IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2000/09

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of JOHN MIKLOSOWA

Hearing Dates: 15 November 2011

Appearnaces: Senior Constable Kelly Ramsey, Police Coronial Support Unit (PCSU)

Findings of: AUDREY JAMIESON, Coroner

Delivered On: 6 February 2012

Delivered At: Coroners Court of Victoria
Level 11, 222 Exhibition Street
Melbourne 3000

I, AUDREY JAMIESON, Coroner having investigated the death of JOHN MIKLOSOWA

AND having held an inquest in relation to this death on 15 November 2011
at Melbourne

find that the identity of the deceased was JOHN JOSEPH MIKLOSOWA

born on 25 November 1970

and the death occurred on 9 April 2009

at Austin Hospital, 145 Studley Road, Heidelberg, Victoria 3084

from:

1a. UROSEPSIS
2. HYPOXIC BRAIN INJURY, DOWNS SYNDROME

in the following circumstances:

1. Mr John Joseph Miklosowa was 38 years of age at the time of his death. He was diagnosed with congenital Down Syndrome, intellectual disabilities and microcephaly. He suffered from multiple medical problems and his disabilities were such that he was confined to a wheelchair and could not communicate verbally. His medical problems also included cholecystectomy, reflux oesophagitis and constipation. Mr Miklosowa lived at a Department of Human Services care house at 30 Kenthurst Court, Lilydale, a residential facility run by Melba Support Services. Mr Miklosowa required assistance with all activities of daily living.

2. In July 2007, Mr Miklosowa was admitted to Maroondah Hospital with acute renal failure and urinary retention. He was discharged with an indwelling catheter and received follow ups through the urology outpatient department.

3. In August 2007, due to problems associated with the indwelling catheter, his general practitioner, Dr Gurcharan Ubhi, referred Mr Miklosowa to Mr Damien Bolton, Urologist, for opinion and management. Mr Bolton recommended that Mr Miklosowa would benefit from a permanent suprapubic catheter.

4. On 1 May 2008, Mr Miklosowa was admitted to Maroondah Hospital for insertion of a permanent suprapubic catheter. He was seen again at the hospital on 5 May, 2008, due to leaking around the catheter. He continued to have problems with the suprapubic catheter and on 19 June 2008, his catheter was replaced and arrangements put in place to have the catheter changed every three months by the Royal District Nursing Service (RDNS).

5. On 20 August 2008, Mr Miklosowa was reviewed by Mr Bolton at which time the catheter appeared to be draining well. Mr Bolton discharged Mr Miklosowa back to the care of the RDNS and his Community Residential Unit (CRU). Periodic urine testing did not identify the presence of any

specific organism despite ongoing problems with the leakage. A renal and bladder ultrasound organised by Dr Ubhi, was reported as normal.

6. On 31 December 2008, Dr Ubhi reviewed Mr Miklosowa due to haematuria but again the urine culture failed to identify any specific infection.

7. On 18 February 2009, Mr Miklosowa was reviewed by Dr Ubhi's Associate, Dr Michael Kreltszhein who suspected a urinary tract infection, however, again no specific organism was identified in urine cultures.

8. On 28 March 2009, Melba Services contacted the RDNS requesting them to attend to Mr Miklosowa as there had been no flow into his catheter bag overnight. It was recorded by RDNS that Mr Miklosowa had been experiencing some discomfort and that the catheter had been bypassing for three days. RDNS Division 1 Nurse, Andrea Hindle, attended the facility and following her examination of the suprapubic catheter, decided to change the catheter although the next routine change was not scheduled for a further two weeks. Following the changing of the catheter, Ms Hindle reported that she remained at the premises until urine commenced to drain into the bag. She then inflated the catheter balloon with 10mls of sterile water in accordance with RDNS policy and procedure guidelines.

9. At approximately 11.20am, RDNS Nurse Hindle telephoned the CRU to enquire on the status of the suprapubic catheter and was informed by staff that no urine was flowing into the bag but had been flowing from the penis and the stoma.

