IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 4763

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Simon McGregor, Coroner
Deceased:	Ian Lindsay Gould
Date of birth:	16 August 1955
Date of death:	4 September 2019
Cause of death:	1(a) Complications of Creutzfeldt-Jakob Disease following a fall
Place of death:	St Vincent's Hospital 41 Victoria Parade, Fitzroy, Victoria

INTRODUCTION

1. Ian Lindsay Gould **(Ian)** was a 64-year-old man who lived with his wife in Rainbow at the time of his death. He died after a fall in hospital.

THE CORONIAL INVESTIGATION

2. Ian's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

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.

4. 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.

5. Constable Aiden Blake filed a report describing the circumstances of Ian's death. In response to my further request, Ballarat Health Services (**BHS**) provided their medical records and prepared a statement in this matter. I have also received information provided by the Senior Next of Kin, the forensic pathologist and other medical records.

6. This finding draws on the totality of the coronial investigation into the death of Ian Lindsay Gould. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

7. In considering the issues associated with this finding, I have been mindful of Ian'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.

[1] 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.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

8. Ian was described by his wife and family as an active and vibrant member of his community who had successfully built his own business, as well as lovingly raising his family, until he unfortunately began suffering vision loss in June 2019.[2] Prior to this, he had a past medical history of tachy-brady syndrome[3] (for which a permanent pacemaker was inserted in 2005), deep vein thrombosis, peptic ulcer disease and hypercholesterolaemia. His medications included Rivaroxaban[4], Ezetimibe[5] and pantoprazole[6].

9. On 21 June 2019, Ian was reviewed by neurologist and neuro-ophthalmologist Dr Neil Shuey[7] who found he had normal results from a neurologic and ophthalmologic exam[8]. A CT brain scan revealed no abnormality. An MRI was not performed because Ian's pacemaker was not MRI compatible[9]. Dr Shuey noted that Ian was very anxious and depressed and given that no medical cause for his symptoms could be found, queried a diagnosis of functional visual loss[10] and suggested he be referred for a psychological assessment.

10. Ian had that assessment in late July 2019, and was noted to be significantly depressed, with suicidal ideation. As a result, he was referred to BHS Emergency Department for a psychiatric assessment. On 1 August 2019, the BHS psychiatric team concluded that Ian met the diagnostic criteria for a major depressive illness[11] and he was also given a provisional diagnosis of

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[2] Statement of Lynne Gould dated 26 September 2019, Coronial Brief.

[3] A variant of atrial fibrillation where the irregular heart rhythm can go either very fast or so slow that the patient collapses. A pacemaker prevents the latter.

[4] A Direct Oral Anticoagulant (DOAC). A blood thinning agent similar to warfarin that decreases the recurrence of deep vein thrombosis.

[5] Cholesterol lowering medication

[6] A proton pump inhibitor commonly prescribed for gastroesophageal reflux but also as an agent to decrease the incidence of gastric bleeding when on agents such as rivaroxaban.

[7] Dr Shuey trained as an optometrist, then as a doctor specializing in neurology, then completed two fellowships in neuroopthalmology. He currently heads the neuro-ophthalmology clinic at the Royal Victorian Eye and Ear Hospital.

[8] Including having preserved visual acuity (i.e. a normal eye-chart test) whilst stating he was blind.

[9] Pacemakers are electronic devices that fire synchronized electrical activity to make the heart contract in patients whose natural cardiac rhythm is abnormal or absent. MRIs obtain images by generating a very powerful magnetic field. Early pacemakers were not designed to be compatible with MRI technology and are instantly and permanently damaged by MRIs which has resulted in patient deaths in the past. Newer pacemakers are MRI compatible.

[10] Functional neurologic symptom disorder or conversion disorder is a recognized psychiatric disorder. It is sometimes applied to patients who present with neurological symptoms, such as numbness, blindness, paralysis, or fits, which are not consistent with a well-established organic cause, which cause significant distress, and can be traced back to a psychological trigger. It is thought that these symptoms arise in response to stressful situations affecting a patient's mental health or an ongoing mental health condition such as depression – in Mr Gould's case, his father in law's recent death and son in law's two open heart surgeries.

[11] Lowered mood, reduced weight, reduced sleep, loss of motivation and energy, increased tearfulness and decreased coping.

functional visual loss.[12] Ian was admitted to BHS's Steele Haughton Unit for Acute Aged Mental Health as a voluntary patient. On admission, Ian was assessed as a high falls-risk and a falls prevention strategy was enacted. [13]

11. On 7 August 2019, whilst walking back to his bedroom, Ian fell backwards down onto his buttocks then further backwards, hitting his head with sufficient force to send his glasses sprawling.[14] He was assessed by medical staff and found to be orientated and showing no signs of bruising and complained only of sore buttocks. As per BHS policy, Ian had neurological observations which remained stable.

