IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 4494

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of:	Allan Phipps
Delivered On:	17 November 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank 3006
Hearing Date:	17 November 2014
Findings of:	Caitlin English, Coroner
Representation:	
Coroners Assistant:	Leading Senior Constable Stuart Hastings

I, CAITLIN ENGLISH, Coroner having investigated the death of Allan Phipps

and having held an inquest in relation to this death on 17 November 2014
at Melbourne
find that the identity of the deceased was Allan Phipps
born on 24 November 1935
and the death occurred on 22 October 2012
at Austin Hospital, Studley Road, Heidelberg
from:

1 (a) EXSANGUINATION
1 (b) PULMONARY AORTIC FISTULA
1 (c) THORACIC AORTA ANEURYSM
2 DILATED CARDIOMYOPATHY

in the following circumstances:

1. Allan Phipps was a 76 year old male who resided at 24 Hobson Street Greensborough with his wife Lorna Phipps who was his main carer. Mr Phipps was also supported at home by the transition care program based at Austin Health. Mr and Mrs Phipps had four children together; Sharon, Craig, Cameron and Julie. Mr Phipps has two brothers.

2. At the time of his death, Mr Phipps was an involuntary patient at the Austin Hospital subject to an involuntary treatment order pursuant to section 8 of the *Mental Health Act 1986*. Due to Mr Phipps' 'in care status', his death is a reportable death to the coroner (s 11 *Coroners Act* 2008). Further, his 'in care' status mandates a coroner to hold an inquest into his death (s 52(2)(b)).

3. Mr Phipps' had a complex medical history including; ischemic heart disease, hypertension, left eye blindness from birth, macular degeneration in the right eye, thoracic aortic aneurysm, polymyalgia rehumatica, peripheral vascular disease and renal impairment. Mr Phipps' mental health history included; bipolar affective disorder, depression, steroid induced psychosis in 1996 and a manic episode in 2000.

4. A police investigation was conducted into the circumstances surrounding Mr Phipps' death.

5. On 5 March 2011, Mr Phipps had a fall in the street whilst walking the dog. His wife took him to see Dr Claire Barrington at St Helena Mediplex. Dr Barrington referred Mr Phipps to the Austin Hospital for further tests. At the Austin Hospital it was discovered that Mr Phipps

had a tear in his aorta and he remained at the Austin for further testing which revealed an aneurysm in his aorta.

6. Vascular surgeon Mr Jason Chuen reviewed Mr Phipps at the Austin Hospital, Vascular Surgery Outpatient Clinic on 18 May 2011 in regard to his 5.5cm thoracoabdominal aortic aneurysm. Mr Chen stated that "Allan's options for management of this aneurysm are conservative review, open thoracoabdominal surgery with very high morbidity and mortality or complex repair with endovascular stent grafting which still carries significant risk of spinal cord ischaemia and renal failure, especially given that his right kidney is already ischaemic due to renal artery stenosis. At 5.5cm, I think Allan's risk of rupture is relatively low in comparison to the operative risks. I have discussed this with Allan and his family and we have agreed not to pursue repair at this time. I plan to keep him under surveillance with low dose non-contrast CT chest scans on a 6-monthly basis. If his aneurysm progresses beyond 6 or 6.5 cm, then we will reassess his treatment options."[1]

7. Mr Phipps was reviewed by Registrar Hannah Rothermel at Austin Hospital Medical Outpatients Clinic on 27 September 2011. At review Mr Phipps reported, "his mood had been worse, since the diagnosis of the aneurysm was made".[2] Mrs Phipps reported that "he had been feeling more depressed".[3]

8. In October 2011, Mr Phipps suffered a heart attack at home and was taken to the Austin Hospital where he remained in the Intensive Care Unit for a week prior to being transferred to a general ward for a week before being released.

9. On 12 November 2011, Mr Phipps was admitted to Peter James Centre South Ward "showing signs of manic episode".[4] Mr Phipps was transferred and admitted as an involuntary patient to the Kath Atkinson Wing (KAW) of the Bundoora Extended Care Centre on 18 November 2011 after he expressed "erotomaniac and religious delusions and showed disorganised behaviour".[5] According to Dr Geeta Rudra, Psychiatrist at Melbourne Health, Mr Phipps was

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[1] Coronial Brief, Appendix 2, Letter of Mr Jason Cheun, 30 May 2011.

