.*'[21]

27. Ms Portbury states that Mrs Vizard, '*...had stated to her that she had had enough of life and wished she was dead as life was hard for her.*'[22]

28. Dr David Church, her GP, states Mrs Vizard following her stroke had dysphasia of moderate severity and mild hemiparesis and that '*dysphasia is a universally frustrating and distressing symptom.*'[23]

Identification

29. On 18 August 2015 Ray Vizard visually identified his wife, Yvonne Rose Vizard, born 11 December 1942.

Cause of death

30. On 21 August 2015, Dr Michael Burke, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon Mrs Vizard's body and provided a written report, dated 10 September 2015. In his report, Dr Burke concluded that a reasonable cause of death was '*I(a) Hanging*'.

31. Dr Burke commented that:

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[18] Ibid.
[19] Statement of Sasha Portbury dated 26 January 2016, Coronial Brief p 23; see also statement of S/C Ray Cook dated 31 January 2016, Coronial Brief p 26 and statement of Lea Rose dated 23 January 2016, Coronial Brief p 20.
[20] Statement of Lea Rose dated 23 January 2016, Coronial Brief p 19.
[21] Statement of Ray Vizard dated 23 January 2016, Coronial Brief p 13.
[22] Statement of Sasha Portbury dated 26 January 2016, Coronial Brief p 51.
[23] Statement of Dr David Church dated 1 July 2016, Coronial Brief p 44.

'Death in hanging occurs as a result of (a) obstruction to the airway, (b) obstruction to the great vessels within the neck and (c) stimulation of the carotid body.'

32. Toxicological analysis did not identify the presence of ethanol (alcohol) or any other common drugs or poisons.

33. I accept Dr Burke's conclusions as to cause of death. I have noted the comments in his report, and concerns raised by the family regarding nomenclature. As 'hanging' is a reference to the mechanism of death rather than medical cause, I find that Mrs Vizard's medical cause of death can be formulated as *'I(a) Obstruction of the airways of the neck.'*

Coronial Investigation

34. Mrs Vizard's death was reported to the coroner as it appeared to be unnatural and so fell within the definition of a reportable death in the *Coroners Act 2008.*

35. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

36. A coronial brief was prepared which included statements from witnesses including Mrs Vizard's family members, her General Practitioner Dr David Church, the investigating officer and the forensic pathologist who examined Mrs Vizard after her death.

37. Statement from Mrs Vizard's family members on the coronial brief alerted me to the fact that stroke survivors had an increased risk of self-harm. I subsequently requested advice from the Coroners Prevention Unit (CPU)[24] about suicide in survivors of stroke and potential prevention opportunities.

38. Following advice from CPU, I contacted the Stroke Foundation and obtained details about their Clinical Guidelines for Stroke Management. I also asked the health service providers involved with Mrs Vizard's health care following her stroke for statements detailing their clinical

[24] 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. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

pathway, including screening for mood disorders as part of post stroke rehabilitation. Those statements form part of the coronial brief.

39. This finding does not purport to recite all of the evidence heard at Inquest, only that which is relevant to the statutory requirements, namely the identity, cause of death and circumstances as set out in section 67 of the Coroners Act 2008. Circumstances of death must be relevant and proximate to the death. The circumstances include a focus on the scope of the inquiry at inquest.

40. In the coronial jurisdiction facts must be established to the standard of proof which is the balance of probabilities.[25]

Request for Inquest and family concerns

41. Mrs Rose requested an Inquest into Mrs Vizard's death on 18 September 2016.[26]

42. Mrs Rose submitted a number of concerns (summarised) as follows:

    (a) The lack of information given to the family regarding the increased likelihood of suicide in stroke survivors and changes to mental health; and

    (b) The lack of information about the extent of damage caused to Mrs Vizard's brain by the stroke, both with the family and between her treating clinicians.

43. Mrs Rose was particularly concerned about the refusal by staff at Epworth HealthCare and Donvale Rehabilitation Hospital to provide her with copies of brain scans taken after Mrs Vizard's stroke. Mrs Rose stated that if the family had been given more information on these matters, they would have been in a better position to understand Mrs Vizard's condition and make choices regarding her support and care.

44. On 28 September 2016 Mrs Rose was advised pursuant to section 52(6) of the *Coroners Act 2008* that coronial investigations were continuing.

Coroners Prevention Unit review

45. Following Mrs Rose's Request for Inquest, I asked the CPU to consider the appropriateness of Mrs Vizard's medical and mental health care following her stroke.

<u>Medical care</u>

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[25] This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

[26] Form 26 Request for Inquest, Exhibit 4.