12. Over the following days, Ian became increasingly anxious, agitated and tremulous, and his mobility decreased. This progressed to increased limb stiffness, decreased oral intake and an inability to speak.

13. On 11 August 2019, Ian was noted to have a fever and a fast heart rate and so was transferred to the BHS Emergency Department for further investigation. A CT brain scan was performed which showed bilateral occipital haemorrhage.[15] The images were sent to the Royal Melbourne Hospital neurosurgical team for an opinion. The advice was that no surgical intervention was necessary, so Ian could stay in Ballarat and just have his anticoagulation reversed and the CT scan repeated the following day to ensure that there was no progression of the bleed.

14. Overnight, however, Ian's level of consciousness declined and he was intubated and placed on a ventilator.[16] The next CT scan showed no progression of his intracerebral bleed to account for the drop in consciousness. Ian also showed signs of hypertonia,[17] clonus[18] and a fever, which symptoms were not explained by the abnormalities seen on the CT scan. Differential diagnoses were considered and treated at the same time, including status epilepticus,[19] serotonin syndrome[20] and sepsis[21]. Given the complexity of this case, Ian was transferred to St Vincent's

[12] The diagnosis is provisional as it could only be proven to be a conversion disorder if his symptoms resolved with the treatment of his depression.
[13] Obstacles removed, call button within reach, room near nurses' station, floor sensor mat, supervision in shower and observation/ assistance of staff or family when walking
[14] Statement of Lynne Gould dated 26 September 2019, Coronial Brief.
[15] The posterior aspect of the brain.
[16] As a patient's conscious state drops, the risk of the patient vomiting and aspirating increases. Intubation prevents this by placing a breathing tube in the airway protecting it from vomitus. The patient needs a general anaesthetic to tolerate the breathing tube which in turn is attached to the ventilator.
[17] Stiff limbs.
[18] Rhythmically jerky limbs.
[19] Continuous ongoing seizure activity – treated with numerous antiepileptic agents and general anesthesia
[20] Potentially life-threatening syndrome of increased tone and temperature caused the interaction of some psychiatric medications. Is treated by ceasing offending agents and starting the medication cyproheptadine.
[21] Suggested by the fever and treated with broad spectrum antibiotics.

Hospital Intensive Care Unit (**ICU**) for neurosurgical and neurological input on 12 August 2019.

15. On 13 August 2019, the neurosurgical team inserted an intracranial pressure monitor. It did not show raised intracranial pressure, indicating that Ian's symptoms were likely unrelated to his intracerebral bleeding and that no neurosurgical intervention was indicated.

16. On 14 August 2019 an electroencephalogram (**EEG**) showed ongoing status epilepticus despite numerous antiepileptic medications.

17. On 19 August 2019, an MRI was performed with the cardiologist in the MRI scanner ready to respond to any pacemaker failure and to ensure it was still functioning properly after the MRI. The MRI showed non-specific changes that given the clinical context raised the possibility of a neurodegenerative disorder such as Creutzfeldt-Jakob Disease (**CJD**).[22]

18. On 22 August 2019, a lumbar puncture was performed and cerebrospinal fluid was sent for CJD testing at Melbourne University's Florey Institute.[23] Ian's family were counselled about the diagnosis. The result strongly indicated the sporadic version of CJD.[24]

19. On 28 August 2019 a brain biopsy was performed by the neurosurgical team. This also conform a spongiform encephalopathy consistent with CJD.

20. On 3 September 2019, Ian was extubated and transferred to the palliative care ward where he died the following day

Identity of the deceased

21. Lynne Gould visually identified her husband Ian Lindsay Gould, born 16 August 1955.

22. Identity is not in dispute and requires no further investigation.

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[22] Creutzfeldt-Jakob Disease is a rapidly progressive and fatal disease. It is one of a group of rare diseases that affects humans and animals, known as transmissible spongiform encephalopathies (TSEs). CJD is characterised by irreversible physical deterioration of the brain with the majority of patients dying within six months. There is no treatment or cure. CJD in very rare; approximately 1 case per million people per year.

[23] The Florey Institute is the Australian CJD registry. It also performs contact tracing and genetic counselling for non-sporadic types of CJD

[24] Sporadic CJD accounts for the greatest number of human deaths from this group of diseases. Other causes include genetic and acquired. Sporadic CJD affects approximately one person per million people each year. CJD most often affects people between the ages of 50 to 70 years of age. The cause of sporadic CJD is unknown.

