IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 004783

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	David John McDermott
Date of birth:	11 July 1948
Date of death:	22 September 2018
Cause of death:	1(a) Congestive cardiac failure in a man with ischaemic and hypertensive heart disease
Place of death:	Austin Health, Heidelberg Repatriation Hospital, 300 Waterdale Road, Ivanhoe, Victoria, 3079

INTRODUCTION

1. David John McDermott was 70 years of age at the time of death. He resided at Kew disability group home managed by Department of Health and Human Services (**DHHS**) along with five other residents. He had formally been a resident of Kew Cottages until it closed down.

2. Mr McDermott had an intellectual disability and had remained in supported care since the age of six. He did not have any known family or legal guardian and his finances was managed by the State Trustees. The Office of the Public Advocate (**OPA**) was engaged in relation to making decision for his living arrangement and medical care.

3. He was described as a friendly and very house-proud man. He enjoyed spending time pottering and caring for his pet cat, Molly.[1]

4. Mr McDermott had a complex medical history including, atrial fibrillation, ischaemic heart disease, myocardial infarction, heart failure, aortic stenosis, impaired renal function, third degree heart block, hypertension, hypercholesterolaemia, type two diabetes mellitus, hyperparathyroidism, cerebral infarction, osteopenia and cellulitis.[2] He also suffered from hearing loss which he refused the aid of a hearing device.[3]

5. Mr McDermott was treated with numerous medications and managed under specific health management plan to these conditions.[4]

6. On 22 September 2018, after a decline in his health Mr McDermott died at the Heidelberg Repatriation Hospital ("Repatriation Hospital").

THE CORONIAL INVESTIGATION

7. Mr McDermott's death was reportable pursuant to section 4 of the *Coroners Act 2008* ("the Act") because he was a person placed in care at the time of his death, even if the death appears to have been from natural causes. Section 3 of the Act states that a person placed in care includes a person who is under the control, care or custody of the DHHS.

8. 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

[1] Coronial Brief of Evidence (**CB**), DHHS Person Centred Plan.
[2] CB, Statement of Dr Elizabeth Button, page 2.
[3] CB, Comprehensive Health Assessment Program, page 12.
[4] CB, Specific Health Management Plans.

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.

9. Victoria Police assigned an officer to be the Coroner's Investigator for investigation into Mr McDermott's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as support workers, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

10. An investigation was also conducted under the auspices *Disability Services Act 2016* by the Disability Services Commissioner ("the Commissioner") with a different scope to that of a coronial investigation. I considered the reporting letter from the Commissioner on the investigation into disability services provided by DHHS. The letter was provided to the Court on a confidential basis. Consistent with the Act, a coroner should liaise with other investigation bodies to avoid unnecessary duplication and expedite investigation.[5]

11. This finding draws on the totality of the coronial investigation into the death of David John McDermott including evidence 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[6]

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

Circumstances in which the death occurred

Admission to Austin Hospital, 23 May to 5 June

12. On 22 May 2018, Mr McDermott presented to the Emergency Department (**ED**) of Austin Hospital with a three-day history of swollen and pain on his lower left leg, four shallow ulcerated areas, confusion, increased agitation and combativeness. He was later diagnosed with congestive cardiac failure, sepsis, acute kidney injury and delirium secondary to sepsis.

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5 Section 7 of the *Coroners Act 2008.*

6 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.

13. Mr McDermott's renal function and cognition improved back to his baseline level, throughout his hospital admission. However, his heart failure was found to be severe. He and remained unable to walk. He was also noted to be distressed at being away from his residential place and Molly.

14. As the carers at the group home were non-clinically trained, Mr McDermott's carers were concerned that they were unable to manage the complexity of his medical needs and suggested that he be moved to a residential aged care facility. Mr McDermott refused the suggestion.

15. On 5 June 2018, Mr McDermott was transferred to Ward 9 of the Repatriation Hospital to undergo slow-stream rehabilitation.

Admission to Heidelberg Repatriation Hospital

16. While inpatient at the Repatriation Hospital, Mr McDermott's primary care doctor, Dr Elizabeth Britton stated he made limited rehabilitation progress and remained unable to walk. He was also and frequently agitated about returning home.

17. On 12 June 2018, Mr McDermott developed erythema over the dorsum of his left foot. His left foot, was observed to be swollen and experienced pain on palpation. A bone scan undertaken suggested an infective or inflammatory process in the left second tarsometatarsal joint. Mr McDermott's left foot deteriorated further despite being administered intravenous broad-spectrum antibiotics and a diffuse erythema was later observed on the dorsum of his left foot.

