IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 002932

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Iris Winifred Beecham
Date of birth:	6 December 1935
Date of death:	9 June 2019
Cause of death:	1(a) Intracranial haemorrhage in the setting of a recent fall in a woman with multiple comorbidities
Place of death:	Latrobe Regional Hospital, 10 Village Avenue, Traralgon, Victoria, 3844

INTRODUCTION

1. On 9 June 2019, Iris Winifred Beecham was 83 years old when she died at Latrobe Regional Hospital (**LRH**) in Traralgon following a fall. At the time, Ms Beecham lived at Koorooman House Nursing Home (**Koorooman House**), an aged care facility in Leongatha.

2. Ms Beecham's medical history included dementia, ischaemic heart disease, chronic obstructive pulmonary disease, type II diabetes mellitus, and osteoarthritis. At the time of her death, Ms Beecham's regular medications included quetiapine (an anti-psychotic) and lorazepam (a benzodiazepine).

THE CORONIAL INVESTIGATION

3. Ms Beecham'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.

4. 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.

5. 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.

6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Beecham's death. The Coroner's Investigator 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.

7. This finding draws on the totality of the coronial investigation into the death of Iris Winifred Beecham 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.[1]

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

Identity of the deceased

8. On 9 June 2019, Iris Winifred Beecham, born 6 December 1935, was visually identified by her daughter, Debra Schinagl who signed a formal Statement of Identification to this effect before a member of the clinical staff at Latrobe Regional Hospital.

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

Medical cause of death

10. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 12 June 2019 and provided a written report of her findings dated 2 April 2020.

11. The post-mortem examination revealed a right subdural haematoma, a left intracranial – lobar haemorrhage, a left temporalis muscle haemorrhage with no other obvious subgaleal haematoma. There was evidence of bilateral acute bronchopneumonia and pulmonary emphysema. Findings showed moderate to severe coronary artery atherosclerosis, and cardiomegaly with mild to moderate myocardial fibrosis. There were also autolytic changes in the liver with acute hepatitis, dense small bowel adhesions with no evidence of complication, and evidence of previous hysterectomy and salpingo-oophorectomy.

12. Routine toxicological analysis of post-mortem samples detected midazolam (~0.06 mg/L) and sotalol (~0.5 mg/L) (a beta blocker). The toxicologist advised that the presence of these medications may be attributed to medical interventions performed at LRH.

13. The post-mortem computed tomography (**CT**) scan was reviewed by Dr Sutherland, a consultant radiologist. He opined that the most likely cause of the intracranial haemorrhage (given its site) was a fall rather than the haemorrhage (or stroke) precipitating a fall. Similarly, post-mortem microbiology showed patchy acute Staphylococcus aureus growth in both lung swabs, likely a consequence of immobility following the fall rather than a precipitating cause.

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[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.

14. Ms Beecham's heart showed cardiomegaly (her heart weight was increased in comparison to her height and weight) which is associate with increased myocardial oxygen demand, arrhythmias, and sudden death. The underlying cause of Ms Beecham's cardiac enlargement is most likely to be a combination of hypertension and coronary artery disease.

15. Dr Francis provided an opinion that it would be reasonable to attribute the medical cause of death to *intracranial haemorrhage in the setting of a recent fall in a woman with multiple comorbidities*.

16. I accept Dr Francis' opinion.

Circumstances in which the death occurred

17. Ms Beecham lived with her disabled son for most of her life. As her dementia progressed, however, there were reports of increasing verbal aggression and, despite attempts by her family to support her, Ms Beecham required residential aged care and moved to Koorooman House. Following the move, Ms Beecham's behaviours escalated, including verbal and physical aggression, outbursts of abuse, damage to property, and assaults upon staff, including allegations of biting, kicking, spitting, pinching, and kicking at staff.

18. Ms Beecham was resistive to care, suffered from disturbed sleeping patterns, wandered intrusively, and was the subject of other resident and family formal complaints, including threatening to stab other residents. Ms Beecham was not compliant with the need for supervision and mobility aids whilst ambulating and suffered multiple falls.

19. Multiple attempts were made to settle Mrs Beecham, including testing for urinary infections, review of medications including review by a psycho-geriatrician, and an urgent request for a transfer to a dementia specific unit. On 9 May 2019, Ms Beecham was reviewed by a consultant psychiatrist who ceased multiple medications and commenced her on quetiapine and lorazepam on PRN or "as required" basis.

