

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 1877/07

Inquest into the Death of ANTHONY MANDEL

Delivered On: 21st July 2011

Delivered At: Melbourne

Hearing Dates: 21st July 2011

Findings of: IAIN TRELOAR WEST

Place of death/Suspected death: Box Hill Hospital

PCSU: Sergeant Dave Dimsey

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the Coroners Act 2008

Court reference: 1877/07

In the Coroners Court of Victoria at Melbourne
I, IAIN TRELOAR WEST, Deputy State Coroner

having investigated the death of:

Details of deceased:

Surname: MANDEL
First name: ANTHONY

AND having held an inquest in relation to this death on 21st JULY 2011
at Melbourne
find that the identity of the deceased was ANTHONY MANDEL
and death occurred on the 18th May, 2007

at Box Hill Hospital

from

- 1(a) Pneumonia
- 2 Intellectual disability, schizophrenia

in the following circumstances:

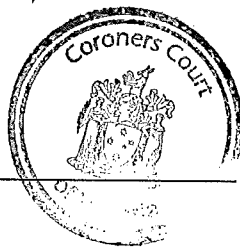
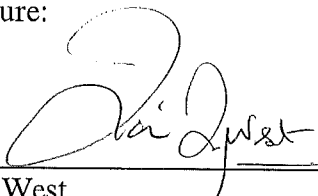
1. Anthony Mandel, aged 50 years, was of male gender and was in the supportive care of the Department of Human Services at the time of his death, residing at Doncaster Lodge, 107 Wittens Lane, Doncaster. He had a past medical history that included intellectual disability and paranoid schizophrenia, which had deteriorated over the three months prior to his death.
2. On the 4th May 2007, Mr Mandel was admitted to Box Hill Hospital for assessment, following an acute psychotic episode. Various tests and investigations were performed and having excluded a medical diagnosis, despite a number of medical setbacks, he was transferred to Upton House high dependency unit on the 9th May 2007, as an involuntary patient. Following assessment, a differential diagnosis of resolving delirium, organic psychosis or psychotic disorder was made, on a background of intellectual disability. An appropriate management plan was put in place, however, ongoing behavioral problems continued, with Mr Mandel having episodes of refusing fluids which led to him becoming dehydrated and hypotensive. On the 16th May 2007 it was felt that a possible infective process was evolving, which led to assessment by the medical registrar. Mr Mandel was found to be dehydrated, but to have normal findings on examination of the chest, heart and abdomen. Following further investigations, Mr Mandel was transferred on the 18th May at 12: 30am to Box Hill Hospital, for rehydration therapy. A nurse from Upton House accompanied him to assist with behavioural problems.

3. Following hospital admission, Mr Mandel was found at approximately 3:00am, to be vomiting and in an altered conscious state, requiring intubation and admission to the resuscitation area. A chest x-ray revealed a "white out" and he had decreased air entry and reduced oxygen saturation. Following review by the ICU team he was transferred to the Intensive Care Unit, however, his condition continued to deteriorate and he subsequently died at 10:35 am, on the 18th May, 2007.

4. On the 22nd May 2007, a post mortem examination was performed by Dr Shelley Robertson, senior pathologist with the Victorian Institute of Forensic Medicine. Dr Robertson performed an external and internal examination and reviewed the circumstances of the death, the medical deposition and clinical notes, and reported that a reasonable cause of death was pneumonia.

5. The evidence in this case satisfies me that the transfer of Mr Mandel from Upton House to Box Hill Hospital was in line with hospital policy, and that a management plan was in place prior to transfer and that it was communicated to hospital staff. It would appear that Mr Mandel suffered a sudden deterioration that was not anticipated and did not match the clinical finding following assessment at Upton House, a few hours earlier. Where care appears to have been sub optimal in this caes was in the area of observations performed and lack of nursing handover upon admission to Box Hill Hospital. The evidence does not permit a finding, however, as to whether these failures contributed to the death.

Signature:



Iain T West
Deputy State Coroner
21st July, 2011