10. In the afternoon of 28 March 2009, Mr Miklosowa was taken out with staff but did not want to eat any lunch or drink any fluids. He returned to the CRU at approximately 2.00pm and was returned to his bed to rest. At approximately 4.30pm, he was noted to be breathing at a faster than normal rate and his temperature was elevated to 38.4°C. At approximately 5.15pm, an ambulance was requested after Mr Miklosowa was noted to be very short of breath and blue around the lips. Ambulance paramedics arrived at the CRU at approximately 5.21pm and found Mr Miklosowa to be unconscious with a Glascoma Score of 5/15[1] and no recordable blood pressure. His temperature was 39.7°C and his respiratory rate was 40 with grunting respiration. His oxygen saturation was 88% on room air and increased to 92% on 8L of oxygen per minute. He was transported to Maroondah Hospital Emergency Department (ED). In the ED, the differential diagnosis of septic shock was made and he was administered intravenous fluids, intravenous antibiotics, intravenous noradrenaline and he required the insertion of an endotracheal tube for ventilation, a central line, an arterial line and nasogastric tube. On 29 March 2009, he was transferred to the Austin Hospital Intensive Care Unit. Despite active medical treatment, Mr Miklosowa failed to respond to treatment. He was transferred to the general ward on 8 April 2009 following a decision to implement palliative care only. Mr Miklosowa died on 9 April 2009 at 7.40pm.

[1] Glasgow Coma Scale is a standardised system for assessing response to stimuli in a neurologically impaired patient; reactions are given a numerical value in three categories (eye opening, verbal responsiveness, and motor responsiveness), and the three scores are then added together. The lowest values are the worst clinical scores. (Source: *Dorland's Illustrated Medical Dictionary*, 30th Edition)

11. A death certificate was issued by the hospital attributing the cause of death to Urosepsis with significant contributing conditions being hypoxic brain injury and Downs Syndrome. The death of Mr Miklosowa was in fact a reportable death[2] under the *Coroners Act 1985* (as it then was) as immediately before death, Mr Miklosowa was a "**person held in care**" as it was defined in the Act.[3]

Investigations

12. On 15 April, 2009 at the Victorian Institute of Forensic Medicine, Associate Professor and Forensic Pathologist, Dr David Ranson carried out a medical investigation by conducting an external examination on the body of Mr Miklosowa, reviewing a post mortem CT scan, along with the documentary materials in his possession including the Death Certificate issued at the hospital, an Incident Report dated 30 March 2009 and the medical records from the Austin Hospital. Associate Professor Ranson concluded that it was not unreasonable in all the circumstances to attribute the cause of Mr Miklosowa's death to Urosepsis with contributing factors being hypoxic brain injury and Down's Syndrome.

13. The police investigation was conducted by Senior Constable Adele Collard from Lilydale Uniform.

14. An inquest was held in accordance with the Act.

Jurisdiction

15. At the time of Mr Miklosowa's death, the *Coroners Act 1985* (the old Act) applied. From 1 November, 2009 the *Coroners Act* 2008 (the new Act) as applied to the finalisation of investigations into death that occurred prior to the new Act commencement.[4]

16. In the preamble to the new Act, the role of the coronial system in Victoria is stated to involve the independent investigation of deaths for the purpose of finding the causes of those deaths and to contribute to the reduction of the number of preventable deaths and the promotion of public health and

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2 **"reportable death"** means a death-
(a) where the body is in Victoria; or
(b) that occurred in Victoria; or
(c) the cause of which occurred in Victoria; or
(d) of a person who ordinarily resided in Victoria at the time of death-
being a death-
(e) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury; or
(f) that occurs during an anaesthetic; or
(g) that occurs as a result of an anaesthetic and is not due to natural causes; or
(h) that occurs in prescribed circumstances; or
(i) **of a person who immediately before death was a person held in care**; or.......

3 **"person held in care"** means-
(a) a person under the control, care or custody of the Secretary to the Department of Human Services; or.....