46. The CPU review concluded Mrs Vizard's GP, Dr Church's care was appropriate there was good communication by Epworth Hospital and Donvale Rehabilitation Hospital with Dr Church.

47. The CPU review also advised medical care by the Epworth Hospital was appropriate for the week she was there, as was the treatment provided by Donvale Rehabilitation Hospital.

48. Although there was an instance on 2 June 2015 when Mrs Vizard appeared to be overwhelmed when discussing a support group, otherwise the records showed Mrs Vizard to have been enthusiastic in participating in her rehabilitation program.

49. There was also communication from Donvale Rehabilitation Hospital to Eastern Health, which provided ongoing care after Mrs Vizard's discharge.

50. Mrs Viard participated in post-stroke rehabilitative programs and made functional gains. The CPU review noted that whilst the health services had no reason to suspect any psychiatric issues requiring Mrs Vizard to be referred for psychological care, neither had there been any purposeful screening and questioning of Mrs Vizard about her mood and how she was coping. The focus of Mrs Vizard's rehabilitation was on her physical recovery rather than her mental state.

Mental Health care

51. The CPU review found there was no routine screening or assessment of Mrs Vizard's mental state at Donvale Rehabilitation Hospital.[27] There was one cursory question asked at admission to the Eastern Health Yarra Ranges CRP.

52. Mrs Vizard's presentation to physicians did not include indicators of a mood disorder – it was only to her family members that Mrs Vizard expressed some of her doubts and concerns.

Stroke and suicide

53. The Stroke Foundation Clinical Guidelines for Stroke Management 2010 suggest post stroke routine screening for mood disorders with a validated tool and psychological strategies to prevent depression.

54. Mrs Vizard's medical records do show routine screening or use of a validated tool or prevention focussed psychological strategies.

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[27] Other than the existence of a 'Cognitive / Emotional State' heading on Case Conference forms

55. The National Stroke Foundation promotes education of clinicians, further research and strategies to promote access to psychological services post stroke.

56. The Stroke Foundation was invited to provide information to the coronial investigation regarding the current best practice and literature related to stroke and suicide. Associate Professor Bruce Campbell, Chair of the Stroke Foundation Clinical Council stated that:

'*Mood is frequently affected after a stroke, with depression recognised as the most common mood disturbance affecting survivors. ... Approximately one in three stroke survivors will be experiencing depression at any one time, in the first year after stroke. The proportion drops to one in four up to five years after stroke. Identification and appropriate management of mood disorders is recommended as an essential component in the rehabilitation and recovery plans of people with stroke.*'[28]

57. According to A/Prof Campbell, '*Current data suggests that in many instances this is not occurring.*'[29] Data collected from 32 Victorian hospitals for the Stroke Foundation's 2016 National Stroke Rehabilitation Audit indicated that:

'*Nearly half (44%) of Victorian stroke patients did not have documentation of a mood assessment during their rehabilitation admission;*

Of the 56% of patients who were assessed for mood, about half (51%) had an identified impairment (depression, emotionality and/or anxiety);

14% of patients with an identified mood impairment received no documented treatment; and

39% of patients with an identified mood impairment were seen by a psychologist.

Only 53% of hospitals in Victoria report regular involvement of clinical psychologists in the management of stroke patients'.[30]

58. The *Clinical Guidelines for Stroke Management (2010)*, published by the Stroke Foundation, have recently been updated and approved on 25 July 2017.

59. The 2010 guidelines included the following recommendations regarding mood disturbance:

'*Identification*

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[28] Submission of Associate Professor Bruce Campbell (Stroke Foundation) dated 16 May 2017, Coronial Brief p 104 (references omitted).
[29] Ibid.
[30] Ibid p 106.

1. *All patients should be screened for depression using a validated tool.*
2. *Patients with suspected altered mood (e.g. depression, anxiety, emotional lability) should be assessed by trained personnel using a standardised and validated scale.*
3. *Diagnosis should only be made following clinical interview.*

Prevention

4. *Psychological strategies (e.g. problem solving therapy, motivational interviewing) can be used to prevent depression after stroke.*
5. *Routine use of antidepressants to prevent post-stroke depression is NOT recommended.*

Intervention

6. *Antidepressants can be used for stroke patients who are depressed (following due consideration of the benefit and risk profile for the individual) and for those with emotional lability.*
7. *Psychological (cognitive-behavioural) intervention can be used for stroke patients who are depressed.*'[31]

60. The updated 2017 guidelines included a major change to point one regarding the screening of all stroke patients. The 2017 guidelines state that '*there is a lack of evidence about whether routine screening for depression outweighs the potential harms, or is cost effective, therefore specific recommendations about who should be screened and when cannot be made.*'[32]

61. In the Stroke Foundation's submission and the 2010 and 2017 Clinical Guidelines there is an absence of information about the importance of educating and advising family and carers about the potential for mood disorders post stroke and advice about when and where to seek help.