20. Ms Beecham was placed on a waiting list for a bed at the Nautilus Unit at Seahaven House in Inverloch. However on 15 May 2019, discussions were had between staff and Ms Beecham's daughter about either increasing Ms Beecham's sedation or transferring her to the psychogeriatric ward at LRH on an assessment order under the *Mental Health Act 2014* (Vic).[2]

[2] Part 4, Division 1 of the *Mental Health Act 2014* (Vic) allows an individual suffering from mental incapacity to be transported to a designated mental health service to be examined by an authorised psychiatrist for treatment.

21. On 16 May 2019, Ms Beecham was admitted to the psychogeriatric ward at LRH under an Assessment Order. In that setting, she continued to be to be resistive to care and aggressive towards staff and other residents. On the night of 6 June 2019, Ms Beecham was wandering the halls of the ward in an intrusive manner despite staff attempts to settle her. She was given lorazepam 1mg orally at 12.10am by a nurse but remained restless and continued to wander.

22. At 12.50am, whilst attending to another patient, a staff member observed Ms Beecham suffer a fall onto her backside, before falling backwards onto her back and head. She was immediately assisted by staff members who noted that she had not been using her mobility aid when she fell, despite repeated requests to do so by staff.

23. Following a physical and neurological assessment by staff, including an assessment by the on-call psychiatric registrar who found her vital signs were normal (despite being resistive to the assessment), Ms Beecham was placed in a wheelchair and moved to her bedroom, with her bed placed at its lowest level. Ms Beecham eventually settled on the floor beside the bed and went to sleep. Staff continued to check on Ms Beecham throughout the night.

24. On 7 June 2019, Ms Beecham was found to be persistently drowsy, hypertensive with low oxygen saturations, and in altered conscious state. A delirium workup was performed, including a CT of her brain which identified a catastrophic intracranial haemorrhage.

25. Ms Beecham was placed on a palliative care pathway and kept comfortable until she passed away at 10.00am on 9 June 2019.

FAMILY CONCERNS

26. In correspondence with the court, Ms Beecham's daughter, Debra Schinagl, raised several concerns about the standard of care provided to Ms Beecham as regards her medication regimen and general care at both Koorooman House and LRH.

CPU REVIEW

27. To assist my investigation into the death of Ms Beecham, I asked the Coroners Prevention Unit[3] to appraise the clinical management and care provided to Ms Beecham including falls risk management at Koorooman House and at LRH. Sources of evidence that were considered

[3] 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.

included the coronial brief, Ms Beecham's medical records, and Ms Schinagle's correspondence with the court.

28. The CPU clinician advised that they did not identify any deviation from reasonable and appropriate practice and medical decision making and care in a highly challenging situation.

FINDINGS AND CONCLUSION

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

    a) The identity of the deceased was Iris Winifred Beecham, born 6 December 1935.

    b) The death occurred on 9 June 2019 at Latrobe Regional Hospital, 10 Village Avenue, Traralgon, Victoria, 3844.

    c) The cause of Ms Beecham's death was *intracranial haemorrhage in the setting of a recent fall in a woman with multiple comorbidities*.

    d) The death occurred in the circumstances described above.

    e) The available evidence supports a finding that Mrs Beecham died in circumstances which are all too familiar in the coronial jurisdiction in that while the injurious fall is the immediate cause of death, dementia is the major underlying disease.

COMMENTS

Pursuant to section 67(3) of the ***Coroners Act 2008***, I make the following comments on matters connected with the death, including matters relating to public health and safety or the administration of justice:

1. The behaviours displayed by Mrs Beecham represent a serious challenge in aged care where the vicious circle of sedation and falls leads to a dangerous and downward trajectory towards death. The medical records demonstrate that appropriate falls prevention strategies were in place including constant supervision, falls mats and sensor alarms. It is difficult to identify the point where different management was indicated or where any prevention opportunities might lie.

2. The clinician considered it likely that the underlying cause of Mrs Beecham's distress and escalating behaviours related to her separation from her son. While it was clearly not appropriate for her to continue living with her son, it was equally necessary for healthcare workers to have a safe working environment and for other residents to be in a safe

environment. These competing priorities led to the need to provide extra sedation to protect both the resident, the other residents, and staff, at the expense of Mrs Beecham's risk of falls.

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

Debra Schinagl, Senior Next of Kin

Dr Neil Coventry, Office of the Chief Psychiatrist

Dr Philippa Hawkings, Latrobe Regional Hospital

Senior Constable Lauren Grech, Victoria Police, Coroner's Investigator

Signature:

Paresa Antoniadis Spanos

Coroner

Date: 10 January 2022

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.