IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 005029

FINDING INTO DEATH WITH INQUEST

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

Deceased:	ANGELO RAFFAELLE PALMA
Delivered on:	7 March 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	7 March 2017
Findings of:	PARESA ANTONIADIS SPANOS
Assisting the Coroner:	Samantha Brown
Catchwords	Mandatory inquest, death in care, fall, intracranial haemorrhage

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of ANGELO RAFFAELLE PALMA
and having held an inquest in relation to this death on 7 March 2017
in the Coroners Court of Victoria at Melbourne
find that the identity of the deceased was ANGELO RAFFAELLE PALMA
born on 27 March 1950
and that the death occurred on 3 October 2015
at Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria 3128
from:

I (a) INTRACRANIAL HAEMORRHAGE FOLLOWING A FALL

in the following circumstances:

1. Mr Palma was a 65-year-old single man who had a medical history that included intellectual disability, schizoaffective disorder, non-insulin dependent diabetes, hyponatraemia, and a persistent cough thought to be associated with gastroesophageal reflux. He was independently mobile and articulate, able to communicate his needs verbally in simple terms.
2. Mr Palma was cared for at home by his father, along with two older brothers, and attended a special school for disabled children. After his father died in 1993, Mr Palma lived with his eldest brother, Francesco, until 2000. Thereafter, given the level of care he required, Mr Palma lived in facilities operated under the auspices of the Department of Health and Human Services [DHHS], initially at a group home in Croydon and, after 2012, at Nadrasca House [Nadrasca] in Blackburn. When Francesco Palma died in 2007, Mr Palma's surviving brother, Saverio, became his guardian.
3. At Nadrasca, Mr Palma lived with four other residents with cognitive and/or physical impairments who required varying degrees of assistance and support from the disability support workers on staff all day and sleepover staff at night. Mr Palma was helpful around the house, sociable and well-liked by other residents and staff. He enjoyed visits to and from his brother(s), playing his guitar and listening to the radio.
4. Mr Palma's medical needs were coordinated by his general practitioner, Dr Peter Sharp, at the Dorset Medical Centre. Dr Sharp performed annual general health assessments of Mr Palma and saw him as needed in the interim. His schizoaffective disorder was well-controlled with risperidone, sodium valproate, citalopram and quetiapine while heartburn was treated with antacid medications. Mr Palma's sodium level was monitored and managed by restricted fluid intake. Blood sugar lowering medication was ceased in early September 2015 as appropriate blood glucose levels were achieved and remained stable with a healthy diet.

5. A range of care plans were developed to assist Nadrasca's staff to manage Mr Palma's medical conditions and daily medications, and risk assessments and living skills assessments were performed regularly. Mr Palma was never identified as a resident with a falls risk. He was able to attend to some activities of daily life independently, such as toileting, bathing, dressing and the preparation of light meals. He required some support or prompting from staff with other tasks and required full supervision for activities like crossing the road.
6. In the afternoon of 1 October 2015, Mr Palma returned from an outing in good spirits. He ate a full meal that evening and watched some television before retiring to bed around 9.30pm. At about 11.45pm, House Supervisor Angela Zaia heard Mr Palma get out of bed, which was not unusual as he would often get up to go to the bathroom in the night and otherwise had a tendency to be a bit of a 'night owl'.
7. A short time later, at about 12.10am on 2 October 2015, Ms Zaia heard Mr Palma out of bed again. He was in the kitchen and when she asked him why, Mr Palma told her he felt sick. Ms Zaia saw that Mr Palma was pale and appeared a little unsteady on his feet. She wondered if he had caught a gastrointestinal virus from the co-resident who had recently been unwell. She checked Mr Palma's blood glucose level which was high rather than low as she had expected.
8. Ms Zaia escorted Mr Palma to the bathroom and then to his bedroom. In his room she noticed a small amount of vomit on the carpet at the foot of the bed. Mr Palma lay down on the bed while Ms Zaia cleaned up his vomit and found a bucket he could use if he felt like vomiting again. She left the doors between Mr Palma's room and her own open so that she could hear him easily if he needed help.
9. About 10 minutes later, Ms Zaia heard a loud noise. Upon investigation, she found Mr Palma on the carpeted floor of his bedroom near a chest of drawers on which was a lamp that he had apparently just turned on. Mr Palma was conscious and alert and explained that he had fallen. Ms Zaia looked for signs of injury, particularly around Mr Palma's head, but found none. Mr Palma said that he did not think he had hurt himself but, when he tried to get up, he was unable to do so.
10. Ms Zaia called an ambulance. While waiting for paramedics to arrive, Mr Palma vomited again and Ms Zaia thought that his right leg appeared somewhat limp and that his speech was slower than usual. She called the emergency services a second time when no ambulance had arrived after 20 minutes. Mr Palma, however, remained in reasonable spirits, asking what was for dinner and which staff would be working the following shift. Paramedics arrived at about 1.50am and transported Mr Palma to the Box Hill Hospital [BHH].