62. The CPU advice was that it is likely that Mrs Vizard developed an affective or other psychiatric disorder in the weeks after her discharge from hospital. The impact of stroke could have resulted in impulsivity and disinhibition that she did not have pre-stroke, which would increase her vulnerability to following through on any suicidal ideation.

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[31] Ibid p 105.
[32] Stroke Foundation, *Clinical Guidelines for Stroke Management 2017,* Chapter 6, Section 14.

63. Mrs Rose and her family believe that if they had had more information about the risks stroke survivors face post-recovery, this may have changed how they interpreted Mrs Vizard's behaviour and confidences about her sadness and wanting to end her life.

64. Mrs Vizard's death reveals the important role of families and care givers in recognising mental health issues or mood disturbance in stroke survivors after their return home.

Directions Hearings

65. In response to Mrs Rose's application for Inquest, the information from the CPU review of medical and mental health care and information provided by the Stroke Foundation I decided to hold an Inquest.

66. Two directions hearings were held on 20 March and 19 July 2018 at which members of Mrs Vizard's family including Mr Vizard, Mrs Rose and Ms Portbury expressed their concerns about her death and the issues they sought to be ventilated at a hearing.

67. The scope of the Inquest was to consider:

- What education and information should be provided to families and care givers about the risk of suicide post stroke (and the implication of changes to mood, cognitive function and personality) they need to be aware of;
- How to recognise and strengthen the family and care giver role in monitoring mood changes that might indicate the need for referral;
- What sort of psychological testing should be done at the rehabilitation stage, including a consideration of its utility and effectiveness; and,
- Is there a benefit in providing families with the brain scans regarding the 'extent of injury'?

Inquest

68. The Inquest was held on 28 August 2018. Two witnesses were called: Mrs Lea Rose gave evidence and was spokesperson for the Vizard family, and expert evidence was heard from Professor Ian Kneebone from the Stroke Foundation.

Mrs Lea Rose's evidence

69. Mrs Rose's statements were read to the court (Exhibits 1 & 2) and her additional statement, request for Inquest, email and summary of concerns were tendered as Exhibits 3, 4, 5 & 6.

70. Sergeant Weir took Mrs Rose to a number items in the coronial brief such as the Stroke Rehabilitation Booklet from Donvale Rehabilitation Hospital.[33] Mrs Rose gave evidence she was unable to relate the information in the booklet to her mother's situation: '*Because I hadn't had any medical information shared to me by her specialists...*'[34]

71. Since looking at that material Mrs Rose's evidence was the booklet related to someone with problems with their physical body after stroke, *'and mum wasn't even presenting like that...She didn't have any physical problems at all.*'[35]

72. Sergeant Weir also took Mrs Rose to the Stroke Foundation's publication, '*My Stroke Journey*' (Exhibit 9). Mrs Rose noted the booklet was '*very good*' but lacked information about '*risk of suicide, ...mood changes or personality changes.*'[36] Mrs Rose noted that although the family had kept a journal recording hospital visitors, it stopped once she went home. She was of the view that keeping a journal in which the family recorded changes in mood or personality could have made a vital difference.

73. Mrs Rose indicated she and her family were not made sufficiently aware by medical staff about the seriousness of Mrs Vizard's stroke, and that she was under the impression her mother's '*brain was fine and all had cleared.*'[37] Mrs Rose noted she had only recently read in the medical records that her mother had an '*acute medical situation.*' She also referred to gaps in the discharge process from rehabilitation to home, for example, Mrs Vizard's personality changes were not discussed with the family nor were they advised about the higher risk of suicide or depression in stroke survivors.

Evidence of Professor Ian Kneebone

74. Professor Kneebone adopted and read the statement of Bruce Campbell, Chair of the Stroke Foundation Clinical Council (Exhibit 7), and was taken to specific questions provided previously from the court by Sergeant Weir (Exhibit 8).

75. Professor Kneebone's evidence touched on the change to the 2017 Stroke Foundation Clinical Guidelines, namely, that the recommendation for routine screening for mood disturbances is no longer supported as it cannot be determined *who* should be screened and *when*.

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[33] Coronial Brief p 63.
[34] Transcript p 11.
[35] Transcript p 12.
[36] Transcript p 13.
[37] Transcript p 18.

