IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2008 / 3968

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: MICHAEL DESMOND McWHIRTER

Delivered On:	30 October 2013.
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street, Melbourne
Hearing Dates:	10 May 2013
Findings of:	JUDGE IAN L GRAY, STATE CORONER
Representation:	Ms D Foy on behalf of Eastern Health
Police Coronial Support Unit	Leading Senior Constable N Harrison

I, JUDGE IAN L GRAY State Coroner, having investigated the death of MICHAEL DESMOND McWHIRTER

AND having held an inquest in relation to this death on 10 May 2013

at MELBOURNE

find that the identity of the deceased was MICHAEL DESMOND McWHIRTER

born on 23 April 1929

and the death occurred 28 June 2008

at Peter James Centre, Burwood Victoria

from:

1. Acute Myocardial Infarction; Underlying multiple pathologies including vascular dementia, asbestosis, pulmonary fibrosis, ischemic heart disease, hypertension and renal impairment.
2. Dementia of many years

Circumstances of death (s.67)

Summary

1. Michael McWhirter was 79 years old when he died, with a past medical history including asbestosis with pulmonary fibrosis, ischemic heart disease, hypertension, permanent pacemaker, renal impairment and episodes of depression. In 2006, he was diagnosed with dementia.

2. Mr McWhirter had been admitted to Maroondah Hospital on three occasions in 2008. On 11 June 2008, the third admission was for agitation and cognitive decline. He was diagnosed with vascular dementia and a past history of psychotic depression and was treated with antipsychotic medication. Whilst at Maroondah, Mr McWhirter was also treated for broad complex tachycardia.

3. Mr McWhirter remained at Maroondah until 27 June 2008, when he was reviewed by the treating medical team and transferred to an acute aged psychiatric inpatient unit at the Peter James Centre. This unit is a locked ward, but Mr McWhirter was admitted as a voluntary patient. On arrival, a full medical assessment was not possible as he was very anxious and agitated.

4. At 00:30am, on 28 June 2008, Mr McWhirter was reviewed by the duty registrar and an involuntary status was recommended. Mr McWhirter was secluded from 00:45am to

04:45am. The duty consultant, Professor George, reviewed him the following day at 16:00 hours and discharged Mr McWhirter from his involuntary status.

5. After dinner, at about 17:50pm on 28 June 2008, Mr McWhirter became upset and verbally and physically agitated. Because he was upsetting other patients, Mr McWhirter was escorted to the seclusion room and was given olanzapine orally at 18:35pm. He was left alone briefly when the nurse went to get a machine to monitor his vital signs. When she returned at 18:43pm, Mr McWhirter was in clear physical distress. A code blue was initiated and the Code Blue Team commenced CPR and continued until a MICA ambulance arrived. CPR was continued until it was confirmed that the family had a Not For Resuscitation (NFR) order in place.

6. Active resuscitation efforts were stopped and Mr McWhirter was certified as deceased at 19:05 hours on 28 June 2008.

History

7. Mr McWhirter had been admitted to Maroondah Hospital on 8 May 2008 with pneumonia. He suffered from a number of other conditions, namely cardiac disease (he had a pacemaker), renal failure, pulmonary fibrosis and hyponatraemia. He had previously suffered transient ischemic attacks ('TIAs') and a lacunar infarct, demonstrated on CT brain scan in May 2008, resulting in loss of blood in the brain.

8. At the Maroondah Hospital on 20 June 2008, Mr McWhirter's daughter, Mrs Cheryl Laver, discussed his declining cognitive capacity with a neuropsychologist, following a significant worsening over recent months.

9. While he was generally a cooperative and pleasant patient, Mr McWhirter was very restless and had occasional verbal outbursts. He was given "special" nurses on a number of occasions, due to his high level of restlessness and agitation. He was moved to a single room because his night-time behaviour was distressing to other patients.

10. He was seen by psychiatric staff on a number of occasions to manage restlessness and agitation. On 20 June 2008, following an assessment by a psychiatrist and neuropsychiatrist, it was confirmed that he suffered from vascular dementia.

11. Given his diagnosis of vascular dementia and the difficulty in returning him home, Mr McWhirter's family agreed that he would be transferred to the South Ward at the Peter James Centre. On transfer to the Peter James Centre, after discussion with Mr McWhirter's wife and

daughter, a further NFR order was made. It was agreed on 24 June 2008 that should he suffer a further TIA, or other life threatening condition, he was not to be resuscitated.

Issues

12. The family raised the following issues before, and at, the inquest:-

- Whether it was or not appropriate for Mr McWhirter to be taken to the seclusion room at the Peter James Centre.
- What happened in the seclusion room.
- Whether the olanzapine was administered orally or intramuscularly.
- How long Mr McWhirter was left unsupervised in the seclusion room.
- Whether or not CPR was commenced immediately or only on arrival of the code blue team.
- Whether or not Mr McWhirter's death was reportable.