11. On arrival at the Emergency Department [ED] at about 2.25am, Mr Palma's condition had deteriorated such that his conscious state had decreased to a Glasgow Coma Scale [GCS] score of nine out of 15 indicating a moderate brain injury. His pupils were unequal, with the left significantly larger than the right, he did not respond to painful stimuli on the right side of his body and he was no longer able to speak. His vital signs were within normal limits.

12. Over the next hour, Mr Palma's condition rapidly deteriorated, with his consciousness state falling further to a GCS score of four indicating coma. A computerised tomography [CT] scan of his brain showed a large left-sided acute on chronic subdural haemorrhage with midline shift. His ED clinician, Dr Allister Ware, discussed the CT findings with Neurosurgeon, Mr Chris Thien. The neurosurgeon considered Mr Palma's intracranial injury highly likely to lead to death – before, during or after any attempt to surgically decompress the bleed – and that even if he survived surgery, poor neurological recovery was a strong possibility.

13. Dr Ware contacted Saverio Palma to discuss Mr Palma's grave condition and poor prognosis. Ultimately the decision was made to treat Mr Palma palliatively and he died at 11am on 3 October 2015 with family in attendance.

14. Apart from a jurisdictional nexus with the State of Victoria, reportable deaths are, generally, deaths that appeared to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury.[1] However, some deaths are reportable irrespective of the nature of the death, based on the status of the person immediately before death. Mr Palma's death was reportable as he was a *person placed in custody or care*[2] of the Secretary to the DHHS. This is one of the ways in which the *Coroners Act* 2008 recognises that people in the control, care or custody of the State are vulnerable, and affords them the protection of the independent scrutiny and accountability of a coronial investigation.

15. Another protection is the requirement for mandatory inquests. While there is a discretionary power to hold an inquest in relation to any death a coroner is investigating,[3] this was a mandatory or statutorily prescribed inquest as Mr Palma was, immediately before death, a person placed in custody or care.[4]

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[1] See section 4 of the Coroners Act 2008 [the Act] for the definition of "reportable death".

[2] See section 3 of the Act for the definition of a "person placed in custody or care".

[3] Section 52(1) of the Act provides that a coroner may hold an inquest into any death that the coroner is investigating.

[4] See section 52(2) and the definition of "person placed in custody or care" in section 3 of the Act. I note that since the insertion of subsection (3A) into section 52 of the Act in November 2014, coroners are no longer required to hold an inquest into the death of a person in custody or care immediately prior to death if the death was due to natural causes. Section 52(3B) outlines the circumstances in which a coroner may consider a death to be due to natural causes.

16. This finding draws on the totality of the material the product of the coronial investigation of Mr Palma's death, namely, his medical and Nadrasca resident records, the inquest brief compiled by Senior Constable Leigh Moroney of Box Hill Police Station and the additional statement provided by Meghan Coulter on behalf of Nadrasca. The brief and statements, together with the inquest transcript, will remain on the coronial file. In writing this finding, I do not purport to summarise all evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.
17. Mr Palma's identity, and the date and place of his death were never at issue. I find, as a matter of formality, that Angelo Raffaelle Palma, born on 27 March 1950, aged 65, late of 27 Gardenia Street, Blackburn, died at Box Hill Hospital in Box Hill on 3 October 2015.
18. Nor was the medical cause of death contentious. Forensic pathologist Dr Yeliena Baber of the Victorian Institute of Forensic Medicine reviewed the police report of death, medical records and the medical deposition from BHH and post-mortem CT scanning of the whole body [PMCT], and performed an external examination of Mr Palma's body. Dr Baber noted no signs of recent significant injury during her external examination of Mr Palma's body while a massive mixed density left subdural haematoma with midline shift and increased lung markings were evident on PMCT.
19. Dr Baber observed that there was no clinical evidence, nor evidence on ante-mortem or post-mortem imaging to indicate that Mr Palma had suffered a cerebrovascular accident (stroke) such as may have triggered the fall that led to his subdural haemorrhage.
20. Post-mortem toxicology detected citalopram, quetiapine and risperidone at levels consistent with their therapeutic use.
21. Dr Baber advised that it was reasonable to attribute Mr Palma's death to intracranial haemorrhage following a fall without the need for an autopsy.
22. In accordance with Dr Baber's advice, I find that Mr Palma died as a result of an intracranial haemorrhage following a fall.
23. While I am unable to determine precisely why Mr Palma fell early on the morning of 2 October 2015, I am satisfied by the evidence before me that the fall was not related to the relatively recent cessation of his diabetes medication nor was it indicative of any deficiency in Nadrasca's falls risk assessment or management plan.
24. The available evidence does not support a finding that any want of clinical management by Mr Palma's general practitioner or BHH clinicians nor any want of care on the part of his carers at Nadrasca caused or contributed to his death.

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

Saverio Palma

Angela Zaia, Housing Supervisor, Nadrasca House

Dr Yvette Kozielski, Medico-Legal Officer, Eastern Health

Meghan Coulter, Accommodation Manager, Department of Health Human Services (Inner Eastern Melbourne)

Senior Constable Leigh Moroney, Box Hill Police Station

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 7 March 2017