FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 1474/09

Inquest into the Death of CHRIS CHRISTODOULOU

Delivered On:	26 August 2010
Delivered At:	Hearing Room, Level 1, 436 Lonsdale Street, Melbourne 3000
Hearing Dates:	6 August 2010
Findings of:	JOHN OLLE
Representation:	John Carmody for Devinder Singh Neil Murdoch for Meadowglen Nursing Centre
Place of death:	Northern Hospital, 185 Cooper Street, Epping 3076
PCSU:	Sergeant Tracey Weir

FORM 37

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Court reference: 1474/09

In the Coroners Court of Victoria at Melbourne
I, JOHN OLLE, Coroner

having investigated the death of:

Details of deceased:

Surname: CHRISTODOULOU
First name: CHRIS
Address: Meadowglen Nursing Home, 202 McDonalds Road, Epping 3076

AND having held an inquest in relation to this death on 6 August 2010
at Melbourne Magistrates Court
find that the identity of the deceased was CHRIS CHRISTODOULOU
and death occurred on 9th March, 2009

at Northern Hospital, 185 Cooper Street, Epping 3076

from

1a. INTRACRANIAL HAEMORRHAGE SECONDARY TO BLUNT FORCE TRAUMA (FALL)

in the following circumstances:

1. Chris Christodoulou was aged 82 years at the time of his death. He lived at Meadowglen Nursing Home, Epping.

2. A coronial brief has fully addressed the circumstances of death. At inquest I received evidence from RN2 Devinda Singh, RN1 Thokozani Sithole, RN1 Lillian Nzenza and Yvonne Bull, Director of Nursing Meadowglen Nursing Centre.

3. I am satisfied the circumstances of death of Mr Christodoulou have been fully addressed.

Chronology

12 January, 2009
Mr Christodoulou admitted as a permanent resident to the Meadowglen Nursing Home.

14 January, 2009

Decision made to allow Mr Christodoulou access to mainstream unit during the day. Mr Christodoulou required to sleep in the dementia specific unit of an evening.

12 February, 2009

Dr Giapoakis, General Practitioner, prescribed medication to address Mr Christodoulou's wandering behaviour.

19 February, 2009

Dr Giapoakis reviewed Mr Christodoulou following observed unsteadiness on his feet and a subsequent fall.

7 March, 2009

- At approximately 8.24am, Mr Christodoulou was observed by nursing staff following an unwitnessed fall. Nil injuries observed and Mr Christodoulou was able to walk without signs of pain.
- The family visited Mr Christodoulou between 7pm and 7.30pm and advised RN2 Singh of a fall earlier that day.
- At approximately 7.35pm, Mr Christodoulou was found by a staff member lying on the floor beside his chair. RN2 Singh was alerted and attended Mr Christodoulou who was in the process of getting up. With assistance, Mr Christodoulou walked to his room. RN1 Nzenza was contacted and reviewed Mr Christodoulou.

4. RN1 Nzenza knew Mr Christodoulou. She noted he was responding in a normal fashion. Neurological observations performed by her were within normal range. RN1 Nzenza directed RN2 Singh to make appropriate entries in the progress nursing notes. She instructed a personal care assistant (PCA) to monitor Mr Christodoulou.

5. RN2 Singh concluded his shift at 8.00pm. He informed RN1 Nzenza that he had left message for the family. Mr Christodoulou was sleeping at that time.

6. Throughout the evening RN1 Nzenza performed regular neurological observations.

7. At approximately 5.30am, Mr Christodoulou was observed bleeding from the nose. Mr Christodoulou was promptly conveyed by ambulance to the Northern Hospital.

8. Sadly, Mr Christodoulou died later that day.

Lessons Learnt

9. The facility has learnt valuable lessons following the death of Mr Christodoulou. Of particular significance:

a) Inadequate handover process

The first fall on the 7 March was the subject of entry in the progress notes. At the time, RN1 Nzenza would receive a handover and subsequently appraise staff on duty. RN2 Singh should have received a hand over from RN1 Nzenza at the commencement of his 4pm shift.

Regrettably, RN1 Nzenza did not receive a hand over on the 7 March, 2009. Accordingly, RN2 Singh commenced his shift without hand over. Having not read the progress notes, RN2 Singh was unaware of the fall earlier that day.

b) RN1 Nzenza was unaware of the fall, earlier that day

When RN1 Nzenza was called to examine Mr Christodoulou following the second fall, she was unaware he had had a fall earlier that day. In evidence explained had she known, a General Practitioner would have been called.

10. RN1 Nzenza explained:

"The thing that we didn't do on that day was call a doctor. We didn't call a doctor on this occasion because there was no obvious injury to Chris. After Chris died, we call the doctor every time a patient has a fall, whether it is witnessed or not."

11. Further:

"When I finish my shift, I hand it over to night shift exactly what had transpired. The night shift were not aware of the first fall either because I was unaware and could not pass this information on to them."

Communication problems did not reflect a lack of professional care

12. The care and attention offered Mr Christodoulou by facility staff was caring and professional. The shortcomings identified are not causative of death.

13. A general practitioner was not called to attend. However, the neurological observations undertaken by RN1 Nzenza were all in range. There was no clinical need to transfer Mr Christodoulou to hospital.

14. Mr Christodoulou was monitored through out the evening. Upon noting his deterioration, a speedy hospital transfer occurred.

The facility has implemented change

15. Having heard the evidence and considered the material before me, in particular the procedural changes implemented, I am confident handover will always take place and, if a resident suffers a fall, a general practitioner will be called to attend.

16. I note the dignified manner in which the family of Mr Christodoulou participated in the inquest. I offer all family members my condolences.

Post Mortem Medical Examination

17. On the 10th March 2009, Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an examination on the body of Mr Christodoulou. Following his examination and review of post mortem CT scans, and noting the family's preference that an autopsy not be performed, Dr Lynch found the cause of death to be intracranial haemorrhage secondary to blunt head trauma (fall).

Signature:

John Olle
Coroner
Date: 26 August 2010

Coroners Court of Victoria