IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 001291

FINDING INTO DEATH WITH INQUEST

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

Inquest into the death of KENNETH JAMES MORRISON

Delivered on:	12 February 2014
Delivered at:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne, Victoria
Hearing dates:	31 October 2012
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Mr John SNOWDON represented Southern Health/Casey Hospital Mr SIERAKOWSKI attended in person on behalf of the deceased's family
Police Coronial Support Unit Assisting the Coroner:	Sergeant David DIMSEY assisted the Coroner

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of KENNETH JAMES MORRISON

and having held an inquest in relation to this death on 31October 2012 in MELBOURNE

find that the identity of the deceased was KENNETH JAMES MORRISON

born on 21 January 1947, aged 61

and that the death occurred on 29 March 2008

at Casey Hospital, 62-70 Kangan Drive, Berwick, Victoria 3806

from:

1 (a) PNEUMONIA

CONTRIBUTING FACTORS

2 GENERAL DEBILITY, DOWN'S SYNDROME, DEMENTIA, RECURRENT URINARY TRACT INFECTIONS AND BOWEL OBSTRUCTION

in the following circumstances:

BACKGROUND AND PERSONAL CIRCUMSTANCES

1. Mr Morrison was born with Down's syndrome and resided with his family until 1990 when his mother, Gwen Morrison, was no longer able to care for him. He moved into a Community Residential Unit (CRU), at 1 Goff Street, Beaconsfield, managed by the Department of Human Services.
2. The CRU was staffed by Disability Services Officers (DSOs). In the main, the DSOs were qualified to TAFE Certificate IV level in disability services and/or had many years experience working in the field.[1] They had no medical or nursing qualifications and relied on the public health system, local doctors or the Royal District Nursing Service (RDNS) to provide medical and nursing care for Mr Morrison and the other residents.
3. According to the medical records provided by his regular GP Dr Mark Robinson, Mr Morrison had a past medical history that included a hiatus hernia, osteoarthritis of the lower spine and left knee, a shortened leg, mild deafness, a right supraspinatus tear, rheumatoid arthritis, pseudo-gout, early cataracts and Alzheimer's dementia from early 2005, and was a hepatitis B carrier.[2]

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[1] Exhibits A, C and D and transcript pages 12, 27 and 37.

[2] Exhibit G under "Health Management".

4. For all these medical problems, the DSOs caring for him described him as a reasonably independent man who required support with daily living activities and community involvement. He was personable and easy-going and enjoyed relatively good health until about five years before his death, when he developed early mild symptoms of Alzheimer's. At about this time he stopped mowing the lawns at the CRU and doing those chores that he had managed quite well up until that time. Mr Morrison's functional decline over the five-year period immediately preceding his death was reasonably gradual, but noticeable to those who cared for him and were familiar with his ways.

5. Records from the CRU demonstrate that Mr Morrison's health was particularly problematic from about 23 January 2008 until his death on 29 March 2008, requiring frequent attention from Dr Robinson, the RDNS and a number of admissions to Casey Hospital and Dandenong Hospital. He complained of abdominal pain and was treated for bowel problems, urinary retention and a chest infection or infections.

6. In the early hours of 9 March 2008, CRU staff found Mr Morrison on the floor of his bedroom with his catheter dislodged. The cause or mechanism of this fall was not known as the fall was unwitnessed. After discussions between CRU staff and the RDNS, it was felt that Mr Morrison would require admission to hospital as his care needs were escalating and could no longer be met at the CRU.

7. Mr Morrison was taken to Casey Hospital by ambulance, and his clinical course there will be discussed in some detail below. Suffice for present purposes to say that he continued to deteriorate, developed a further chest infection, and died on 29 March 2008 after three days of palliative care.

PURPOSE OF A CORONIAL INVESTIGATION

8. The purpose of a coronial investigation of a *reportable death*[3] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[4] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is

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[3] The *Coroners Act 2008,* like its predecessor the *Coroners Act 1985,* requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, generally, a reportable death is one that appears *"to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury"* – see section 4 of the Act.

[4] Section 67(1) of the *Coroners Act 2008.* All references which follow are to the provisions of this Act, unless otherwise stipulated.

confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[5]

9. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the prevention role.[6] Coroners may also report to the Attorney-General in relation to a death; comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[7] These are effectively the vehicles by which the prevention role can be advanced.[8]

CORONIAL INVESTIGATION & INQUEST

10. Apart from a jurisdictional nexus with the State of Victoria, reportable deaths are, generally, deaths that appeared to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury.[9]

11. However, some deaths are reportable irrespective of the nature of the death, based on the status of the person immediately before death. Mr Morrison's death was reportable as he was a person under the control, care or custody of the Secretary to the Department of Human Services.[10] This is one of the ways in which the Act recognises that people in the control, care or custody of the State are vulnerable, and affords them the protection of the independent scrutiny and accountability of a coronial investigation.