[2] Letter of Hannah Rothermel, Registrar, Austin Health, 3 October 2011.

[3] Ibid.

[4] Bundoora Extended Care Centre, Aged Persons Mental Health Unit – Discharge Summary 4 January 2012.

[5] Ibid.

"angry that he had been admitted when he felt he did not need to be".[6] He was treated in the psychiatric ward suffering from hallucinations.

10. Dr Rudra stated that "[o]ver a period of time, the dose of Quetiapine was gradually increased as was the dose of Sodium Valproate which was started after his admission to KAW. His mental state improved slowly and he was allowed to leave with his family. His understanding of the need to take ongoing medications improved and he was made a voluntary client...He was discharged from the ward to the care of the community team on 3 January 2012."[7]

11. On 22nd September 2012, Mr Phipps complained of chest pains and was seen at the Austin Hospital. He was admitted for unstable angina.

12. Mr Phipps' electrocardiography showed changes indicating myocardial ischemia. Mr Phipps underwent coronary angiography on 24 September 2012. This showed only minor coronary artery disease and no surgery was required.

13. Mr Phipps was further assessed as to whether the dissection of his thoracic aorta could be repaired however, the risks of surgery were felt to be too high and it was recommended that Mr Phipps not have surgery. [8]

14. Lorna Phipps stated that after Mr Phipps learned of the decision not to proceed with the surgery "this made him depressed".[9]

15. Dr Katherine Bate stated that "after his situation had been assessed by the Vascular team and it was decided that his dissecting thoracic aneurysm was inoperable...[t]his meant that as surgical treatment could not be offered, the only treatment to reduce the risk of rupture of his thoracic aorta was to control his blood pressure with medication. Mr Phipps was living with the risk of sudden death from rupture of the aneurysm causing a sudden drop in cardiac output. This could occur at any time, and there was little that could be done to prevent this."[10]

16. Mr Phipps was transferred from the Austin Hospital to the Royal Talbot Rehabilitation Centre on 27 September 2012 for rehabilitation. Whilst he was there, he became severely depressed,

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[6] Statement of Dr Geeta Rudra, 20 March 2013.

[7] Statement of Dr Geeta Rudra, 20 March 2013.

[8] Statement of Dr Katherine Bate, 8 February 2013.

[9] Statement of Lorna Phipps, 18 December 2012.

[10] Supplementary statement of Dr Katherine Bate, 20 June 2014.

refusing food stating that he was nauseous. A gastric nasal tube was inserted and Mr Phipps was medicated for depression under the care of a psychiatrist.

17. By 5 October 2012, Dr Katherine Bate, noted: "Mr Phipps was noted to appear severely depressed, refusing all treatment, medications, food, fluids and [n]ursing care was recommended for involuntary treatment from an approved mental health service."[11] An involuntary treatment order was made on 5 October 2012.

18. Dr James Olver was the acting director of General Hospital Mental Helath at Austin Health at the time of Mr Phipp's death and completed the Mental Health Act form (MHA 33), "Notice of Death" on 23 October 2011. Dr Olver did not have any direct clinical contact with Mr Phipps during his admission from 22 September 2011 to 22 October 2011.

19. Dr Olver provided a report to the court compiled from entries made in the Austin Health hospital record.

20. Dr Olver stated that *"[o]n review (5/10/2012, Dr James), Mr Phipps was continuing to refuse essential medical and antidepressant treatment, was unable to indicate the reasons for this and was found on examination to have psychomotor retardation, depressed and irritable affect and was not cooperative with the interview. Dr James discussed the presentation and management with Dr Theologis. He was recommended for Involuntary Treatment under the Mental Health Act (5/10/2012, Dr Kate James) to ensure essential medical care and antidepressant treatment and the Involuntary Treatment Order was confirmed by a psychiatrist on 6/10/2012 (Dr Richard Bonwick). Dr Bonwick confirmed the diagnosis of a Major Depressive Episode with Bipolar Affective Disorder. The medication was changed to olanzapine 2.5mg, valproate 600mg and mirtazapine 30mg and Mr Phipps was transferred to a medical unit at Austin Hospital on 8/10/2012 for further medical care as he was found to be dehydrated secondary to poor oral intake, hypotension, had evidence of chronic cardiac failure and unstable angina."*[12]

21. On 8 October 2012, Mr Phipps was transferred back to the Austin Hospital as he "was considered too unwell to participate in the rehabilitation programme"[13] and required more intensive medical treatment. Dr Bate noted that *"Mr Phipps had experienced a decline in his*

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[11] Statement of Dr Katherine Bate, 8 February 2013.

