Rule 63(1)

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2019 3863

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of: MARK JAMES O'BRIEN

Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	14 April 2021
Delivered At:	Coroners Court of Victoria
Hearing Dates:	14 April 2021
Appearances:	*Peter Ryan, Senior Corporate Counsel for Monash Health*
Counsel Assisting the Coroner:	*Hayley Challender, Coroners Solicitor*

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I, AUDREY JAMIESON, Coroner having investigated the death of MARK JAMES O'BRIEN

AND having held an Inquest in relation to this death on 14 April 2021

at the Coroners Court of Victoria

find that the identity of the deceased was MARK JAMES O'BRIEN

he was born on 13 June 1963

and he died on 22 July 2019

at Monash Health - Kingston Centre, 400 Warrigal Road, Cheltenham 3192

from:

1(a) COMPLICATIONS OF ATRAUMATIC BILATERAL FEMORAL FRACTURES (REPAIRED) DURING A SEIZURE

(b) DOWN SYNDROME

In the following summary of circumstances:

1. Mark James O'Brien had three seizures in March 2019, June 2019, and July 2019, respectively. These seizures resulted in fractures requiring surgery and ultimately, long-term hospitalisation, as well as significant health deterioration. Mr O'Brien was palliated on 19 July 2019 after his final seizure.
2. At 2.45pm on 22 July 2019, Mark James O'Brien died in his hospital bed with his brother Paul O'Brien by his side, at Monash Health – Kingston Centre.

BACKGROUND CIRCUMSTANCES

3. At the time of his death, Mark James O'Brien was 56 years of age. He had dementia (Alzheimer's Disease) and Down Syndrome. Mr O'Brien was non-verbal[1] and was unable to self-care; he had lived in a Department of Health and Human Services (DHHS)[2] residential care facility in Rowville, Victoria, for approximately 16 years.
4. On 26 May 2019, Mr O'Brien's residential care funding was transferred from DHHS to the National Disability Insurance Scheme (NDIS). Consequently, the Rowville facility

[1] Mr O'Brien did speak at times, however, his overall capacity and diagnosis was "non-verbal".

[2] As the Department was called at that time.

was transferred to private management "Home@Scope". Mr O'Brien's living circumstances at "Rowville" and his care requirements remained the same.

JURISDICTION

5. Mark James O'Brien's death was a reportable death under section 4 of the Coroners Act 2008 ('the Act'), because it occurred in Victoria, and was considered unexpected. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes. Mr O'Brien was in care and his funding arrangements changed whilst he was in hospital. I consider Mr O'Brien's circumstances to be analogous to "in care".

PURPOSE OF THE CORONIAL INVESTIGATION

6. The Coroners Court of Victoria is an inquisitorial jurisdiction.[3] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[4] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[5]

7. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the 'prevention' role.[6] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death,

[3] Section 89(4) Coroners Act 2008.

[4] Section 67(1) of the *Coroners Act 2008*.

[5] See for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[6] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.

including public health or safety or the administration of justice.[7] These are effectively the vehicles by which the prevention role may be advanced.[8]

8. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

9. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

STANDARD OF PROOF

10. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*.[9] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

    - the nature and consequence of the facts to be proved;
    - the seriousness of any allegations made;
    - the inherent unlikelihood of the occurrence alleged;
    - the gravity of the consequences flowing from an adverse finding; and
    - if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

11. The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

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[7] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[8] See also sections 73(1) and 72(5) of the Act which requires publication of Coronial Findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a Coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[9] (1938) 60 CLR 336.

INVESTIGATIONS PRECEDING THE INQUEST

Identity

12. On 23 July 2019, the body of Mark James O'Brien, born 13 June 1963, was visually identified by his brother Greg O'Brien.

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

Medical Cause of Death

14. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 25 July 2019, reviewed a post mortem computed tomography (CT) scan, reviewed the Monash Health E-Medical Deposition Form, and referred to the Victoria Police Report of Death, Form 83. Dr Burke provided a written report of his findings dated 26 July 2019.

Post mortem examination

15. The post-mortem examination revealed increased lung markings. Dr Burke noted that Mr O'Brien's Monash Health medical records included CT imaging of bilateral hip fractures and a longitudinal fracture to the posterior cortex of the femur on the left side.

Forensic pathology opinion

16. In the absence of an autopsy, Dr Burke ascribed the medical cause of death to

'*1(a) COMPLICATIONS OF ATRAUMATIC BILATERAL FEMORAL FRACTURES (REPAIRED) DURING A SEIZURE*

(b) DOWN SYNDROME'

DISABILITY SERVICES COMMISSIONER REPORT

17. The Disability Services Commission (DSC) was established under the Disability Act 2006 (Vic) [the Disability Act]. The DSC is an independent oversight body for the Victorian disability sector. The Minister for Housing, Disability and Ageing (the Minister) has requested that the Disability Services Commissioner inquire into and, at her discretion, investigate any matter relating to the provision of disability services or regulated disability services to a person who was receiving these services at the time of their death.