76. Professor Kneebone elaborated that mood disturbance can occur any time after stroke.

77. He distinguished mood and behaviour changes and clarified that personality changes in stroke survivors, such as changes to taste and emotional lability can occur with or without depression.[38] He agreed there was an important role for family in identifying these changes once a stroke survivor was discharged home and that information and training for families could include identification, risk and the steps families can take as to who to contact for assistance, advice and referral.[39]

78. With respect to the families' concerns about accessing the brain scans, Professor Kneebone was of the view that providing copies of the brain scans to families could help inform families in layman's terms about the extent of brain injury.

79. Professor Kneebone elaborated that information about depression and anxiety, which are common following a stroke, should be provided to families so that they could report back to the medical team.

80. Professor Kneebone confirmed that the rate of suicide in stroke survivors was double in this first two years following stroke and that this information was commonly omitted, he suspected, because although the rate is doubled, the rate of suicide itself is low.[40] [41]

81. Professor Kneebone alerted the Inquest to the current research specific to aphasia[42] and emotional difficulties following stroke. He referred to recent funding, part of which will '*be devoted to providing research to develop... treatments for depression for people with aphasia after stroke.*'[43]

82. Professor Kneebone explained that aphasia is being researched, firstly because it is under-researched, and secondly because '*aphasia could double the rate of depression in stroke.... So*

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[38] Transcript p 27.
[39] Transcript p 28.
[40] Transcript p 31.
[41] The Coroners Prevention Unit has confirmed stroke as a contributing factor in a completed suicide is low when compared across all suicides for the whole population data. Nonetheless, stroke patients are at an increased risk of suicide and often become depressed following their stroke, which contributes to suicidal ideation, suicide attempts and suicide death. In addition, stroke survivors are at an approximately doubled risk for suicide and the risk appears to decline with time after a stroke, being greatest within the first five years. One third of patients with stroke suffer from communication disorders, including dysphasia which seems to increase the risk of depression.
[42] 'Aphasia' is a condition in which a person is unable to speak or write, or to understand speech or writing because of damage to the brain centres controlling speech.
[43] Transcript p 32.

when we are talking about that around 30% of people have expressed depression after stroke, the limited information we have is about 60% of people with aphasia.'[44]

83. Professor Kneebone stated that screening for mood disturbance or depression, which is '*remarkably persistent*' and common at any time post stroke, should happen at any time. When specifically questioned about which stage of rehabilitation he noted: '*...we do get people to do it when they are in the acute sector, if that's possible...because we have seen, the further that people get away from the hospital, the less contact with services, the less chance to pick up these pre-disorders.*'[45]

84. Professor Kneebone noted there were methods available to screen for depression in stroke survivors with speech difficulties and that his research team at the University of Surrey had developed a measure called the 'Behavioural outcomes of anxiety' which screens for anxiety in people with aphasia which uses an observation scale. He also described an instrument to screen for mood which is designed for family or carers who know the person well to complete.

85. With respect to the value of the brain scan to identify mood disorders, Professor Kneebone stated that whilst there are centres in the brain known to be responsible, for example, movement, it is not possible to identify those brain parts that if damaged would cause a mood disturbance. Professor Kneebone also clarified what 'recovery' means in a stroke survivor and stated: '*...we're not particularly sophisticated in understanding this mechanism but certainly there is recovery, brain cells recover...other brain cells take over previous functions...*'[46] Professor Kneebone also considered what Mrs Vizard's family may have understood 'recovery' to mean and whether the brain would return to its pre-stroke state: *'...a third of people with stroke do have a very good recovery over time, but its highly variable. It's hard to predict in many ways...people could be recovering well physically...but you know emotionally there can still be an impact, particularly in the face of a major communication disorder.*'[47]

86. Mrs Rose asked Professor Kneebone to comment on the fact that whilst her mother did not present with a low mood, she did have a significant personality change post stroke. Professor Kneebone noted post stroke euphoria is not unusual and that depression can occur any time after stroke. He opined it was possible this developed in Mrs Vizard on her discharge home.[48] He

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[44] Transcript p 32 -33.
[45] Transcript p 33.
[46] Transcript p 41.
[47] Transcript p 42.
[48] Transcript p 44.

emphasised the importance of vigilance to the emergence of depression so that it is not missed simply because it was not present on an initial screening.