[12] Statement of Dr James Olver, 22 August 2014.

[13] Statement of Dr Katherine Bate, 8 February 2013.

level of function over approximately 2 years. Surgical repair of his thoracic aneurysm was not possible. His vision was poor and not improved by cataract surgery." [14]

22. Dr Bate summarised the medical treatment provided to Mr Phipps leading up to his death as follows;

"The clinical issues identified at the time of Mr Phipps' admission under General Medical Unit 4 were constipation, unstable angina, depression, urinary retention, hypotension and poor oral intake. These acute problems were on a background of known thoracic aortic dissection, ischaemic heart disease (previous myocardial infarction) complicated by congestive cardiac failure, impaired kidney function, poor vision and a history of bipolar disorder / steroid induced psychosis.

Mr Phipps' chest pain was initially treated with nitrate medication. His urinary retention was treated by improving his constipation. Mr Phipps' low blood pressure was treated with fluid replacement, adjustment of the dose of frusemide and the dose of bisoprolol was increased to improve his heart function.

Oral antibiotics were ceased as Mr Phipps CRP had improved. Mr Phipps remained very low in mood, with very poor appetite and oral intake. This required the continued maintenance of feeding by naso-gastric tube. Mr Phipps was reviewed regularly by the Psychiatry team throughout. It was planned that once Mr Phipps was sufficiently medically stable, continued in-patient treatment of his depression would occur with transfer to Bundoora Extended Care (Psychogeriatric Unit).

During Mr Phipps' admission with General Medical Unit 4, he had recurrent problems with chest pain. The Cardiology Unit was consulted. Their opinion was that the chest pain was not due to angina, and a CT of the chest to assess Mr Phipps' known thoracic aneurysm was requested. However, the CT scan of the chest was unable to be performed on 22 October 2012 because he was too medically unstable to be taken to the radiology department for the scan. Mr Phipps was found to be anaemic and iron deficient. This was treated with a transfusion of 2 units of packed red cells on 18 and 19 October 2012 and an iron infusion on 22 October 2012. A source of blood loss was not identified prior to Mr Phipps' death.

At approximately 20:00 hours on 22 October 2012, Mr Phipps experienced a sudden large haematemesis, followed by cardiac arrest and death. A Medical Emergency Team response

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[14] Statement of Dr Katherine Bate, 8 February 2013.

was called, upgraded to a Code Blue. CPR was not continued as it had been previously decided that in the event of cardiac arrest, CPR would not be the appropriate medical treatment."[15]

23. According to Dr Olver, *"Mr Phipps remained physically unwell on the medical ward with persistent/continuous chest pain, anaemia and lethargy. Mr Phipps was considered for treatment with electroconvulsive therapy (ECT) but was deemed too medically unwell for this procedure..."*[16]

24. Dr Katherine Bate stated that decisions regarding Mr Phipps' resuscitation plan were repeatedly reviewed throughout the 18 month period following the diagnosis of his dissecting aneurysm in March 2011.

25. In all there were 4 resuscitation plans dated 28 March 2011, 13 October 2011, 27 September 2012 and 19 October 2012.

26. The initial resuscitation plan completed on 28 March 2011 was for full treatment.

27. The second resuscitation plan completed on 13 October 2011 was following the decision that his dissecting thoracic aneurysm was inoperable. Mr Phipps' resuscitation plan was changed to 'not for resuscitation' due to "poor functional status, multiple irreversible medical problem."[17]

28. The third resuscitation plan dated 27 September 2012 again stated that Mr Phipps was 'not for resuscitation'. Next of kin were noted as being notified.[18]

29. The fourth resuscitation plan dated 19 October 2012 maintained the 'not for resuscitation' plan. According to Dr Bate the "medical opinion was that performing CPR would be administering futile treatment."[19]

Post Mortem Examination

30. Dr Heinrich Bouwer performed an autopsy on Mr Phipps on 29 October 2012. In his very thorough report, he made the following comments:

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[15] Statement of Dr Katherine Bate, 8 February 2013.

