FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 2231/08

Inquest into the Death of MARK ANTHONY THEAKSTON

Delivered On:	30th March 2010
Delivered At:	Coroners Court of Victoria at Melbourne
Hearing Dates:	15th January 2010
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	The THEAKSTON family, in person.
	Leading Senior Constable Greig McFARLANE, State Coroners Assistants Unit, appeared to assist the Coroner
Place of Death:	Plenty Residental Care Unit, 5 Henderson Court, Bundoora, Victoria 3083

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

Court reference: 2231/08

In the Coroners Court of Victoria at Melbourne

I, Paresa Antoniadis SPANOS, Coroner,

having investigated the death of:

Details of deceased:

Surname:	THEAKSTON
First name:	MARK
Address:	Plenty Residential Care Unit, 5 Henderson Court, Bundoora, Victoria, 3083.

AND having held an inquest in relation to this death on the 15th January 2010 at Melbourne Magistrates Court

find that the identity of the deceased was MARK ANTHONY THEAKSTON born on the 15th August, 1963,

and that death occurred on the 25th May, 2008,

at Plenty Residental Care Unit, 5 Henderson Crt, Bundoora, Victoria 3083

from a cause which remains: 1(a) UNASCERTAINED

in the following circumstances:

1. Mr Theakston was a forty-five year old single man who had previously resided at Janefield Training Centre, and was a full-time resident of Plenty Residential Services in Bundoora for some years preceding his death[1]. Mr Theakston had an intellectual disability, severe autism, no verbal communication and behavioural problems. According to his carers and general practitioner, he kept excellent physical health and required infrequent medical attention.

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1 The Coroners Act 2008 (the Act) which commenced operation on 1 November 2009 mandates that the death of a person under the control care or custody of the Secretary to the Department of Human Services is reportable (irrespective of the cause of death) and that the coronial investigation of such a death must include an inquest - see sections 3, 4 and 52 of the Act.

His regular medications, unchanged for many years, were Largactil, Cogentin, Diazepam and Tegretol. When he was particularly agitated he was administered additional Largactil (100mg prn). In the days preceding his death, Mr Theakston appeared his normal self with no particular health or behavioural problems.

2. The only unusual incident, occurred at about 2:00am on 21 May 2008, when he collapsed in the hallway and staff need to assist him to the toilet. Once there, staff stepped back and Mr Theakston fell forward from the seated position striking his head on the bathroom floor. His body was then observed to become "rigid and stiff" for about 30 seconds. The night duty supervisor and an ambulance were summoned. Ambulance officers performed an electrocardiogram (ECG) which revealed no cause for his apparent "syncopal" episode. They found his blood pressure low, but when he was told that he was to go to hospital for investigation, he was resistant and displayed aggressive behaviour. To minimise his distress, Mr Theakston was allowed to return to bed where he remained under close observation until medical attention could be sought in the morning.

3. Later that morning, at about 11:00am, Mr Theakston was taken to his regular general practitioner, Dr Lyndsey Kabat at the Mill Park Superclinic. Consistent with his usual presentation at medical appointments, he was agitated and somewhat uncooperative. He was accompanied by two carers who gave a history regarding the incident earlier that morning. They advised that he had eaten a normal breakfast and had not vomited. On examination, he appeared to move normally, his eye movements were normal, but he refused the blood pressure cuff. Dr Kabat noted an abrasion on his nose with mild swelling, but the nose appeared straight and he saw no visible blood within the nose, on a quick view. He was unsure of the cause of Mr Theakston's syncopal episode and felt that a CT scan of the head was required. He ordered blood tests, a Tegretol level and a CT scan for the following week, and arranged to see Mr Theakston the next day in his own surroundings.

4. Staff reported that on 22-23 May, there was nothing in Mr Theakston's demeanour to indicate anything out of the ordinary, and certainly nothing to raise any concerns for his well-being. When Dr Kabat attended Henderson Court on 22 May 2008, Mr Theakston was at his day program (where he also attended on 23 May), so he was not reviewed. On 23 May, the blood

tests were taken as ordered by Dr Kabat. The results subsequently reported revealed nothing of any significance.

5. Mr Theakston went to bed on 23 May, and was regularly checked overnight in accordance with his current care plan. According to evidence given by Ms Rhoades at the inquest, Mr Theakston preferred to sleep in a curled up position with his doona over his head, so that although staff would have looked in on him, they would not lift the doona to check his face/breathing as this would disturb his sleep. He was last checked, albeit in this limited manner, at 6:00am on 24 May.[2]

6. At 7:35am, when a staff member tried to rouse him, he appeared to be sleeping. The staff member decided to assist other residents who had begun their daily routines, and to allow Mr Theakston to sleep. When they returned at 8:15am and tried to wake him by speaking to him and tapping him on the shoulder, they realised he was not breathing or exhibiting any other vital signs. They noticed blood on his bedclothes, near his head/nose. Ambulance officers attended shortly thereafter and confirmed that Mr Theakston had passed away, apparently while he slept.[3]

7. An autopsy was conducted by Senior Forensic Pathologist Dr Noel Woodford from the Victorian Institute of Forensic Medicine (VIFM) who provided a detailed report of his findings at autopsy and the results of a number of ancillary investigations. Dr Woodford identified a number of relatively minor injuries (scab over the nose and bruising to the lower legs) consistent with the fall/possible seizure on 20 May but advised that these were not injuries of a type likely to have caused or contributed to death. He found a small amount of blood stained fluid within the mouth but could not identify a definite site of haemorrhage.

8. Although he concluded that the cause of death remained unascertained, he identified a number of pathological features with potential significance in causing or contributing to death -

8.1 A degree of fibromuscular dysplasia of an artery in the region of the atrioventricular node, a condition which may be associated with relatively sudden onset of rhythm disturbance and cardiac arrest.