12. Another protection is the requirement for mandatory inquests. While there is a discretionary power to hold an inquest in relation to any death a coroner is investigating,[11] this was a

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[5] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[6] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[7] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[8] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[9] See section 4 and footnote 3 above.

[10] See section 3 for the definition of a "person placed in custody or care" and section 4(2)(c) of the definition of "reportable death".

[11] Section 52(1) provides that a coroner may hold an inquest into any death that the coroner is investigating.

mandatory or statutorily prescribed inquest, as Mr Morrison was, immediately before death, a person placed in custody or care.[12]

13. This finding draws on the totality of the material the product of the coronial investigation of Mr Morrison's death. That is, the investigation and inquest brief compiled by Leading Senior Constable Peter Day, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them. All this material, together with the inquest transcript, will remain on the coronial file. In writing this finding, I do not purport to summarise all evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

FINDINGS AS TO UNCONTENTIOUS MATTERS

14. In relation to Mr Morrison's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. His identity, the date, place and medical cause of death were never at issue. <u>I find, as a matter of formality, that Kenneth James Morrison born on 21 January 1947, aged 61, late of 1 Goff Street, Beaconsfield, Victoria 3975 died at the Casey Hospital, 62-70 Kangan Drive, Berwick, Victoria 3806 on the 29 March 2008.</u>

15. Nor was the medical cause of death contentious. No autopsy was performed, as Senior Forensic Pathologist Dr Shelley Robertson from the Victorian Institute of Forensic Medicine (VIFM), conducted an external examination of Mr Morrisons' body in the mortuary, reviewed his medical records and the police report of death to the coroner, and provided a written report of her findings. Dr Robertson concluded that it would be reasonable to attribute Mr Morrison's death to *pneumonia* citing a number of contributory factors as indicated above, without the need for autopsy.

FOCUS OF THE CORONIAL INVESTIGATION

16. The focus of the coronial investigation of Mr Morrison's death, including the inquest, was on the adequacy of clinical management and care provided to him in relation to the last two months or so of his life, and in particular, during his last admission to Casey Hospital. No concerns about clinical management and care were mentioned in the initial police report of

[12] Section 52(2) and the definition of "person placed in custody or care" in section 3, in particular paragraph (d) thereof – "a person under the control, care or custody of the Secretary to the Department of Human Services.

Mr Morrison's death to the coroner.[13] Nor were any such concerns raised with the Court by any members of Mr Morrison's family.

17. It was not until receipt of the police brief in April 2011, some three years after the death, that I became aware of concerns raised by three DSO staff from the CRU in their police statements. As a consequence of this delay, and the (understandably) vague recollections of the DSOs as to the date and time of certain incidents, and the Casey Hospital staff involved, my ability to investigate their concerns was compromised.

18. In a statement dated 23 March 2011, Ms Braithwaite alleges that Mr Morrison was given inadequate pain relief, that staff misinterpreted his cries of pain as difficult behaviours associated with his disability, that they ignored his personal care needs, and that CRU staff were not provided with adequate information about Mr Morrison's condition.[14] In a statement dated 22 March 2011, Ms Edwardson described an incident where a male and female nurse used a hoist to lift Mr Morrison while he was naked and struggling, and they were 'laughing and saying they had quite a workout that morning'. She also reiterated concerns about failure to recognise that Mr Morrison was in pain, inadequate pain relief, and overall poor level of care.[15] In a statement dated 28 March 2011, Mr Kuzniak reiterated concerns about failure to recognise Mr Morrison's pain, inadequate pain relief and poor overall care, including a failure on the part of nursing staff to assist him with meals.[16]

ADVICE FROM THE HEALTH & MEDICAL INVESTIGATION TEAM

19. To the extent that the concerns expressed by the three DSOs amounted to allegations of inadequate clinical management and care, I asked the Health and Medical Investigation Team (HMIT)[17] to review the medical deposition and records from Casey Hospital and assess the clinical management and care provided to Mr Morrison during his last admission, in light of the concerns articulated in the statements of the three DSOs.