18. On 4 March 2020, the DSC provided its Final Section 128I Investigation Report in relation to Mark James O'Brien (the DSC Report) to the Court, pursuant to section

132ZB of the Disability Amendment Act. Upon provision of the report, the Commissioner requested that the Court comply with certain conditions for further use and disclosure of the same.

19. The DSC documented issues and made recommendations on the basis of their findings about service delivery to Mr O'Brien. This included reference to Mr O'Brien's lack of access to his communication aid whilst admitted to hospital.

CONDUCT OF MY INVESTIGATION

20. The investigation and the preparation of the Inquest Brief was undertaken by Coroner's Investigator (CI) First Constable (FC) Harinder Singh on my behalf. The CI conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

Surrounding Circumstances Leading to Death

21. Mr O'Brien had three younger siblings. Paul O'Brien stated that his eldest brother had lived with his parents in a retirement house prior to moving into Rowville. Paul stated that Mr O'Brien was a happy person who loved to go out for a coffee and enjoyed listening to music.

22. The Rowville House Supervisor Kelly Aitkin knew Mr O'Brien the entire time that he lived in the facility. She said that Paul collected his brother for the night or a daytime excursion at least once a month and that Mr O'Brien always had a family outing for special events. Paul stated that his brother was *'happy and comfortable staying at Rowville. Staff at Rowville really looked after Mark the whole time he was there.'*[10]

23. In July 2018, Mr O'Brien was diagnosed with dementia and his health rapidly declined. Ms Aitkin said that he required physical assistance with almost all tasks; he no longer knew how to complete them. After his dementia diagnosis, General Practitioner (GP) Dr Darrer advised Rowvillé staff that Mr O'Brien may suffer seizures due to his complex range of health concerns.

[10] Coronial File, *Statement of Paul O'Brien*, dated 8 December 2019, p 1 of 3.

24. On 19 March 2019, Rowville staff member Sherylee Heffernan witnessed Mr O'Brien have a seizure while he was sitting on a toilet seat. Ms Heffernan assisted Mr O'Brien to the floor and contacted emergency services. He was transported to the Monash Medical Centre, Clayton, in the company of another Rowville staff member.

25. On 20 March 2019, Mr O'Brien had a surgical repair for bilateral displaced impacted subcapital neck of femur fractures; he had sustained these fractures during the course of his seizure. Mr O'Brien stayed in the Intensive Care Unit (ICU) post-surgery. His post-operative course was complicated by: delirium; pain; aspiration pneumonia, which was treated with oral and IV antibiotics; hypotension, which was treated with fluids.

26. On 5 April 2019, transferred to the Kingston Centre for rehabilitation. The staff were aware of the enormous impact that moving accommodation would have on Mr O'Brien and his family. Therefore, the primary aim of his rehabilitation was to restore mobility so that he may return to his home at Rowville.

27. During his admission, Mr O'Brien was diagnosed with osteoporosis. Kingston Centre staff discussed various treatment plans with Mr O'Brien's family. Ultimately, it was agreed to conservatively treat the osteoporosis with vitamin D supplementation.

28. Geriatric Medicine Advanced Trainee (first year) Dr Anna Sigley was involved in Mr O'Brien's care throughout his admission to the Kingston Centre. Dr Sigley stated that impaired cognition was a key factor impacting his progress in rehabilitation.

29. Dr Sigley said that staff became familiar with Mr O'Brien's personal needs throughout his admission. However, it was difficult to assess his pain levels due to his cognition and communication difficulties. Mr O'Brien's facial expressions were not reliable indicators of pain; he would sometimes wince and grimace, followed by a smile and laughter. Dr Sigley commented that Mr O'Brien's family assisted him to engage and cooperate with medical investigations, which was vital.

30. On 14 June 2019, Mr O'Brien was commenced on a short course of antibiotic for a mild chest infection.

31. On 15 June 2019 Mr O'Brien had a witnessed seizure which lasted a few minutes; a code blue emergency was called but the seizure self-terminated before night-staff attendance. The medical team sought the advice of the neurology unit and implemented their instructions:

    a. There were no changes to Mr O'Brien's antiepileptic medication (sodium valproate)[11] after a single seizure;

    b. Mr O'Brien's regular valproate blood levels were tested, and

    c. Mr O'Brien's dose was gradually increased based on the blood-test results and his response to the increase ("up-titration").