87. Professor Kneebone agreed it was important for families of stroke survivors to be aware that depression rates were 60% in instances of stroke survivors with aphasia. He also noted that in people who have had depression pre-stroke, this is one of the biggest risk factors for depression developing. '*So I think there's room for guidance to say that if people have had depression in the past and they've got aphasia...there's a couple of major risk factors for depression [they should] be aware of. That may make people enough of an indication to screen them in that circumstance.*'[49]

88. Professor Kneebone did not endorse mandatory counselling for stroke patients as part of their rehabilitation. Firstly, he was not of the view everyone needed to be seen by a counsellor, and stated: '*...we are never going to have infinite resources...for counselling for everyone.*'[50] In his view there are other methods that could be employed to prevent potential mood disorders such as the use of support groups, relaxation, music and art therapy and leisure rehabilitation. This could then save resources for those identified based on need.

89. Professor Kneebone also mentioned as an alternative to counselling the potential value of motivational interviewing[51] to look at dealing with adversity post stroke, '*...there's a potential for that to make a difference to the onset of depression after stroke and also things like problem solving.*'[52] Professor Kneebone made the point that research was needed to determine if the evidence supported the effectiveness of this type of strategy, namely that '*if people rehabilitate better, they cost society less, so it's a good investment.*'[53]

90. Professor Kneebone noted there were currently too few psychologists working with people with aphasia which was an area he was hoping to change. Researchers at La Trobe University were currently considering counselling training for speech pathologists so that they can support people with aphasia after stroke. He was also responsive to Mrs Rose's request that her mother's case be used to support research in this area of stroke survivors with dysphasia.

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[49] Transcript p 46.
[50] Transcript p 51.
[51] Motivational interviewing is a counselling method that enhances motivation through the resolution of ambivalence.
[52] Transcript p 53.
[53] Transcript p 53.

Conclusions

91. The evidence at Inquest highlight deficiencies in the information provided to families and care givers of stroke survivors, particularly with regards to the risk of depression developing when discharged home and the increased risk of suicide.

92. I accept Professor Kneebone's evidence which did not support either routine screening for mood disturbances or mandatory counselling for all stroke survivors.

93. Professor Kneebone did note there was a benefit in families being provided with copies of brain scans to help them understand the extent of the brain injury, but was cautious as to whether the brain scan could help identify the presence of, for example, a mood disorder.

94. My recommendations support the importance of education and information for families and caregivers of stroke survivors about both the risks of developing depression or a mood disturbance and how to seek help.

95. The principles illustrated in this case potentially have a broader application to the mental health issues facing those suffering from chronic long term illnesses.

Intent

96. On the basis of the evidence I am satisfied Mrs Vizard intended to end her own life.

Findings

97. I find that Yvonne Rose Vizard, born 11 December 1942, died from obstruction of the airways of the neck on 18 August 2015 at 10 Peppercorn Place, Yarra Junction, Victoria.

98. I direct a copy of this Finding be provided to the Registry of Births, Deaths and Marriages to amend the cause of death.

Recommendations pursuant to section 72(2) of the *Coroners Act 2008*

To the Stroke Foundation:

1. That the clinical guidelines include specific and timely education for family and caregivers of stroke survivors which recognises their risk for the development of depression, particularly in the year post recovery and the increased risk of self-harm following stroke. It should note that one in three stroke survivors is at risk of developing depression and stroke may double the risk of suicide even in the absence of a diagnosed depressive disorder.

2. As half of stroke survivors are likely to experience a change in their mood or mental state, education should also include how family and caregivers can monitor how the stroke survivor is adapting to post-stroke living, what behaviours are attributable to the effects of the stroke and the type of red-flags that might indicate the need for referral, and when and where to seek help. In addition and where relevant, this should include families and caregivers of stroke survivors with dysphasia being made aware (1) the high risk survivors have (60%) of developing depression, and (2) that if the stroke survivor had a prior history of depression and dysphasia, that these are two major risk factors for depression.

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

I direct that a copy of this finding be provided to the Registrar of Births, Deaths and Marriages to amend the cause of death.

I convey my sincere condolences to Mrs Vizard's family for their tragic loss.

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

Mr Ray Vizard, Senior Next of Kin

Mrs Lea Rose

Mr Bruce Campbell, Chair, Stroke Foundation Clinical Council

Dr David Church

Dr Debra O'Brien, Director of Medical Services, Epworth Richmond

Caroline Andrew, Director of Clinical Services, Donvale Rehabilitation Hospital

Erin Wilson, Associate Program Director, Specialty Medicine and Ambulatory Care, Eastern Health

Dr Yvette Kozielski, Medico-Legal Officer, Eastern Health

Leading Senior Constable Ray Cook, Coroner's Investigator

Signature:

CAITLIN ENGLISH

CORONER

Date: 5 October 2018