20. HMIT noted that between 23 January 2008 and his death, Mr Morrison had and number of procedures in Casey and Dandenong Hospitals involving his colon and a twisted bowel. He

[13] Victoria Police Form 83 dated 29 March 2008.

[14] Exhibit A.

[15] Exhibit C.

[16] Exhibit D.

[17] The HMIT is part of the Coroners Prevention Unit (CPU), and is staffed by practising physicians and nurses (independent of the health care institutions or professionals involved), who assist coronial investigations of deaths occurring in health care settings and, where possible, identify systems issues and areas where patient safety can be improved so as to contribute to a reduction in preventable deaths.

also experienced urinary retention for which he required an indwelling catheter (IDC), and received regular visits from the RDNS for catheter care in particular, and general care. Overall, between 8 February 2008 and 9 March 2008, Mr Morrison had a total of six admissions because he was experiencing ongoing groin pain, bowel problems and suffered from a chest infection.

21. As regards Mr Morrison's last admission to Casey Hospital, commencing on 9 March 2008, HMIT noted that he was admitted following an unwitnessed and unexplained fall, during which she had dislodged his IDC. In addition to management of the IDC, Mr Morrison developed a chest infection that was treated with intravenous antibiotics. Despite treatment, he continued to deteriorate, eventually becoming almost entirely dependent on nursing staff and CRU staff who were rostered to attend hospital as part of their duties, to assist with his care.

22. On 26 March 2008, after discussions with his next of kin, it was decided that Mr Morrison would be transferred from the general medical ward to the Palliative Care Unit as he was not responding to treatment and had a very poor prognosis. Thus, active treatment was withdrawn, and he was kept comfortable with palliative measures until his death on 29 March 2008.

23. HMIT concluded that the medical record notes reflect a high level of care, multiple medical reviews, appropriate assessment and treatment of agitation and altered behaviour, frequent nursing observations and appropriate involvement of family in decision-making and palliative care.

24. As regards the specific concerns raised by the DSOs, HMIT advised that –

- There was nothing in the medical records to indicate that Mr Morrison's agitation and altered behaviour were ignored or misinterpreted by nursing and medical staff. Agitation and aggressive behaviours were documented, and while pain may have contributed, there appeared to be many other factors that may have contributed (an unfamiliar environment, episodic low blood pressure, chest infection, urinary tract infection).
- There were documented medical reviews specifically to assess Mr Morrison's pain, and administration of appropriate analgesia, noting that when he was being treated for constipation secondary to suspected bowel obstruction, opioids were administered cautiously so as not to exacerbate constipation or increase drowsiness, already clinically apparent.

- Although HMIT could see no reference in the medical records to Mr Morrison being held down for the taking of bloods, it is not uncommon for a patient's arm to be held when they are experiencing agitation or confusion, and a blood sample needs to be taken.

EVIDENCE FROM SOUTHERN HEALTH – PROFESSOR BRUCE JACKSON

25. Again, because of the effluxion of time, Southern Health was at some disadvantage in addressing the concerns raised by the DSOs. However, at my request, they provided a clinical overview from Professor Bruce Jackson, Deputy Head of Medicine at Casey Hospital at the time, and a physician who attended on Mr Morrison for part of his admission.[18]

26. Professor Jackson stated that Mr Morrison was discharged home to the CRU from Dandenong Hospital on 7 March 2008, however, his decline continued with reduced appetite, reluctance to eat or drink, reduced mobility and a fall from his bed. He was readmitted to the general medical ward at Casey Hospital on 9 March 2008, where he was assessed as having a progressive decline in his general functional and cognitive state with fluctuating drowsiness, agitation, aggression and increased distress. The cause of his decline was investigated. In particular, clinicians were seeking a source of sepsis. Mr Morrison was provided with hydration and reassessed regarding constipation and abdominal discomfort, including further imaging, surgical assessment and signal endoscopy. CT scan of the brain revealed generalised atrophy but no acute changes.

27. Clinicians thought it most likely that he had a respiratory infection contributing to his decline but a course of intravenous antibiotics failed to significantly improve his delirium. Mr Morrison continued to have fluctuating drowsiness, agitation and aggression, making management difficult. At times, he was resistive to treatments, laboratory studies such as blood tests, and intake of food, fluid and medication.