32. On 17 June 2019, Mr O'Brien had a pelvic and hip x-ray as Allied Health staff had noted a reluctance for Mark to mobilise after his second seizure. Upon review of the imaging, the radiologist reported no complications. Mr O'Brien continued to be monitored on the ward. He was still reluctant to mobilise, which was initially thought to be because of pain in his right leg.

33. Dr Sigley stated that examining Mr O'Brien was difficult as he was unable to communicate verbally and would get very agitated on physical examination. It was evident that he was in pain and regular pain relief medication was commenced after discussion with his family.

34. On 19 June 2019, Mr O'Brien had an x-ray of his entire right leg as staff continued to note that he appeared to be in pain and his mobilisation continued to deteriorate. The imaging results were reported as normal. Staff considered the possibility that Mr O'Brien suffered a delirium[12] triggered by the seizure, and that this was affecting his mobility. His condition did not improve over the following week.

35. On 26 June 2019, Mr O'Brien had a CT scan of his hips to establish the cause of ongoing deterioration of his mobility. A longitudinal fracture of the posterior cortex of

[11] Medication primarily used to treat bi-polar disorder and epilepsy.

[12] Increased confusion/behaviour changes.

the left proximal-mid femoral shaft and mild protrusion of the left total hip replacement was ultimately identified.

36. On 27 June 2019, Mr O'Brien had a plain radiograph of his hips. The Head of Orthopaedics assessed Mr O'Brien's condition and advised that further surgery for stabilisation was not recommended; conservative management would be most appropriate. Mr O'Brien was made "non-weight-bearing" on his left leg and was to continue bed exercises where he could manage to complete them.

37. On 13 July 2019, Mr O'Brien became febrile and he had a cough; he was treated for aspiration pneumonia and provided another course of antibiotics. His chest x-ray (CXR) showed patchy right lower lobe consolidation consistent with this diagnosis, and he clinically improved on treatment with oral antibiotics.

38. On 19 July 2019, Mr O'Brien had a third seizure which self-terminated. Ward Consultant Dr Ng and a junior doctor reviewed Mr O'Brien that morning and identified a deformity of his left leg associated with significant pain. Dr Sigley arranged for pain-relief to swiftly alleviate Mr O'Brien's pain and distress, as well as preventing further seizures. An x-ray showed his left femoral fracture was now displaced approximately 7.6 cm distal to the tip of the femoral prosthetic stem with associated shortening.

39. After discussions with his family, medical staff ceased active treatment and provided palliative care to Mr O'Brien. He was provided comfort care measures until the date of his death.

Further Investigations

40. In light of the issues raised by my preliminary investigations, I requested a supplementary statement from Monash Health. I directed that the statement address the misdiagnosis of Mr O'Brien's fractures sustained on 15 June 2019 and first scanned on 17 June 2019.

41. Professor Stephen Stuckey responded on behalf of Monash Health. At the time that he provided the statement, Professor Stuckey was the Director of Monash Imaging at Monash Health and Professor and Head of Department of Imaging, School of Clinical

Sciences at Monash Health, Monash University. Professor Stuckey noted that the reporting radiologist who reviewed Mr O'Brien's scans on 17 June 2019 was named "John Stuckey". Professor Stuckey declared that there was no personal connection between him and the reporting radiologist.

42. Professor Stuckey was not involved in the provision of care to Mr O'Brien. With a view to responding to my request for a statement, he reviewed the diagnostic imaging reports, including:

    a. hip x-ray of 17 June 2019;

    b. the CT of the hips 26 June 2019, and

    c. plain radiographs of the hips 27 June 2019.

43. Professor Stuckey stated that the initial hip x-ray of 17 June 2019 demonstrated a '*linear lucency on the anteroposterior view extending inferiorly from the region of the inferior tip of the left total hip joint replacement femoral component*'.[13] He explained that this finding is suspicious for a fracture but it is uncertain given the unusual location, trajectory and lack of displacement. The CT imaging of 26 June 2019 ultimately demonstrated that Mr O'Brien had suffered a posterior undisplaced cortical fracture. Subsequent plain radiographs of the hips support that finding.

Concessions

44. Professor Stuckey conceded that the reporting radiologist did not recognise findings suggestive of fracture on 17 June 2019. He stated that he had provided feedback and education to the staff member.

45. Professor Stuckey stated that this type of fracture was considered subtle and likely to be missed or misinterpreted by the majority of radiologists. He said that it was a rare fracture and located toward the periphery of the radiograph which is a notorious location for radiologists (and others) to not appreciate pathology. Professor Stuckey stated that the referral for an x-ray did not include a history of Mr O'Brien's most

[13] Coronial File, Professor Stephen Stuckey, dated 11 March 2020, p 1 of 2.

recent seizure and subsequent pain. He commented that reference to these events may have prompted clinical concern and a '*rigorous review of this location. The history provided suggested this was a "routine" follow-up examination post hip replacement which is done frequently as a baseline for later image comparison when pathology is suspected.*'[14]

Preventative Measures

46. Professor Stuckey stated that Monash Imaging and Monash Health will augment the annual orientation program for new medical staff. The program will reinforce the importance of ensuring that complete medical information is contained in any staff requests for procedures. Specifically, information on the patient's current presentation and the clinical indicators or other reasons for referral ought to be included. Professor Stuckey specified that Mr O'Brien's care and treatment will be referenced as an example in that program.