13. At the inquest, Mr McWhirter's daughter, Mrs Laver, spoke to these issues, made a statement about the care of her father and asked questions of witnesses through my assistant Leading Senior Constable Nadine Harrison.

14. After Mr McWhirter's death, Dr Yu signed a death certificate citing the causes of death as "1(a) Acute Myocardial Infarction and, 2. Dementia of many years". Following a letter of complaint from Mrs Laver to the Health Services Commissioner, the matter was subsequently referred to the Coroners Court.

15. At the inquest, the issues referred to above were addressed by evidence on the following topics:

- Whether Mr McWhirter was an involuntary patient or a voluntary patient at certain relevant points in time.
- Whether he was, in fact, secluded in the seclusion room or whether the door was open and it was used for a more therapeutic purpose.
- Whether the death was reportable.

16. Mr Peter Southern and Ms Anne Bergin, nurses at the Peter James Centre gave evidence at the inquest. Nurse Southern was present in the seclusion room and familiar with Mr McWhirter's treatment at the time and had made the hospital notes. Nurse Bergin was also present.

Professor Kuruvilla George, psychiatrist, also gave a substantial amount of evidence in relation to Mr McWhirter's discharge from involuntary status, hospital practices in relation to patients like Mr McWhirter and developments and changes in recent years, including in response to Mr McWhirter's death.

Mr McWhirter's status under the *Mental Health Act 1986*

17. All hospital witnesses gave evidence on this point. I accept that on the night of 27 June 2008, Mr McWhirter's state of agitation and disturbance was causing distress to other patients at the Peter James Centre and that as a consequence, at approximately 00.30 hours on 28 June 2008, he was made an involuntary patient and placed in seclusion. This was a decision taken by On Call Registrar, Dr Keogh. The evidence is that Mr McWhirter was removed from seclusion, and the seclusion therefore "broken", at 04.45am on 28 June 2008. During that period of seclusion, Mr McWhirter was, strictly speaking, an involuntary patient. When the family was informed of the status on the morning of 28 June 2008, they were concerned and upset. That afternoon (at about 4.00pm) the family met with Professor George and communicated their concerns. Professor George responded by discharging Mr McWhirter off his involuntary status. Mr McWhirter's family had been particularly upset about Mr McWhirter's distress and questioned the decision to make him an involuntary patient without prior consultation with the family. Professor George's reaction to the family concern was, in my opinion, appropriate and his evidence was that he revoked the involuntary status at about 16.30pm on 28 June 2008. I can understand the family's criticism of the failure to consult them in respect of that status, but equally I accept that the practical nursing and hospital management decisions confronting the staff in the early hours of the morning justified a short seclusion of Mr McWhirter. The key to seclusion is that it is properly and strictly monitored, complies with the protocols relating to it and is brought to an end as soon possible, having regard to the clinical circumstances.

18. On the evidence, the period of seclusion in the early hours of 28 June 2008 and his involuntary status, did not have any direct bearing on, or contribute to, Mr McWhirter's death. He died much later on 28 June 2008, well after his involuntary status had been discharged. I summarise the circumstances of his death that evening at paragraph 5 (above).

19. In light of the revocation of his involuntary status under the *Mental Health Act*, I accept Ms Foy's submission that Mr McWhirter's death was not reportable by virtue of his status under the *Mental Health Act*. In other words, it was not reportable because when he died he

was no longer detained on an involuntary basis under the *Mental Health Act*. However, in reaching this conclusion, I certainly do not imply a criticism of Mrs Laver for having the matter referred to the Coroners Court. It was understandable that she would want have the circumstances investigated and explained.

Placement in the seclusion room – evening of 28 June 2008

20. I accept the evidence that in order to reduce Mr McWhirter's stress and the impact of his behaviour on other patients, Nurses Southern and Bergin decided that he should be taken to an area by himself with reduced stimulation. They decided that it would be safer to place Mr McWhirter in the seclusion room, leaving the door open so he could be observed by passing nursing staff. I accept that this was an appropriate professional decision in the circumstances. Both Nurses Southern and Bergin gave evidence as to the reasons for their decision and their actions and I accept that evidence. In essence, it was that his best interests would be served, the interests of other patients would be promoted and he would be more easily observed than if placed in his own room. Professor George supported that decision and believed that it was therapeutic.