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[18] Professor Jackson's statement dated 6 March 2012 is part of Exhibit G, balance of the inquest brief. I note the following excerpt from the last two paragraphs of his statement – *"I have attempted to meet with Allied Health and Nursing staff working at Casey during Mr Morrison's admission, however, I have had limited success as the majority of those people have now left... My comments are formulated from my recollection of my limited contact with Mr Morrison during my period of ward service (the first part only of his admission) and discussions with our Palliative Care Nurse Consultant who was involved with him during the terminal part of his care. My comments are gleaned mainly from perusal of the medical record notes. As you will appreciate, it is extremely difficult to try to address the types of criticism made by DHS personnel when they are first brought to us almost 4 years after we reported Mr Morrison's death to the Coroner."*

28. According to Professor Jackson, despite medical interventions, Mr Morrison progressively declined and after a conference with his DHS Case Manager and his cousin (next of kin) on 26 March 2008, he was transferred to the Palliative Care Unit where he subsequently died.

29. As regards the specific concern of inadequate analgesia, Professor Jackson stated that the drug chart documents that he received analgesic of varying levels of escalation according to his apparent discomfort. He further stated that it is extraordinarily difficult in a patient such as Mr Morrison to distinguish between distress due to pain, and agitation related to confusion or delirium of other causes. His pain management was further complicated by a concern that opiate analgesics would aggravate his constipation and could lead to further bowel obstructions. He was unaware that Mr Morrison was given children's Panadol, but recognised the possibility that he may have been given a Panadol suspension (available as an imprest item in the ward) as he had rejected tablets, and that this may have been misconstrued as children's strength Panadol.

30. Professor Jackson felt unable to respond specifically to the complaint that Mr Morrison's carers/DSOs were not "heard" by nursing staff, other than to observe from the medical records that when distress occurred analgesic was administered, though sometimes he did not settle and alternate agents for control of agitation were administered (for example Haloperidol on occasions). Similarly, Professor Jackson was unable to reply to the allegation that staff had ridiculed Mr Morrison when they were transferring him in the lifting machine or hoist, or had failed to provide adequate oral/mouth care. However, as to the latter he did observe that there was considerable difficulty providing care as, when agitated, Mr Morrison would spit food and fluids around the room. He also noted that the medical records suggest that mouth care was given, and one entry noted that it was given by his Carers/DSOs, with whom he was more familiar.

31. Professor Jackson did state a belief that on occasion, Mr Morrison was held for blood to be taken, as staff noted great difficulty in obtaining blood tests because of his agitation/aggression.

EVIDENCE FROM SOUTHERN HEALTH – SHIRLEE GRAHAM

32. Ms Graham was Director of Nursing at Casey Hospital in 2008, and by the time of the inquest was Operations Director/Director of Nursing. Ms Graham provided a statement addressing the concerns raised by the DSOs, which were fundamentally allegations of poor nursing care, and testified at inquest.

33. In a statement dated 15 October 2012, Ms Graham provided an overview of nursing care from her perspective as Director of Nursing, indicating amongst other things, that Southern Health is a value-led organisation where nursing staff are required to provide safe, effective person-centred care and are expected to participate in ongoing professional development. Ms Graham also provided a number of protocols/procedures which on their face addressed the concerns raised by the DSOs.[19]

34. Without intending any criticism of Ms Graham, hers was something of a motherhood statement, which could hardly be criticised as a management-level document from a health service about what is expected of nursing staff and how complaints or performance management are addressed.[20] Significantly, Ms Graham stated that she visits wards regularly to review the care and talk to patients and their families as well as staff, and that she was concerned and saddened that the carers for Mr Morrison did not discuss their issues with staff at the time or follow the complaints process, so that the perceived issues could have been addressed at the time, both with the carers and with Mr Morrison.[21]

35. At inquest, Ms Graham reiterated that she was unaware of the concerns raised by the DSOs at the time of Mr Morrison's admission.[22] She was particularly distressed at the hoist incident, and testified that she would have addressed that with the staff concerned and dealt with it, had she been aware. Although she testified that there was no formal requirement or arrangement for DHS/CRU staff being at the bedside to support their residents during an admission, she could see the benefit of having them there to assist with the patient's care given their familiarity with the patient, and recognised that the DSOs would have valuable

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[19] See Exhibit E Appendix 1: Safe, Effective Person Centre Care – Background and Strategic Policy. Appendix 2: Nursing, & Midwifery Foundations of Care – Implementation Tool. Appendix 3: Delirium Assessmetn, Delirium and Dementia Management – Procedures. Appendix 4: Communication with patients/clients/residents, their families and carers – Background. Appendix 5: Communicative Impairment recognition for patients/clients/residents, their families and care [sic] – Procedure.