18. On 25 June 2018, an ultrasound was conducted and revealed a fluid collection within Mr McDermott's left foot. Surgery to drain the collection was considered but was deferred due to his comorbidities posing a high anaesthetic risk. He was instead put on a prolonged trial of antibiotics.

19. On 11 July 2018, the OPA provided consent for a surgical drainage as antibiotic treatment had not improved the collection of fluid and Mr McDermott remained unable to walk. Sterile swabs taken during the surgery revealed evidence of infections in deep tissues of the left foot.

20. Throughout 24 July to 13 September 2018, Mr McDermott's foot and mobility continued to improve. Mr McDermott was keen to return home, however, his carers remained concerned about the unpredictability of his medical conditions.

21. Dr Button considered that Mr McDermott could be managed as an outpatient although his medical conditions were acknowledged as being advanced and were likely to relapse. A plan was later made for Mr McDermott to return home on 18 September 2018 after discussions with the OPA and his carers. On the grounds that he regained his mobility.

22. On 13 September 2018, Mr McDermott was diagnosed with gravitational oedema and treated with elevation, compression bandaging and reinforced fluid restriction.

23. On 18 September 2018, Mr McDermott's planned discharge was delayed as Dr Button found some reddening on his right foot suggestive of possible early infection. Dr Button then resumed antibiotics.

24. On 21 September 2018, Mr McDermott was observed to be lethargic and non-specifically unwell although all his vital signs were within the normal range. It was also noted that Mr McDermott was behaving agitated and confused while being assessed. A blood test performed revealed a marked deterioration in renal function without a possible cause.

25. Mr McDermott was transferred to the Austin Hospital as the treating team at the Repatriation Hospital determined that his conditions would be best investigated and monitored in an acute setting. Prior to his transfer he became argumentative and stated he did not want to be transferred back to the hospital. He also became distressed and needed persuading that his antibiotics needed to be recommenced.

26. On 21 September 2018, at 4.30pm, Mr McDermott left Ward 9 and arrived at the Austin Hospital at approximately 4.45pm. He was chemically restrained with Olanzapine to enable further assessment and treatment.

27. At 6.10pm, while being admitted to Ward 7 West, Mr McDermott remained agitated and combative that he was unable to be assessed. Further attempts at 8.00pm to administer intravenous antibiotics was also unsuccessful.

28. At 9.09pm, a venous blood gas analysis performed and revealed evidence of severe acidosis with pH 7.08 and lactate of 8.2 suggesting an extremely poor prognosis.

29. At 10.00pm, it was noted that Mr McDermott voluntarily pulled out his intravenous cannula and catheter and was unable to tolerate intravenous resuscitation forty-four minutes later.

30. At 11.55pm, a nursing staff found Mr McDermott unresponsive and had no signs of life. Cardiopulmonary resuscitation was not performed as the geriatric team ordered Mr McDermott "Not for Resuscitation".

31. On 22 September 2018, at 12.25am, Mr McDermott was declared deceased.

Identity of the deceased

32. On 26 September 2018, David John McDermott, born 11 July 1948, was visually identified by Katrina Hallal, his carer. Identity is not in dispute and requires no further investigation.

Medical cause of death

33. Forensic Pathologist Dr Gregory Ross Young from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 1 October 2018. Prior the autopsy, Dr Young reviewed a post-mortem computed tomography (**CT**) scan and referred to the Victoria Police Report of Death (Form 83) and E-medical disposition form. Dr Young also reviewed medical records from Austin Health, Kew Junction Medical Centre and notes from the DHHS after the autopsy and provided a written report his findings dated 13 December 2018.

34. The autopsy showed evidence of congestive cardiac failure, including pericardial and pleural effusions, ascites, and centrilobular congestion in the liver. The heart was enlarged[7] weighing at 600 grams and showed myocardial fibrosis. There was severe atherosclerosis on the left anterior descending coronary artery.

35. Dr Young explained congestive cardiac failure occurs when the heart is unable to maintain sufficient cardiac output to meet the demands of the body. He commented in Mr McDermott's case was due to ischaemic[8] and hypertensive heart disease.