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2 See transcript pages 3 and following.

3 This finding is based on the brief of evidence compiled by one of the attending police officers, Constable Mark Beraldo from Mill Park Police, and on the evidence of those witnesses required to testify at inquest. These facts were not contentious.

8.2 Moderate fatty change in the liver (steatosis), a condition which may be associated with significant biochemical and metabolic derangements.

8.3 Findings within the brain (right frontal lobe) suggesting previous injury (organised, focal, subdural haemorrhage) remote from the time of death.[4]

9. Dr Woodford also commented on the results of toxicological analysis of post-mortem samples undertaken at VIFM. These showed chlorpromazine ("Largactil" a tranquilizer), diazepam and its metabolite nordiazepam ("Valium" a sedative/hypnotic), and carbamazepine ("Tegretol" an anticonvulsant used in the treatment of epilepsy, neuralgia and schizophrenia), at levels consistent with therapeutic dosing. Analysis of a specimen of serum for tryptase, a marker for severe acute allergic reactions, showed an elevated level (104µg/L) where normal in a clinical setting is less than 12µg/L. However, Dr Woodford advised that tryptase may be spuriously elevated in post-mortem samples and the significance of this finding remains unclear.[5]

10. The family's main issue of concern, aired for the first time at the inquest, was the failure to investigate Mr Theakston by way of CT scan of the head in the immediate aftermath of the fall/possible seizure in the early hours of 21 May 2008. In the absence of clear evidence of a head injury sustained during this incident and any causal connection with the cause of death, it is inappropriate for me to be critical of either the staff of Plenty Residential Services or Dr Kabat in this regard. Given the reasonable expectation that it would be difficult to undertake a CT scan without recourse to sedation, the conservative approach of observing Mr Theakston closely for any neurological deterioration was not unreasonable. On the evidence before me, no such deterioration was observed by staff in the days between the incident and Mr Theakston's death.

11. The other issue raised by the family was the level of staffing overnight. Ms Rhoades clarified that there was one "active" staff member overnight who did not simply sleep at the residence, but who conducted regular checks of residents, in accordance with their care plans and any doctors orders.[6] When Mr Theakston was found deceased, in the morning, the day shift had commenced and two staff members were present to deal with the six residents. Staffing levels

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4 See Dr Woodford's autopsy report and his evidence at inquest(transcript page 26) where he clarifies that these were not acute injuries occurring on, say, 21 May, 2008 but much earlier.

5 See Dr Woodford's autopsy report and his evidence at inquest from page 20 and following.

6 See trancript at page 10.

aside, I have concerns about the efficacy of the overnight checks of Mr Theakston, which I expressed during the inquest and which were not allayed,[7] and which found the basis for my comment below.

12. I find that the cause of Mr Theakston's death remains unascertained despite full autopsy and ancillary investigations. Although I accept Dr Woodford's evidence that a number of pathological features were identified which potentially could have caused or contributed to his death, I am unable to make a positive finding that they did so, but the possibility remains open. Similarly, there is no basis for an adverse finding or comment about the care, supervision or clinical management of Mr Theakston in relation to his death. In particular, as the cause of death is unascertained, I cannot find that more thorough overnight checks would have prevented his death, although that possibility also remains open.

COMMENT:

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. Every resident in supported accommodation requires a health plan, an important component of which is the Health Support Needs Summary, which sets out the resident's health needs and the instructions for addressing these needs, including overnight monitoring requirements.[8] This summary needs to be reviewed and/or updated following any change in a resident's health and support needs. A review can also be initiated at the request of the relevant medical or health professional.[9]

2. Mr Theakston's fall/seizure on 21 May 2008 should have been the subject of an incident report (Category 2)[10] and should have resulted in a review of his health and support needs. The advice from ambulance officers and Dr Kabat that he should be kept under observation, also supported the need for review of his Health Support Needs Summary. One possible outcome of

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7 See transcript at pages 3 and following.

8 See the Department of Human Services "Residential Services Practice Manual" Section 5.2, 2009.

9 Ibid, Section 5.2-4.

10 Ibid, Section 6.4-2. Although a number of Category 3 incident reports and the final Category 1 incident report were in Mr Theakston's records, there did not appear to be a Category 2 incident report relating to the fall/seizure in the early hours of 21 May 2008, and no documented change to his Health Support Needs Summary.

such a review, given the fall and the possibility of a head injury, may have been to change overnight monitoring from visual sighting only to checking for breathing, for such period of time as his doctor thought appropriate. Although I can understand the desire not to disturb a resident while they are sleeping, by checking on them in an intrusive manner, such "intrusion" would be warranted by reference to the paramount obligation to look after the resident's health and well-being.[11]

3. Whilst the impact that closer overnight monitoring might have had in preventing Mr Theakston's death is speculative, the circumstances highlight the importance, not simply of incident reporting, but also of following through with review of a resident's Health Support Needs Summary. The Department of Human Services might consider strengthening the procedures around incident reporting and consequent review of the Health Support Needs Summary, and/or re-emphasising its importance to supervisors and managers of residential supported accommodation.

DISTRIBUTION OF FINDING:

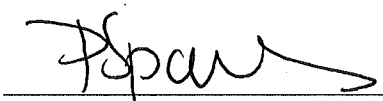
The Theakston Family

Ms Fran Thorn, Secretary, Department of Human Services.

Mr Arthur Rogers, Executive Director, Disability Services Division.

Cluster Manager, Plenty Residential Care Unit, 5 Henderson Court, Bundoora, Victoria, 3083.

Signature:



Paresa Antoniadis SPANOS
Coroner
Date: 30th March 2010

11 Section 4.11-2 of the Manual.