[20] Exhibit E – *"In summary, nurses at Casey Hospital professionals who undertake the role within the scope of practice. They are often challenged by individuals' circumstances. We provide support for all staff to undertake their role using knowledge, research and practice. If we identify staff who do not conform to the standard where required, we assist them with education and counselling. Staff are often reminded that, as nurses, we have a privileged position, particularly when caring for a dying patient and their family."*

I visit wards regularly to review the care and talk to patients and their families as well as staff. I'm concerned and saddened that the carers for Mr Morrison did not discuss their issues with the staff at the time or follow the complaints process, so we could have addressed perceived issues with them and Mr Morrison at the time."

[21] Exhibit E page 4.

[22] Transcript page 54, 60-61.

information which could only enhance hospital staff's communication with and understanding of the patient.[23]

EVIDENCE OF DSOs AT INQUEST

36. Ms Braithwaite, Ms Edwardson and Mr Kuzniak all attended the inquest and swore to the accuracy of their respective statements. Their recollection of events was tested by cross-examination. It is sufficient, in the circumstances to deal with their evidence globally. I found them all to be credible witnesses, in the sense that they were doing their best to tell the truth as they recollected it, and to assist the coronial investigation of Mr Morrison's death. It was apparent to me that they not only cared for, but cared about, Mr Morrison, and that their concerns were bona fide.

37. It also became clear at inquest that they had each conflated, to some extent, their experience of the clinical management and care provided to Mr Morrison across campuses (Casey and Dandenong Hospitals), and across several admissions. Their evidence was also insufficiently specific as to date and time, so that even a temporal connection with Mr Morrison's death is tenuous.

38. Even if the evidence supported substantiation of their concerns, I am unable to find that a plausible causal connection exists between Mr Morrison's death and poor pain management and poor nursing care, even demeaning treatment as described in relation to the hoisting incident.

CONCLUSION

39. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[24] The effect of the authorities is that coroners should not make adverse findings against or comments about individuals or institutions involved in the clinical management or care of the deceased, unless the evidence provides a comfortable level of satisfaction that their negligence and/or

[23] Transcript pages 55-60.

[24] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…"

departure from the generally accepted standards of their profession caused or contributed to the death.[25]

40. Having applied that standard to the evidence before me, I find that Mr Morrison died from pneumonia with contribution from a number of underlying medical problems, namely general debility, Down's syndrome, dementia, recurrent urinary tract infections and bowel obstruction.

41. The available evidence does not support a finding that there was any want of clinical management and care on the part of the medical and nursing staff of Casey Hospital during his last admission to Casey Hospital, and/or that any such want of clinical management or care, caused or contributed to his death.

COMMENTS

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

1. The care provided to Mr Morrison during his last admission was enhanced by the presence of DSOs from his CRU who were fond of him, familiar with his ways and willing to assist in his care. Enhanced communication between nursing staff and the DSOs could have further improved the care provided to Mr Morrison. By keeping the DSOs aware of Mr Morrison's clinical condition and treatment plan, nursing staff could have garnered their active support and informed their own clinical approach to Mr Morrison. Such an approach aligns with the current Southern Health paradigm of safe, effective person-centred care.

2. A coronial investigation is not the optimal setting for resolution of complaints about clinical management and care, particularly where there is no plausible causal link with the death. While I accept that it is appropriate for the DSOs and, preferably, their managers to advocate for the residents in their care, concerns such as those raised by the DSOs regarding Mr Morrison should have been addressed to hospital management through the appropriate formal channels, as close as possible to their occurrence. This would have ensured a timely investigation and focused remedial action where concerns are substantiated.

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[25] *Anderson v Blashki [1993] 2 VR 89 at 95; Secretary to the Department of Health & Community Service v Gurvich [1995] 2 VR 69 at 73-74; Re State Coroner; ex parte Minister for Health (2009) 261 ALR 152 at [21].*

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

The family of Mr Morrison

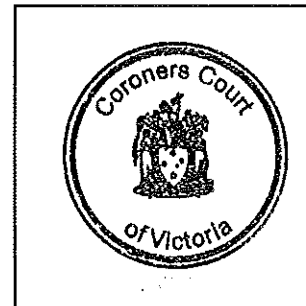
Casey Hospital c/o Southern Health

Ms Donna Wilde, Disability Accommodation Services Manager, Department of Human Services

Ms Katie Haire, Deputy Secretary, Community and Executive Services Group, Department of Human Services

Leading Senior Constable Peter Day.

Signature:



PARESA ANTONIADIS SPANOS
CORONER
Date: 12 February 2014

cc: Manager, Health and Medical Investigation Team, Coroners Prevention Unit.