FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 1183/06

Inquest into the Death of BRIAN O'CONNOR

Delivered On:	8 September 2010
Delivered At:	Level 1, 436 Lonsdale Street, Melbourne
Hearing Dates:	8 September 2010
Findings of:	JANE HENDTLASS
Place of death:	Dandenong & District Hospital, David Street, Dandenong Victoria 3175
Assistant:	Sergeant Tracy Weir

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 1183/06

In the Coroners Court of Victoria at Melbourne

I, JANE HENDTLASS, Coroner

having investigated the death of:

Details of deceased:

Surname: O'CONNOR
First name: BRIAN
Address: 4 Latrobe Street, Cranbourne, Victoria 3977

AND having held an inquest in relation to this death on 8 September 2010

at Melbourne

find that the identity of the deceased was BRIAN O'CONNOR
and death occurred on 15th March, 2006

at Dandenong & District Hospital, David Street, Dandenong Victoria 3175

from

1a. ACUTE ON CHRONIC SUBDURAL HAEMATOMA
1b. RECENT HEAD TRAUMA
2. VASCULAR DEMENTIA

in the following circumstances:

1. Brian O'Connor was 73 years old when he died. He lived with his wife, Marlene O'Connor, at 4 Latrobe Street in Cranbourne. Mr O'Connor had a past medical history of stroke causing paralysis of his left arm, diabetes and hypertension. Mr O'Connor gradually developed advanced dementia which was associated with marked changes in his personality.

2. On 16 November 2005, Mr O'Connor was admitted as an involuntary patient to Biala Aged Acute Mental Health Inpatient Unit at Dandenong Hospital. His treating psychiatrist was Dr Hugh Lowy. Dr Lowy reported to the Chief Psychiatrist that he Mr O'Connor's admission medication and with low dose depot fluphenazine. Despite this change, Mr O'Connor's aggression remained high and his mental state continued to deteriorate.

3. On 8 December 2005, Mr O'Connor was transferred to the Amaroo Unit because of his sexually disinhibited and aggressive, agitated behaviour. Nursing staff had seen him walking past other patients, staff and visitors and just hit out at them for no reason. This behaviour was more pronounced with co-patients who did not get on well with Mr O'Connor so staff kept them separated as much as possible.

4. On admission to Amaroo House, Mr O'Connor's falls risk was assessed as Level 3. He was placed on 15 minute observations to minimise risk to other patients. Increased sedation was also considered but rejected on the grounds that it would also increase risk of falls.

5. On 1 February 2006, Mr O'Connor became involved in a fight with a co-patient. Afterwards, he showed no neurological problems. However, at 3.00pm, Mr O'Connor had a another fight with a different patient. He fell and received a cut above his left eye. There was no loss of consciousness and his neurological signs continued to remain stable.

6. At 9.00pm on 2 February 2006, Mr O'Connor fell next to his bed and sustained a further hit to his head. In the short time after this fall, he was somewhat disoriented and agitated but his continued observations were unremarkable.

7. On 8 February 2006, Mr O'Connor fell while sitting in a chair. The reason for this fall was undiagnosed. On 10 February, he fell again. On that day he was reviewed by his consultant psychiatrist.

8. At 8.40am on 8 March 2006, Mr O'Connor hit his head on a door when he was pushed by another patient with whom he was known to have a poor relationship. He walked back to his room after the incident. However, at about 8.50am, he became unresponsive. He was transferred to the Intensive Care Unit. A CT head scan showed a 30mm acute on chronic subdural haematoma.

9. Mr O'Connor's condition contiued to deteriorate. On 9 March 2006, Mr O'Connor was extubated.

10. On 15 March 2006, Mr O'Connor died.

11. Mr O'Connor's death was reported to the Registrar of Births Deaths and Marriages as a natural causes death. It was subsequently reported to the State Coroner because it involved an acute subdural haematoma associated with falls and an altercation with another involuntary mental health patient. Release of information from this patient's medical records is subject to legal protections provided by the *Mental Health Act* 1986.

12. A forensic pathologist reviewed Mr O'Connor's Medical Records from Dandenong Hospital. On the basis of the information before him, the forensic pathologist was of the view that the cause of death was acute on chronic subdural haematoma, recent head trauma and vascular dementia.

Signature:

Dr Jane Hendtlass
Coroner
8 September 2010