[16] Statement of Dr James Olver, 22 August 2014.

[17] Supplementary statement of Dr Katherine Bate, 20 June 2014.

[18] Ibid.

[19] Supplementary statement of Dr Katherine Bate, 20 June 2014..

1. *The cause of death in Allan Phipps is exsanguination due to a ruptured thoracic aorta aneurysm. The aneurysm measured 9cm in diameter and had dissected and ruptured into the adjacent adherent left lung, which caused massive haemorrhage into the lung. This was observed as the massive haemoptysis prior to his death. He also had dilated cardiomyopathy which may have contributed to his death.*

2. *According to Victoria Police Report of Death Form No.83, I understand the deceased attended the Austin Hospital in March 2012 after he collapsed and was diagnosed with aneurysm of his aorta. He complained of chest pain in recent weeks and was admitted to the Royal Talbot Hospital for a trial of rehabilitation for cardiovascular investigation. The deceased became depressed and refused food and anasogastric tube was inserted. On the 8th October 2012 he was transferred to the Austin Hospital for further cardiovascular investigations and urinary management. He was managed with analgesia and the CT scan was organised but was delayed until his renal function was more stable. It was noted that his haemoglobin level was dropping and he received a blood transfusion. At approximately 2000 hours on the 22nd October 2012 he coughed or vomited up a large amount of blood and then became unresponsive. A "Do not Resuscitate" order was in place and he was therefore not resuscitated.*

3. *The Austin Hospital medical records and medical deposition have been reviewed. According to these, the deceased was admitted on 7th October 2012 with angina. He had a past history of idiopathic dilated non-ischaemic cardiomyopathy, ischaemic heart disease due to mild coronrary aretery disease, and a thoracic aorta aneurysm which was management conservatively. He also had bipolar disorder, previous steroid induced psychosis, benign prostatic hyperplasia, hypertension and chronic renal impairment. He was admitted from the Talbot Hospital for investigation and recurrent chest pain, optimisation of depression, acute urinary retention and constipation. An aniogram showed minor coronary artery disease. He received two units of red blood cell transfusion and iron infusions. Chest x-rays showed increase in left lung opacity. He was awaiting a CT chest to assess the status of his thoracic aneurysm as a potential cause of chest pain. He died after coughing up a large volume of frank blood. He was not resuscitated.*

4. *Post mortem toxicological analysis detected drugs that may have been administered in a therapeutic setting.*

5. *On the basis of the information available to me at this time, I am of the opinion that this death is due to natural causes.*

6. *There was no post mortem evidence of violence or injury contributing to death.*

31. Dr Bouwer concluded his report with a specific finding of the medical cause of death as exsanguination secondary to pulmonary aortic fistula and thoracic aorta aneurysm in the setting of dilated cadiomyopathy. In all the circumstances, I accept that as the cause of Mr Phipps' death.

32. Dr Olver details in his report a summary of the psychiatric review of Mr Phipps on the day of his death;

"Mr Phipps was last reviewed from a psychiatry point on 22/10/2012 by psychiatry registrar Dr Aileen Shuey. During this review it was noted that his mood was noted to have improved, he was more reactive in his affect and was enquiring as to when he could be transferred to the psychiatric unit at Bundoora Extended Care for further treatment. There was no suicidal ideation at this time."[20]

[20] Statement of Dr James Olver, 22 August 2014.

Finding

33. In the months preceding his death, Allan Phipps suffered from multiple health issues. His physical condition was exacerbated by his mental illness, severe depression, which resulted in him refusing all treatment. An involuntary order was made on 5 October 2012 to facilitate treatment of his depression and medical problems. He had a sudden deterioration of his health on 22 October 2012, which resulted in him dying of natural causes. These were exsanguination secondary to pulmonary aortic fistula and thoracic aorta aneurysm in the setting of dilated cadiomyopathy.

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

Mrs Lorna Phipps
Senior Constable Amanda Pouw

Signature:

CAITLIN ENGLISH
CORONER
Date: **17 November 2014**