36. Post-mortem specimens were taken for microbiology testing where a swab from the right foot cultured *Stentrophomonas maltophilia*[9]. A mixed growth cultured from urine revealed a

[7] Cardiomegaly is enlargement of the heart, not in keeping with normal physiological change in an individual. The predicted normal heart weight in a man of Mr McDermott's weight of 82 kilograms is approximately 354 grams, with a 95th percentile of 467 grams. The predicted normal heart weight in a man of Mr McDermott's height of 164 centimetres is approximately 300 grams, with a 95th percentile of 423 grams. Cardiomegaly is commonly associated with hypertension (so-called "hypertensive heart disease") and ischaemic heart disease.

[8] Ischaemic heart disease (**IHD**) is a disease process resulting from myocardial ischaemia, which is an imbalance between cardiac blood supply and myocardial oxygen demand. Most cases are due to a reduction in coronary blood flow caused by obstructive atherosclerotic disease (coronary artery atherosclerosis). The mechanism of death may be a myocardial infarction, heart failure or a fatal cardiac arrhythmia ("heart attack"). Significant risk factors for the development of IHD include hypertension, cigarette smoking, hypercholesterolaemia and diabetes mellitus.

[9] A bacterium that can colonise wounds in hospital patients.

likelihood of contamination. There was no bacterial growth from the lungs, left foot or blood and no viral nucleic acids were detected in the lungs.

37. Dr Young found no unequivocal autopsy evidence of sepsis and commented that administration of antibiotics, or lack thereof, near the time of death was unlikely to have prevented Mr McDermott's death.

38. There was no post-mortem evidence of any injuries which may have caused or contributed to death. Dr Young formed the opinion, based on the information available to him, that Mr McDermott's death was due natural causes.

39. Dr Young ascribed the medical cause of death was 1 (a) congestive cardiac failure in a man with ischaemic and hypertensive heart disease.

COMMENTS

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

40. I note that the significant delay during the admission to the Austin Hospital from the Repatriation Hospital was due to Mr McDermott's behaviour and reaction to medical interventions. Mr McDermott's was unable to comprehend medical interventions and refused medical treatment on many occasions to the extent that chemical and physical restraint was necessary.

41. I also note from Dr Elizabeth Button's statement on the Austin Hospital's policy for transfer of patients and the rationale for not admitting Mr McDermott to the ED. At the time of Mr McDermott's admission at the Repatriation Hospital, Austin Heath had a policy that deteriorating inpatients of the Repatriation Hospital were not required to be reviewed in the ED. Dr Button also explained in her statement that a transfer via the ED, a busy environment would be intolerable for Mr McDermott and unnecessary in terms of practicability.

42. There is no evidence to suggest that there is any public interest in taking this matter to a Hearing by way of an Inquest, Mr McDermott's medical care and treatment appears reasonable. There are no family concerns in relation to the same. I am satisfied that the Commissioner's investigation did not identifying any issues with Mr McDermott's care by the DHHS by way of the Kew disability group home that were casual or connected to Mr McDermott's death. I am also satisfied that Mr McDermott's medical care and treatment

provided to him by Austin Hospital and Heidelberg Repatriation Hospital had no casual connection between the cause of Mr McDermott's death.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was David John McDermott, born 11 July 1948;

    b) the death occurred on 22 September 2018 at Austin Health, Heidelberg Repatriation Hospital, 300 Waterdale Road, Ivanhoe, Victoria, 3079; and

    c) I accept and adopt the medical cause of death ascribed by Dr Gregory Ross Young and I find that David John McDermott died from congestive cardiac failure in the circumstances which arose in a man with medical history of ischaemic and hypertensive heart disease.

44. I further find that David John McDermott's death arose from natural causes.

45. Consequently, the Finding into the death of Mr McDermott has been finalised without an Inquest pursuant to section 52(3A) of the Act and the written findings in relation to all deaths which occur 'in care' must be published, pursuant to section 73(1B) of the Act.

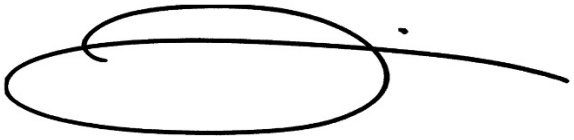
I convey my sincere condolences to Mr McDermott's friends for their loss.

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:

Acting Senior Sergeant Stephen Love, Coroner's Investigator
Austin Health
The Department of Health and Human Services
The Disability Service Commissioner

Signature:



AUDREY JAMIESON

CORONER

Date: 8 December 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.