IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2018 0437

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of WINIFRED JEAN MORFFEW

without holding an inquest:

find that the identity of the deceased was WINIFRED JEAN MORFFEW

born 5 December 1928

and the death occurred on 7 January 2018

at Ballan District Health and Care 164 Inglis Street, Ballan, Victoria 3342

from:

1 (a) COMPLICATIONS OF A PEDESTRIAN ACCIDENT INCLUDING SUBARACHNOID HAEMORRHAGE, SUBDURAL HAEMORRHAGE AND FRACTURED HUMERUS

2 LARGE BOWEL OBSTRUCTION, NSTEMI

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Winifred Jean Morffew was 88 years of age at the time of her death. She had a medical history that included type II diabetes mellitus, ischaemic heart disease, cardiomyopathy,

hypertension, scoliosis, macular degeneration, osteoporosis and transient ischaemic attacks and she was prescribed a number of medications for the same.

2. Ms Morffew was married to Peter Poole but had kept the surname 'Morffew' in order to retain the same name as her children. Mr Poole's Great Nephew Brad Simpkin often visited the couple with his wife Rebecca and their baby, which delighted Ms Morffew.

3. During the morning of 28 November 2017, Mr Poole was leaving the home he shared with Ms Morffew in Ballan to purchase some fresh bread roles. He was in his gold-coloured Toyota Camry (registration TLK013) and was prepared to reverse his vehicle; Ms Morffew had come outside to see him off and was standing at the front passenger side window.

4. At the same time, Mr Simpkin and his family arrived to visit and to help with some minor repairs around the home. Ms Morffew saw them arrive and moved behind the gold Toyota Camry to greet them. Mr Poole was not aware that his wife had moved behind the vehicle and Ms Morffew was struck as the gold Toyota Camry reversed at low speed.

5. Emergency Services were contacted and Ms Morffew was transported by ambulance to the Emergency Department (**ED**) of Ballarat Base Hospital (**Ballarat Health Services**) at approximately 11.50am. She was treated there for approximately three weeks before she was transferred to Ballan Hospital (**Ballan District Health and Care**) to be closer to her family and continue conservative treatment. Ms Morffew died on 7 January 2018.

INVESTIGATIONS

Reportable Death

6. Ms Morffew's death was not reported to the Coroners Court of Victoria by Ballarat Health Services or Ballan District Health and Care.

7. On 29 January 2018, Ms Morffew's death was reported to the Court by the Registrar of Births Death and Marriages (**BDM**) upon production of her Death Certificate. Ms Morffew's death certificate was signed by Dr Rakhi Basu of Ballan District Health and Care.

8. The cause of Ms Morffew's death was registered as '*complications of a pedestrian accident including subarachnoid haemorrhage, subdural haemorrhage and fractured humerus*' with a *'large bowel obstruction'* and an *'NSTEMI'*[1] listed as significant contributing factors to her death.

9. Upon receipt of the Death Certificate, I determined that Ms Morffew's death was reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) (**'the Act'**) because her death was the direct result of an accident or injury.

Police investigation

10. Upon attending the Ballan premises on 28 November 2017, Victoria Police Officers noted visibility was good and conditions were dry. They determined that Ms Morffew had been struck at a very low speed and she was conscious and breathing on their arrival. There was no evidence of the incident on the Toyota Camry in the form of damage or other marks. Upon completing a Breathalyzer Test, Mr Poole returned a negative reading for alcohol and drugs. Victoria Police determined that no offense had occurred.

11. Leading Senior Constable (**LSC**) Kenneth Birch was the nominated Coroner's investigator.[2] At my direction, LSC Birch conducted an investigation of the circumstances surrounding Ms Morffew's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Deputy Chief Medical Officer of Ballarat Health Services Dr Linda Danvers, General Practitioner Dr Farhad Hajizadeh of Ballan District Health and Care, and Dr Rakhi Basu.

12. In the course of the investigation, police learned Ballarat Health Services medical practitioners identified that Ms Morffew had suffered multiple injuries. Upon admission, Ms Morffew underwent CT scans of her brain, facial bones, cervical and thoracolumbar spine, chest, left shoulder, abdomen and pelvis. The scans identified the following injuries: left infra-orbital laceration, subarachnoid and sub-dural bleeding, fractured nasal bones and a fractured left surgical neck of humerus. Ms Morffew's admission was complicated by a significant delirium.

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[1] A Non-ST Elevation Myocardial Infarction (NSTEMI) is a type of heart attack.

[2] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

13. Ms Morffew was reviewed by the Surgical, Orthopaedic and Ophthalmology Registrars. She was placed in a cuff and sling to manage her left shoulder fracture. Ms Morffew's condition was also discussed with the Royal Melbourne Hospital Neurosurgery Registrar. They determined that she was not for transfer at that stage. A treatment plan was formulated to continue observations, repeat CT scans and cease provision of aspirin.

14. On 29 November 2017, Ms Morffew underwent a repeat CT scan of her brain. Following discussion with the Royal Melbourne Hospital Neurosurgery Registrar, it was determined that a further scan should be done in two weeks' time and to consider re-commencing aspirin at that time.