21. However, it is clear that when staff decided to place Mr McWhirter in the seclusion room that evening they believed that he was still an involuntary patient under the *Mental Health Ac 1986*. They should have in fact been aware that he was not an involuntary patient, and the Hospital's information exchange and communication systems should have ensured that they were aware of the status after Professor George changed it. Evidence was given about the changes to this system to ensure that a situation like this would not reoccur and I accept that evidence. I also accept the evidence that it was not intended to place Mr McWhirter in complete "seclusion" within the meaning of the *Mental Health Act*. The evidence on the point was consistent and clear: staff moved him with the intention of having him in a quieter place, causing less disruption to others, rather than secluding him in the strict *Mental Health Act* sense. I accept that the placement was for essentially therapeutic and clinical management purposes, and in the interests of other patients.

Administration of medication

22. In the seclusion room, Mr McWhirter was given a wafer containing 5mg olanzapine, a medication he had previously refused in the sitting room. I accept the evidence of Nurses Southern and Bergin as to the circumstances of the administration of this medication and their evidence, and Professor George's evidence, on it's benefits, purposes and affects. I accept

also that, in circumstances such as this, it was consistent with their view of their duty of care to Mr McWhirter that they administer this particular medication for the reasons they did.

23. I find that Mr McWhirter was not given medication by way of an intramuscular injection. I note that Ms Bergin amended her statement in respect of this controversial issue and I trust that Mrs Laver accepts, as I do, Ms Bergin's sworn evidence on the point. The medical notes confirm the medication of olanzapine by insertion of a bucal medication of the mouth, not an intramuscular injection.

Reportable death or not?

24. On this issue I accept Ms Foy's submissions contained at paragraph 29 – 34 of her written submission. I am satisfied that the death was not "reportable" within the meaning of the *Coroners Act (Vic) 1985*. However, as stated above, I fully understand why Mrs Laver wanted the circumstances of the death investigated and the investigation and inquest have clarified the issue.

25. I am satisfied that Mr McWhirter's death was not "unexpected". On the evidence, he was frail and his overall state of health was poor. His serious underlying conditions were such that the family had signed a NFR order in the face of the distinct prospect that he would die in the relatively near future.

System changes since 2008

26. As Ms Foy, counsel for the Peter James Centre, stated in her submissions, "Dr George conceded that there was a systemic failure to communicate the change in Mr McWhirter's status from involuntary to voluntary"[1]. She also stated that "Nurse Bergin gave evidence that there have been changes in the communication system and in the allocation of nurses to patients."[2] I accept the evidence from both Professor George and Nurse Bergin about changes that have been made, and lessons learned as a result of Mr McWhirter's death and review of internal communication processes. They also informed me:

    a. that there was now a system of ongoing digital progress notes which gave real time information, including information about change in status;

    b. that the Peter James Centre now has a system of patient allocation to a particular nurse, which had not been a practice at the time; and

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[1] Paragraph 36, Submissions by Ms Deborah Foy, Counsel for Peter James Centre.

[2] Paragraph 37, Submissions by Ms Foy.

c. the allocated nurse would expect to be informed by an authorised psychiatrist of a change in status.

As I noted early, this should have happened in this case. However, I note that this system has now been specifically calibrated to ensure that it does. This is a good development and requires no further comment. The changes since 2008 are appropriate and given they have been implemented there will be no recommendation for further internal change.

27. Professor George's evidence on this issue was helpful and expansive. Ultimately, he and the Peter James Centre have focused on practical arrangements in relation to internal information-sharing. The focus has been on real time information. I agree that this is the correct focus and thank Professor George for his assistance with this aspect of the case

Cause of Death

28. Dr Yu issued Mr McWhirter's death certificate. He cited the causes of death as "1 (a) Acute Myocardial Infarction; and 2. Dementia of many years". As the matter was referred to the Coroners Court by the Health Services Commissioner, there was not an opportunity for a post mortem to be conducted. In saying this I am not suggesting that a post mortem would necessarily have been appropriate, but it means that the experts are required to express opinions based on the medical history as to the probable causes of death.

29. I was assisted in this investigation by the opinions of Associate Professor Harry Mond. He provided three reports dated 19 October 2009, 15 August 2011 and 18 October 2011. Having reviewed the information available to him, in his report dated 15 August 2011, Dr Yu stated, "I cannot envisage any causal link between Mr McWhirter's death, his psychiatric medication or his seclusion"[3]. In his third report, he stated "there is no evidence that there was any cardiac cause of death in this patient although there is evidence of ischaemic heart disease as well as evidence of cardiomyopathy with a reduced ejection fraction."[4]

30. I also received a report from Doctor Stephen Scully, a doctor at the North Ringwood Medical Centre. He stated that Mr McWhirter was a patient at the Centre from July 2005 until his death. He was treated at the centre "for cerebrovascular disease, pulmonary fibrosis and major depression. He had had one previous stroke prior to his attendance at this practise"[5].