Medical cause of death

23. Forensic Pathologist Dr Linda Iles from the Victorian Institute of Forensic Medicine **(VIFM)**, conducted an examination of Ian and provided a written report of her findings. Dr Illes commented that the post-mortem CT scan did not demonstrate any large residual occipital haemorrhages, and the comparison of this clinical feature to the rapidity of his neurological decline meant that the fall was likely to be of much less significance than the progress of his Creutzfeldt-Jakob Disease.

24. Hence Dr Iles concluded that a reasonable cause of death was:

    1(a) Complications of Creutzfeldt Jakob Disease following a fall.

25. I accept Dr Iles' opinion..

REVIEW OF CARE

26. In a letter to the Coroner, Ian's wife expressed concern that he was not sent for a CT scan immediately after his fall on 7 August 2019.

27. Due to these concerns, I requested that case investigators from the Coroners Prevention Unit (**CPU**)[25] review the evidence relating to Ian's death and provide advice on the course of my investigation.

28. In a statement to the court, Dr Ram Singh, Acting Director of Mental Health Services at BHS, detailed his staff's compliance with their relevant policies, and provided those policies to the Court. The BHS Clinical Practice Protocol 'Post Fall Management' details that patients on anticoagulation should be observed and that a CT scan should be 'considered' rather than being recommended or mandated.

[25] 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.

29. During their review, the CPU advised me that many state[26] and international[27] guidelines now recommend a CT brain scan for patients on anticoagulation who sustain a head strike, even if they are completely asymptomatic.

30. I find that BHS head injury guidelines do not reflect current standard practice.

31. That said, it is important to note that even though Ian's intracerebral bleed was as a consequence of his fall, I am satisfied on the balance of probabilities that his subsequent deterioration was as a consequence of his CJD, and not the modest observed intracerebral bleed. Thus, an earlier transfer from the BHS Steele Haughton Unit to the Emergency Department would not have altered Ian's progression or eventual outcome.

32. Creutzfeldt-Jakob Disease is an extremely rare, rapidly progressive fatal neurodegenerative disease that due its varying presentation is extremely difficult to diagnose, even very late in its presentation. CJD is difficult to diagnose. Early symptoms[28] are vague, early examinations often unremarkable and diagnostic tests such as CT scans and blood tests are normal. As the number and the intensity of symptoms increase, more diagnostic tests are ordered and it is only in the combination of the symptoms and changes seen on EEG and MRI – each non-specific in its own right – that the diagnosis is initially suspected, then confirmed.

33. I am satisfied in this case that the medical investigation of Ian's symptoms was proceeding with reasonable expedition.

34. Ian's death was not preventable, but my investigation has identified potential systems improvements regarding the management of BHS patients sustaining a head injury. As such, I will recommend that BHS review its policies relating to the management of head injuries in anticoagulated patients.

FINDINGS AND CONCLUSION

35. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[29] Adverse findings or comments

[26] Trauma Victoria. https://trauma.reach.vic.gov.au/guidelines/anticoagulation-in-trauma/head-injury-and-oral-anticoagulants.
[27] The United Kingdom's NICE guidelines: https://www.nice.org.uk/guidance/qs74/chapter/Quality-statement-2-CT-head-scans-for-people-taking-anticoagulants
[28] Confusion, disorientation, rapidly progressive dementia, personality and behavioural changes, disturbed gait, muscle spasm, visual changes.
[29] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable

against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

36. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    (a) the identity of the deceased was Ian Lindsay Gould, born 16 August 1955;

    (b) the death occurred on 4 September 2019 at St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria from complications of Creutzfeldt-Jakob Disease following a fall; and

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

37. Having considered all of the evidence, I am satisfied that BHS would not have been able to prevent Ian's death even had their head injury guidelines reflected current standard practice.

RECOMMENDATION

Pursuant to section 72(2) of the Act, I make the following recommendation:

(i) I recommend that Ballarat Health Services review their policies relating to the management of head injuries in anticoagulated patients with reference to the comparators footnoted above.

I convey my sincere condolences to Ian's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules

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

Lynne Gould, Senior Next of Kin

Dr Linda Danvers, Ballarat Health Services

Dr Neil Coventry, Office of the Chief Psychiatrist

satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

Senior Constable Aidan Blake, Coroner's Investigator

Signature:

SIMON McGREGOR

CORONER

Date: 8 April 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.