15. Dr Danvers stated that Ms Morffew was provided analgesia regularly throughout her admission. She suffered acute delirium, particularly at night. Dr Danvers informed me that Ms Morffew developed an eye infection in relation to her injuries and was treated with antibiotics. Ms Morffew was able to commence rehabilitation and medical practitioners began discharge planning for further rehabilitation at the Queen Elizabeth Centre (**QEC**).

16. On 5 December 2017, Ms Morffew was transferred to the acute geriatric ward of the QEC for continued rehabilitation. Her delirium continued and she was assessed for discharge by the allied health service.

17. On 8 December 2017, Ms Morffew was assessed as having a possible bowel obstruction, or constipation. During the following evening, she complained of stomach pain and abdominal tenderness. Dr Danvers informed me that medical practitioners made a potential diagnosis of coronary ischaemia and Ms Morffew was transferred back to the ED at Ballarat Health Services.

18. At 8.49pm, Ms Morffew arrived at the ED. Dr Danvers stated that her pain had resolved by this time. After further testing, medical practitioners made a tentative diagnosis of myocardial infarction. Ms Morffew was admitted to the care of the Medical Ward for further conservative treatment.

19. On 10 December 2017, Ms Morffew was reviewed; her abdominal pain had continued and her abdomen was distended. A plain x-ray identified a potential pseudo obstruction in her bowel. In view of ongoing symptoms, a CT scan of Ms Morffew's abdomen was

scheduled. The follow day, CT scanning identified a large bowel obstruction and dilation of the caecum.

20. Dr Danvers stated that Ballarat Health Services arranged a meeting between Ms Morffew's daughter, who was her Medical Power of Attorney, and the Surgical Registrar. They agreed that Ms Morffew should be treated non-operatively and to invoke conservative treatment by way of palliative care.

21. On 13 December 2017, Ms Morffew attended the Ophthalmology Outpatient Clinic. Her eye injuries were deemed to be healing satisfactorily and antibiotics were continued. On 15 December 2017, Ms Morffew's general condition seemed improved, and x-ray identified reduced gaseous distention of her bowel.

22. On 20 December 2017, Ms Morffew was transferred to Ballan Hospital to be closer to her family as her condition had sufficiently improved. Dr Hajizadeh was her admitting doctor at Ballan District Health and Care. He stated that the treatment plan throughout her admission was pain management and monitoring for any signs or symptoms of bowel instruction. Ms Morffew continued to be provided conservative, palliative care; she was not for CPR or intubation.

23. Dr Hajizadeh saw Ms Morffew in the Acute Ward on 21, 22, 27 and 28 December 2017. He stated that she did not voice any major concerns. Dr Hajizadeh said he was considering commencing discharge planning for Ms Morffew's transfer to the Transitional Care Program early in the New Year. On 28 December 2017, nursing staff informed him that Ms Morffew had been argumentative with her family; consequently, Dr Hajizadeh was also considering a formal memory and cognitive function test to identify possible cognitive impairment, such as dementia.

24. On 5 and 6 January 2017, Ms Morffew was seen by Dr Basu. He stated that she had some back pain and abdominal distention due to her bowel obstruction. Ballan District Health and Care staff continued to provide end of life care and pain management.

COMMENTS

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

1. I am deeply concerned that neither Ballarat District Health nor Ballan District Health and Care staff recognised their duty to report Ms Morffew's death to the Coroners Court, pursuant to their legislative obligations to report the death.[3] Without the auditing practice at the Registry of Births Deaths and Marriages this reportable death would have gone undetected.

2. The Coroners Court of Victoria is reliant upon those responsible to report a death that falls under the definition of "Reportable" so that the Court may properly dispense its duties under the Act.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations:

1. With the aim of promoting public health and safety, **I recommend** that Ballarat Health Services implement training to educate their clinicians on their obligations to report deaths to the Coroners Court of Victoria.

2. With the aim of promoting public health and safety, **I recommend** that Ballan District Health and Care implement training to educate their clinicians on their obligations to report deaths to the Coroners Court of Victoria.

[3] *Coroners Act 2008* (Vic) ss 10, 11, and 12.

FINDINGS

The investigation has identified that Ms Morffew was tragically struck by a slow moving vehicle when she moved behind it, unbeknownst to her husband who was driving the car. It was appropriate for me to investigate the matter as Victoria Police had determined that no offense occurred during the incident.

Ms Morffew's medical care and treatment at Ballarat Health Services and Ballan District Health and Care appears reasonable and appropriate in the circumstances.

I find that Winifred Jean Morffew died of complications of a pedestrian accident including subarachnoid haemorrhage, subdural haemorrhage, and fractured humerus.

AND I find that Winifred Jean Morffew suffered a large bowel obstruction and an NSTEMI which were significant contributing factors to her death.

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

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

Allan Morffew

Peter Poole

Ballarat Health Services

Ballan District Health and Care

Transport Accident Commission

Leading Senior Constable Kenneth Birch

Signature:

AUDREY JAMIESON
CORONER
Date: **31 October 2018**