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[3] Report from Associate Professor Harry Mond, Cardiologist dated 15 August 2011.

[4] Report from Associate Professor Harry Mond dated 18 October 2011.

[5] Letter from Dr Stephen Scully, North Ringwood Medical Centre dated 5 October 2012

Dr Scully stated that "His physical and mental condition continued to deteriorate through 2008. He was afflicted with severe dyspnoea and required a number of admissions to hospital during this time. He also had chronic insomnia and agitation and needed the addition of Temazepan for nocturnal sedation."[6] Dr Scully stated, "In summary, Mr McWhirter had significant coronary and cardiovascular disease and severe depression and signs of early dementure during his attendances at The North Ringwood Medical Centre."[7]

31. As Ms Foy pointed out, Mr McWhirter had a known cardiac condition, a known pulmonary condition and a known cerebral condition. It is clear, as she submits, that the evidence of Nurses Southern and Bergin is that Mr McWhirter, when in the seclusion room, suffered an event which "deprived him of oxygen".[8] On the medical evidence, such an event "could have been caused by a cardiac or pulmonary or cerebral event".[9] I accept this submission. I also not that Professor Mond's report indicates that in his view "there is no relationship between Mr McWhirter's death, the events of 27 – 28 June 2008 and his medication."[10] I note also that the medical record makes clear that Mr McWhirter was given PRN Olanzapine on at least 5 occasions before 28 June 2008 without any ill effect. I could therefore not conclude on the balance of probabilities that the administration of olanzapine on the night of his death was the physiological cause of, or precipitated, or contributed to his death.

32. In the light of the whole of the medical evidence, including Associate Professor Mond's opinions, I agree with Ms Foy that it is, "more likely than not that Mr McWhirter's death was caused by an event related to his illnesses."[11] I also accept, on the basis of Associate Professor Mond's report that, "it is also possible that his ischaemic heart disease and reduced ejection fraction caused his death."[12]

33. Towards the end of his evidence Professor George, in answer to my questions, endeavoured to describe the cause or causes of death in the following terms "it is a difficult one. As I have said before Mr McWhirter has or had multiple pathologies. Any of them could have caused the death. It could have been a cardiac event. It could have been a sudden ... pulmonary

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[6] Ibid

[7] Ibid

[8] Paragraph 40 - Submissions of Ms D Foy.

[9] Ibid

[10] Paragraph 44 – Submissions of Ms D Foy.

[11] Paragraph 47 – Submissions of Ms D Foy.

[12] Ibid.

failure that could have happened. It could have been a pulmonary embolism that could have happened."[13] He went on to say, "(a)nd also with the doctor who wrote the death certificate, probably if I was in his place I would have probably, looking at his history and the number of vascular risk factors and the previous myocardial infarcts that he has had....I would have probably gone for the same thing, and probably presumed that that was the cause of death."[14]

34. This evidence has to been seen in the light of Associate Professor Mond's opinion about the cardiac issue. As I set out above, Associate Professor Mond stated "there is no evidence that there was any cardiac cause of death in this patient, although there is evidence of ischemic heart disease...".[15]

35. I note that there is a degree of imprecision in defining causes of death in some cases and I accept the evidence of Professor George on the point. He said, "(a)nd so the doctor who is present – and it happens very much in the nursing homes as well, where general practitioners come and do the death certificate, they obviously look at what has been there as pre-morbid pathologies, and look at what might be – and the way that the death has happened suddenly or slowly, or what's – the way that the death has happened and looking at the pathologies that have been present, they make a call on that, a judgment call on what they think might be the cause of death. It is never 100 per cent certain, as you know, the death certificates."[16]

36. On the whole of the medical evidence, I am satisfied that the causes of Mr McWhirter's death were underlying multiple pathologies including vascular dementia, ischemic heart disease and hypertension, with a myocardial infraction being a possible, rather than probable, contributor to his ultimate demise.

I extend my sincere condolences to Mrs Laver and Mr McWhirter's family.

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

Mrs C Laver, Senior next of kin

Professor K George, Interested Party

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[13] Transcript of Inquest – Page 160, lines 10-16.

[14] Transcript of Inquest – Page 160, lines 19-25.

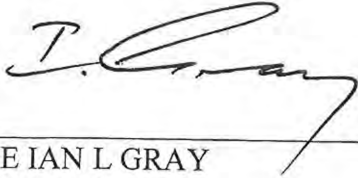
[15] Report of Associate Professor Mond dated 18 October 2011.

[16] Transcript of Inquest – Page 158, lines 3-13.

Ms D Foy, Counsel for the Peter James Centre

Leading Senior Constable Nadine Harrison

Signature:



JUDGE IAN L GRAY
STATE CORONER
Date: 30/10/13