IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 4498

FINDING INTO DEATH WITH INQUEST

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

Findings of:	Simon McGregor, Coroner
Deceased:	**Patricia O'Connor**
Date of birth:	6 April 1933
Date of death:	7 September 2017
Cause of death:	I(a) Multisystem organ failure I(b) Fall resulting in hip fracture (operated)
Place of death:	Western Hospital, 160 Gordon Street, Footscray, Victoria 3011

HIS HONOUR:

INTRODUCTION

1. Patricia O'Connor was an 84-year-old woman who lived with her son, Geoffrey O'Connor, at 103 Pier Street, Altona, Victoria at the time of her death.

2. Patricia suffered from bipolar affective disorder, amongst other conditions, and was admitted to Sunshine Aged Persons Mental Health Unit ('APMHU') as an involuntary patient on 15 August 2017, following a relapse of her bipolar disorder. On 25 August 2017, while receiving treatment in the facility, Mrs O'Connor fell and fractured her right femur. She was transferred to Western Hospital and underwent orthopaedic surgery on 27 August 2017.

3. Following the surgery, Mrs O'Connor's condition deteriorated, and she was palliated. She died in hospital on 7 September 2017 from multisystem organ failure related to complications from the fall.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Mrs O'Connor's death was reported to the Coroner as it appeared to have resulted, directly or indirectly, from an accident or injury and so fell within the definition of a reportable death in the *Coroners Act 2008* ('Act').

5. As Ms O'Connor was an involuntary inpatient under a Temporary Treatment Order pursuant to the *Mental Health Act 2014* (Vic) ('Mental Health Act') at the time of her death,[1] she was considered to be 'a person placed in custody or care'. Consequently, the Act mandates I hold an inquest into her death.[2] This was achieved by way of Summary Inquest held at the Coroners Court of Victoria on 2 October 2019.

6. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[3] 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.

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[1] Western Health medical records.
[2] Section 52(2)(b).
[3] Section 89(4).

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. In the coronial jurisdiction facts must be established on the balance of probabilities. This is subject to the principles enunciated in *Briginshaw v Briginshaw*.[4] 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.

9. A coronial brief was prepared in this matter. The brief includes statements from NorthWestern Mental Health, the forensic pathologist who examined Mrs O'Connor, and Mrs O'Connor's clinical records and medical history. Accordingly, I have made a thorough forensic examination of the evidence, including reading and considering the statements and other documents contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

10. In considering the issues associated with this finding, I have been mindful of Mrs O'Connor's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

BACKGROUND

11. Mrs O'Connor was born in Laverton, Victoria and left school at age 15. She married Geoffrey O'Connor with whom she had six children, three girls and three boys.[5]

12. Prior to her death, Mrs O'Connor's husband moved to a nursing home due to illness and she continued to live relatively independently at home with her son Geoffrey, aside from her involuntary admissions.[6]

Medical history

13. Mrs O'Connor attended Civic Parade Medical Centre where she saw Dr Shawkat Kamal, general practitioner, for regular reviews and medication prescriptions.[7] Mrs O'Connor's co-

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[4] (1938) 60 CLR 336.
[5] Western Health medical records.
[6] Ibid.

morbidities included bipolar disorder, schizophrenia, hypertension, diabetes mellitus and coronary artery bypass graft surgery.[8]

14. According to her medical records, Mrs O'Connor was first admitted to hospital with paranoid delusions in 1964. She subsequently underwent further admissions to hospital over the years for a combination of paranoia and hypomanic behaviour. Most of these admissions occurred in the context of medication non-compliance and were involuntary. There were eight admissions recorded in total.[9]

15. Mrs O'Connor was well known to the Western Aged Psychiatry Assessment & Treatment Team (APATT) between 2001 and 2015. Her last psychiatric admission prior to the admission in August 2017, was in November 2014. Mrs O'Connor was discharged from APATT to her General Practitioner in February 2015.[10]

16. Mrs O'Connor was trialled on a number of mood stabilising medications over the years and prescribed zuclopenthixol between 2001 and 2014.[11] From the available medical records, prior to her admission to the APMHU, it did not appear Mr's O'Connor's general practitioner was prescribing medication to treat her mental illness, and it is unclear whether she was taking any such medication.[12]

August 2017

17. Late on 13 August 2017, Geoffrey called emergency services as his mother was exhibiting concerning behaviours and her mental state had deteriorated over the past two weeks.[13] Police attended the residence and an ambulance transferred Mrs O'Connor to the Werribee Hospital Emergency Department in the early hours of 14 August 2017.[14] She was placed on a Temporary Treatment Order pursuant to the Mental Health Act.[15]

18. It was reported that Mrs O'Connor had been behaving erratically, was non-compliant with her diabetes medication, was making threats to her son, talking to herself and unable to

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[7] Civic Parade Medical Centre medical records.
[8] Western Health medical records; Statement of Janet Farrell dated 6 August 2018.
[9] Ibid.
[10] Statement of Janet Farrell dated 6 August 2018.
[11] Western Health medical records.
[12] Ibid; Civic Parade Medical Centre medical records.
[13] Western Health medical records.
[14] Western Health medical records, VACIS patient care report.
[15] Western Health medical records.

