IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 156 / 2011

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: ANTHONY MANSBRIDGE

Delivered On:	6 June 2012
Delivered At:	Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	6 June 2012
Findings of:	IAIN TRELOAR WEST, DEPUTY STATE CORONER
Representation:	Ms Allan appeared for Eastern Health
Police Coronial Support Unit	Leading Senior Constable Tania Cristiano

I, IAIN TRELOAR WEST, Deputy State Coroner having investigated the death of ANTHONY MANSBRIDGE

AND having held an inquest in relation to this death on 6 June 2012

at MELBOURNE

find that the identity of the deceased was ANTHONY JOSEPH MANSBRIDGE

born on 12 July 1933

and the death occurred on 13 January 2011

at Box Hill Hospital, Nelson Road, Box Hill 3128

from:

1 (a) MULTISYSTEM ORGAN FAILURE

2 RECENT FRACTURE REPAIR-LEFT HIP

in the following circumstances:

1. Mr Anthony Mansbridge, was aged 77 years at the time of his death and had previously resided at Craigcare, a low care facility in Berwick. His past medical history included vascular dementia, ischaemic heart disease, cerebrovascular accident, hypertension, tuberculosis and chronic lung disease.

2. In January 2011, Mr Mansbridge was being treated at Dandenong Hospital for a number of minor medical conditions, however, following a change in his mental state resulting in increased aggressiveness and agitation, he was moved on 8 January 2011 to the Peter James Centre, East Burwood. Following his admission to the Peter James Centre, he was made an involuntary patient pursuant to the *Mental Health Act.*

3. At approximately 12.45pm on Sunday 9 January, Mr Mansbridge was seated in a chair in the lunchroom, however, when he attempted to stand up out of the chair, he fell from it to the floor. The fall was witnessed by members of the staff who immediately came to his aid and on Mr Mansbridge complaining of pain in his hip, he was transferred by ambulance to Box Hill Hospital for treatment. Later in the day, he underwent an operation to his injured hip and post-operatively, he remained at the hospital for treatment and recovery.

4. Following a period of stability after returning to the ward, a Code Blue was called at approximately 9:00am on the 11 January, after Mr Mansbridge was found by nursing staff to be unresponsive and profoundly hypotensive. He received treatment and was stabilised

following transfer to the ICU, however, over the following days his condition continued to slowly deteriorate and after consultation with family members, the decision was made not to pursue further invasive treatment. Mr Mansbridge subsequently slipped into unconsciousness and died shortly before midnight on the 13 January 2011.

5. On the 19 January 2011, a post mortem examination was performed by Dr Malcolm Dodd, Senior Pathologist with the Victorian Institute of Forensic Medicine. Dr Dodd performed an external and internal examination of Mr Mansbridge at the mortuary, reviewed the circumstances of his death, the medical deposition and clinical notes, the post mortem CT scan and provided a written report of his findings. Dr Dodd reported that in all the circumstances a reasonable cause of death was multisystem organ failure. Toxicological analysis of body fluids was non-contributory.

6. Family of Mr Mansbridge wrote to the court raising a number of concerns regarding his management. Their concerns are:

7.

   a. That incorrect medication was prescribed by a visiting doctor whilst at Craigcare.

   b. That the transfer from Dandenong Hospital to Peter James Centre was without family authority.

   c. Questioning whether there was proper supervision prior to the fall as their father was heavily sedated.

7. The investigation into the death does not permit a finding that the wrong medication was prescribed to Mr Mansbridge, when at Craigcare. His period of residence at Craigcare is remote to the time of death and his medication regime when a client at that facility, is not a matter that is related to the cause of death. If the family wish to pursue this matter, it should be directed to the Health Services Commissioner. The fact that Mr Mansbridge was transferred to the Peter James Centre without family consultation, again is not a matter for coronial investigation. The suggestion by the family that Mr Mansbridge was over sedated, prompted a review of his medications by the Court's medical clinicians. The reviewing doctor and nurse noted that while Mr Mansbridge was dispensed Olanzapine and Oxazepam medications, the doses were not indicative of causing over sedation. Staff were present in the room when he

fell and acted promptly to assist him after his fall. It would be an unrealistic onus to place on staff, to expect them to have prevented the fall.

8. I find that Anthony Mansbridge died of natural causes with the cause of death being multiorgan failure. The evidence supports a finding that Mr Mansbridge's care and management was within the normal parameters of reasonable health care practice.

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

Senior Next of Kin
Peter James Centre
Craigcare Berwick

Signature:

Iain West

IAIN WEST
DEPUTY STATE CORONER
Date: 6 June 2012