47. Professor Stuckey said that Monash Imaging used Mr O'Brien's case as a teaching and "peer learning" example both in regard to abnormalities at the periphery of the radiograph and as an example of a rare fracture during lunchtime education sessions and the quarterly consultant council meetings.[15] He also stated that a related teaching vignette was to be prepared and distributed to all diagnostic imaging medical staff.

INQUEST

48. In light of the concession made by Professor Stuckey on behalf of Monash Health and the general circumstances of Mr O'Brien's death, I determined that there was a lack of evident issues to explore by hearing oral evidence. Consequently, I directed that this matter be finalised by way of a Form 37 Finding into Death with Inquest and be handed-down at the conclusion of a Summary Inquest.

49. Interested Parties were informed of my determination by way of a Summary Inquest Notice dated 24 March 2021.

[14] Above n 13, p 2 of 2.

[15] At the Imaging Consultant Council 13 February 2020.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death:

1. Mr O'Brien sustained multiple atraumatic fractures in the context of seizures, one such fracture was not initially recognised. Consequently, his rehabilitation continued, including reluctant mobilisation, whilst he had a fractured leg. He was finally diagnosed nine days later, prior to suffering a further seizure. Mr O'Brien was palliated and ultimately died shortly thereafter. I do not consider this clinical course to represent a natural causes death.

2. Mark James O'Brien was "in care" pursuant to the definition contained in the Act for the entire period that he was living in Rowville; the facility was managed by DHHS until 26 May 2019 when it transferred to Home@Scope under the NDIS. This occurred after Mr O'Brien had been admitted to hospital. For all intents and purposes, Mr O'Brien's living arrangements were analogous to "in care".

3. The DSC identified some issues in relation to Mr O'Brien's care and treatment and provided their findings to Rowville. The DSC identified that Mr O'Brien did not have access to a communication aid during his hospital admission. I note that his non-verbal status created some challenges in identifying that Mr O'Brien was in pain. However, he suffered dementia as well as delirium subsequent to his surgical hip replacement in March 2019. Furthermore, Dr Sigley stated that staff identified that Mr O'Brien was in pain immediately following his second seizure, prompting medical staff to refer him for medical imaging on two occasions in June 2019; despite a normal report after the first scan. At that time, medical staff also postulated that he may suffer ongoing delirium as an alternate to suffering pain. Having regard to all of these factors, it is not clear whether access to his aid would have assisted Mr O'Brien in communicating his pain any better nor changed his clinical course.

4. Professor Stuckey has addressed Monash Health staff's failure to identify a rare and subtle fracture on 17 June 2019. He did not address the further imaging on 19 June 2019 where the fracture remained undiagnosed. However, the balance of the Professor's statement addresses both events, where preventative and restorative measures have been implemented. I endorse these changes.

FINDINGS

1. I find that the identity of the deceased was Mark James O'Brien, born 13 June 1963;

2. I find that Mark James O'Brien's death occurred on 22 July 2019 at Monash Health - Kingston Centre, 400 Warrigal Road, Cheltenham 3192;

3. I accept and adopt the medical cause of death ascribed by Dr Michael Burke and I find that Mark James O'Brien died from complications of atraumatic bilateral femoral fractures (repaired) during a seizure in the setting of Down Syndrome.

4. I find that Monash Health staff did not initially identify that Mark James O'Brien had suffered a fracture after a seizure on 15 June 2019.

5. I further find that the fracture was identified on 27 June 2019 and appropriate care and treatment was provided thereafter.

6. AND I find that Monash Health have instituted appropriate preventative measures to mitigate the risk of practitioners missing or misinterpreting medical imaging that depicts the type of fracture that Mark James O'Brien sustained on 15 June 2019.

To enable compliance with section 73(1) of the Coroners Act 2008 (Vic), I direct that the Findings will be published on the internet.

I direct that a copy of this Finding be provided to the following:
Mary O'Brien
Paul O'Brien
Home@Scope
Lanii Birks, Clinical Review Panel at Monash Health
Peter Ryan, Senior Corporate Counsel for Monash Health
The Office of the Disability Services Commissioner
First Constable Harinder Singh

Signature:

AUDREY JAMIESON
CORONER
Date: **14 April 2021**