organise her thoughts.[16] Hospital records noted Geoffrey O'Connor reported his mother's elevated and irritable behaviour had increased over the past 12 months.[17]

19. While in hospital on 15 August 2017, Mrs O'Connor was reviewed by a psychiatrist and her involuntary status was maintained.[18] She was transferred from Werribee Hospital and admitted to the Sunshine APMHU, a Melbourne Heath facility, to receive treatment for a manic relapse of her bipolar disorder.[19]

Assessment and treatment at APMHU

20. Mrs O'Connor underwent risk screening and evaluation on her admission to APMHU.[20] On assessment, Mrs O'Connor's affect was reported to be labile, irritable, elevated and her judgment impaired by mania. However, she did not exhibit psychotic symptoms or grandiose delusions.[21] She was not at risk of self-harm or a risk to others.[22]

21. Mrs O'Connor declined a full physical examination, however, was described as "robust for her 85 [sic] years".[23] She was without sensory impairment and did not need assistance for transfers or ambulation.[24] She was ambulating without aids and noted not to have had a history of falls in the last 6 months.[25] Despite this recorded history, I note that in a letter to her local council, Mrs O'Connor's general practitioner stated she had a fall in approximately July 2017.

22. While admitted to APMHU, Mrs O'Connor was treated with paliperidone and olanzapine and given intramuscular injections when refusing oral medications.[26] Early on in the admission, her mental state did not improve and she was nursed on 15-minute, close observations.[27] Following further non-improvement, her medication dosages were increased, and she was nursed in a low-stimulus area. She was often non-compliant with nursing interventions, unpredictable and difficult to redirect and engage.[28]

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[16] Western Health medical records.
[17] Ibid.
[18] Statement of Janet Farrell dated 6 August 2018.
[19] Western Health medical records; Statement of Janet Farrell dated 6 August 2018.
[20] Western Health medical records.
[21] Ibid.
[22] Ibid.
[23] Ibid.
[24] Ibid.
[25] Ibid.
[26] Statement of Janet Farrell dated 6 August 2018.
[27] Ibid.
[28] Western Health medical records; Statement of Janet Farrell dated 6 August 2018.

23. In accordance with Melbourne Health's Falls Minimisation Policy, Mrs O'Connor was assessed as a "high falls risk".[29] In line with Melbourne Health protocols, Mrs O'Connor was required to wear non-slip socks and well-fitting shoes, and encouraged and reminded to use her gait aid.[30] Further, a falls risk indicator was placed on her file and an alert sign in her bedroom.[31]

24. During her admission, she was noted to frequently wander around the unit and would not sit for long periods.[32] Records indicated she would ambulate around the unit with a four-wheeled frame,[33] however, she was not always compliant with its use and would have to be redirected to use the gait aid.[34]

25. On 24 August 2017, at approximately 8:40pm, Mrs O'Connor intruded into another patient's bedroom. She was asked to leave when she overbalanced and fell to the floor, striking her head. She was assessed for injuries with none noted and did not complain of pain. Her neurological observations were taken and within normal range and she was noted to be walking as normal.

26. The following day, Mrs O'Connor was reviewed by the psychiatry registrar, although she was uncooperative. She was eventually examined and, apart from a minor graze noted on her back, there were no other medical complications, and neurological observations were ceased. Nonetheless, she continued to be nursed on 15-minute observations and her falls risk assessment was reviewed and updated.[35]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

27. On 25 August 2017, Mrs O'Connor was reported to be restless and wandering around the unit. At approximately 6:00pm, she lost her balance and fell while independently mobilising with her frame in the lounge of the low-stimulus area.[36] Mrs O'Connor initially resisted assistance from staff, however, complained of pain in her right leg. She declined oral analgesia and the on-call psychiatry registrar attended the unit and assessed her.[37]

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[29] Statement of Janet Farrell dated 6 August 2018.
[30] Ibid.
[31] Ibid.
[32] Western Health medical records.
[33] Ibid.
[34] Statement of Janet Farrell dated 6 August 2018.
[35] Western Health medical records; Statement of Janet Farrell dated 6 August 2018.
[36] Statement of Janet Farrell dated 6 August 2018.
[37] Western Health medical records; Statement of Janet Farrell dated 6 August 2018.