4 Section 119 and Schedule 1 - Coroners Act 2008

safety and administration of justice. Reference to preventable deaths and public health and safety are referred to in other sections of the Act.[5]

17. Section 67 of the new Act describes the ambit the Coroners findings in relation to a death investigation. A coroner is required to find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.[6]

18. The 'cause of death' generally relates to the *medical cause of death* and the 'circumstances' relates to the *context* in which the death occurred.

19. A coroner may also comment on any matter connected with the death including matters relating to public health and safety administration of justice.[7] A coroner may also report to the Attorney-General and may make recommendations to any Minister, statutory authority or entity on any matter connected with the death which the coroner has investigated, including recommendations relating to public health and safety and the administration of justice.[8]

Inquest

20. The investigation identified that Mr Miklosowa had suffered significant hypoxic brain damage at the CRU prior to his transfer to hospital. The difficulties with the management of his suprapubic catheter required further clarification.

21. *Viva voce* evidence was taken from the following witnesses:

- Dr Gurcharan Singh Ubhi
- Ms Penny Kendall - Acting Chief Executive Office (previously Manager, Community Living Support Services) Melba Support Services
- Ms Andrea Hindle - RDNS, Registered Nurse Division 1

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. Dr Gurcharan Ubhi had been Mr Miklosowa's treating medical practitioner since 2002. He provided additional information in relation to the persistent problems that were experienced with Mr Miklosowa's suprapubic catheter. The involvement of Associate Professor Damien Bolton, Urologist, and the management role of the RDNS.

2. Ms Penny Kendall provided additional information in relation to the CRU where Mr Miklosowa was cared for. Ms Kendall, despite having a management position with the support service, knew Mr

5 See for example Section 67 (3 and 72) (1) (2)
6 Section 67(1)
7 Section 67(3)
8 Section 72(1) and (2)

Miklosowa and stated that over the preceding 10 years, he had deteriorated physically and had profound intellectual disability. Mr Miklosowa had lived with five other people with physical and mental disabilities and he did not have any words to communicate. He needed assistance with all activities of daily living and the staff that were on duty with him on the day of his deterioration on 29 March 2009, where long-standing staff members at the CRU who were aware of Mr Miklosowa's condition and complex medical problems.

3. RN Andrea Hindle from the RDNS had not previously attended to Mr Miklosowa as she was not his primary nurse. She was rostered to work that weekend and took a call to attend the facility. She said it was not uncommon to get leakage around a suprapubic catheter and she made a judgement on the day that it required changing due to the leakage and lack of flow as reported by the CRU staff. Although she could not remember calling back to the facility to check on the flow from the suprapubic catheter, she was confident that she would not have left the unit until urine was draining from the catheter.

4. Although I did not hear directly from those that were caring for Mr Miklosowa on the 28 March 2009, I am satisfied that there was no clear indicators of his deteriorating health. He had a number of pre-existing medical problems in addition to his profound physical and intellectual disability and the problems with his poorly functioning suprapubic catheter had been long-standing.

5. I am satisfied on the evidence that the staff at Melba Support Services appropriately contacted the RDNS requesting their attendance outside the scheduled timeframe. I accept the evidence of Ms Hindle that she provided appropriate care to Mr Miklosowa and took all reasonable steps to ensure that it was appropriate for her to leave the CRU.

Finding

I find that the deterioration of Mr Miklosowa's medical state was sudden and profound and that it was at that time that he suffered significant hypoxic brain damage.

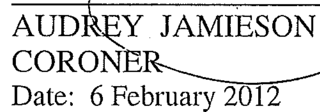
I accept and adopt the medical cause of death as identified by Associate Professor Ranson and find that John Joseph Miklosowa died from Urosepsis and contributing to his death but not directly related to the cause, were the conditions hypoxic brain injury and Down's syndrone.

AND I further find no causal relationship between the fact that Mr Miklosowa was *a person held in care* and the cause of his death and in addition find that his care at the CRU was reasonable and appropriate in the circumstances.

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

Mrs Anna Miklosowa
Melba Support Services
Dr Gurcharan Singh Ubhi
Royal District Nursing Service
S/C Adele Collard, Lilydale Police

Signature:



AUDREY JAMIESON
CORONER
Date: 6 February 2012