28. Mrs O'Connor underwent an x-ray which demonstrated a fracture to her right femur, however, she was unable to be transferred to the Emergency Department, as they did not have a bed available. She was instead nursed on a trolley in the unit and transferred to the Western Hospital for surgery on 26 August 2017 at approximately 11:30am.[38]

29. On 26 August 2017, it was reported Mrs O'Connor exhibited seizure like behaviours, however, she refused treatment and clinicians could not obtain bloods for further assessment.[39]

30. On 27 August 2017, with consent from her family, she underwent an uncomplicated surgical fixation of the right femoral shaft fracture.[40] Before and after surgery, Mrs O'Connor was difficult to manage due to her acute mania and severe agitation, which was likely exacerbated by pain and delirium.[41] Mrs O'Connor exhibited challenging and aggressive behaviours, requiring the use of restraints in order to be treated.[42] Her behaviour remained agitated and difficult to manage while on the ward until 30 August 2017, compromising hospital staff's ability to provide effective treatment.[43]

31. Following her surgery, Mrs O'Connor's condition deteriorated, and she suffered post-operative anaemia. However, a blood transfusion was unable to be administered due to Mrs O'Connor's agitation. The attending staff simply could not gain vascular access.[44] On 30 August 2017, a code blue was recorded as Mrs O'Connor exhibited signs of reduced consciousness and low blood pressure.[45]

32. A meeting was held with Mrs O'Connor's family on 30 August 2017 at the hospital. Mrs O'Connor's treaters explained she was difficult to manage and treat post-operatively due to her severe agitation, which at times required restraints. Care could only be provided opportunistically, and treaters did not want to cause Mrs O'Connor excessive distress.[46] In accordance with her family's wishes, the decision was made to avoid restraints and monitor her condition on the ward.[47]

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[38] Western Health medical records; Statement of Janet Farrell dated 6 August 2018.
[39] Ibid.
[40] Western Health medical records; Statement of Janet Farrell dated 6 August 2018; E-Medical Deposition Form.
[41] Western Health medical records; E-Medical Deposition Form.
[42] Western Health medical records; Statement of Janet Farrell dated 6 August 2018; E-Medical Deposition Form.
[43] Western Health medical records.
[44] Western Health medical records; E-Medical Deposition Form.
[45] Ibid.
[46] NWMH Assessment, Western Health medical records.
[47] Ibid.

33. Unfortunately, Mrs O'Connor remained hypertensive. Given her poor prognosis, previously known wishes and discussions with her family, the decision was made to palliate her. Comfort measures were instituted. Mrs O'Connor remained comfortable in hospital until she was declared deceased on 7 September 2017.

IDENTITY AND CAUSE OF DEATH

34. On 7 September 2017, Michael O'Connor visually identified the body of his mother, Patricia O'Connor, born 6 April 1933. Identity is not in dispute and requires no further investigation.

35. On 8 September 2017, Dr Malcolm Dodd, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination on Mrs O'Connor's body and reviewed a post mortem computed tomography (CT scan), the E-Medical Deposition Form and the Police Report of Death for the Coroner. Dr Dodd provided a written report, dated 18 September 2017, in which he formulated the cause of death as '*I(a) Multisystem organ failure; I(b) Fall resulting in hip fracture (operated)*'.

36. Toxicological analysis of post mortem samples was not performed.

37. Dr Dodd commented the immediate cause of death in this case was best regarded as multisystem organ failure in an elderly woman who had fallen, resulting in a hip fracture.

38. I accept Dr Dodd's opinion as to cause of death.

REVIEW OF CARE

39. At her admission to Sunshine APMHU, Mrs O'Connor underwent a risk assessment screening and a Falls Risk Assessment Tool was completed. The relevant protocols were subsequently followed given Mrs O'Connor's identification as a high falls risk. She was encouraged to use an aid when ambulating around the unit and wear non-slip socks, and she was under close observations at time of the critical incident, following her fall on 24 August 2017.

40. Mrs O'Connor's medical records demonstrate she exhibited challenging behaviours while admitted to APMHU. These included frequently ambulating around the unit, exhibiting intrusive behaviours and being difficult to engage, all factors which increased her risk of injury.

41. I do note however, WesternHealth stated their processes were not fully complied with as Mrs O'Connor was not transferred out of the acute Mental Health Unit when she was medically compromised, due to the unavailability of an orthopaedic bed.[48] While this course would have been preferable and may have reduced Mrs O'Connor's agitation prior to surgery, I do not consider this created a material detriment to her health.

42. Further, while she was a patient at Western Hospital, Mrs O'Connor suffered from complications which were known risk factors associated with her surgery.[49] Her mental state and behaviours made it difficult for appropriate care to be administered without creating excessive distress for Mrs O'Connor.

43. Accordingly, I am satisfied with level of care Mrs O'Connor received at Sunshine APMHU and Western Hospital given the challenging features of her mental health during those admissions.

FINDINGS AND CONCLUSION

44. I express my sincere condolences to Mrs O'Connor's family and friends for their loss.

45. Having investigated the death by holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was Patricia O'Connor, born 6 April 1933;

    (b) The death occurred on 7 September 2017 at Western Hospital Footscray from multisystem organ failure related to complications from a fall; and

    (c) The death occurred in the circumstances described above.

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

[48] Statement of Janet Farrell dated 6 August 2018.

[49] The e-medical deposition form noted death was not an unexpected outcome.

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

(a) Mr Geoffrey O'Connor and Mr Michael O'Connor, senior next of kin;

(b) Dr Neil Coventry, Office of the Chief Psychiatrist;

(c) Mr Peter Kelly, North Western Mental Health; and

(d) Senior Constable Matthew Wright, Coroner's Investigator.

Signature:

SIMON McGREGOR
CORONER
Date: 15 October 2019