FORM 38

Rule 60(2)

REDACTED FINDING INTO DEATH WITHOUT INQUEST

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

Court reference: 834/06

In the Coroners Court of Victoria at Melbourne

I, JUDGE JENNIFER COATE, State Coroner

having investigated the death of:

Details of deceased:

Surname: Redacted
First name: Mr M
Address: Parkdale, Victoria 3195

without holding an inquest:

find that the identity of the deceased was Mr M
and death occurred on 3rd March, 2006

at Monash Medical Centre, 246 Clayton Road, Clayton, Victoria 3168

from
1a. CLOSED HEAD INJURY SUSTAINED IN A FALL
2. ISCHAEMIC HEART DISEASE

Pursuant to Section 67(2) of the **Coroners Act 2008**, an inquest into the death was not held and the deceased was not immediately before the person died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:

1. Mr M passed away on 3 March 2006, at Monash Medical Centre from a subdural haematoma sustained in a fall. He was an inpatient at the Kingston Rehabilitation Centre at the time. His death was reported to and investigated by the coroner.

2. By finding produced on 14 February 2007, Coroner Spooner set out the circumstances of Mr M's death.

3. By letter dated 16 May 2008, solicitors for Mrs M, daughter of the late Mr M, applied for the finding of Coroner Spooner to be set aside and for an inquest to be held into the death of Mr M.

4. At a directions hearing before me on 15 January 2009, the application to set aside the previous finding was granted, but the application for inquest was not.

5. I agreed to direct further investigations and for independent medical opinions to be obtained and exchanged and thereafter, an opportunity for written submissions to be provided upon receipt of that further material.

6. In the ensuing months, opinions as to the circumstances surrounding Mr M's death were obtained from a neurosurgeon, Dr Gavin Fabinyi and an emergency physician Dr Sandra Neate. Further material was also considered from Southern Health including their "Head injury imaging guideline" and a nine page further statement with attachments, from Mr John Snowdon, legal representative for Southern Health.

7. In the wake of the distribution of the further material and the medical opinions obtained, several rounds of further submissions from Southern Health and the family of Mr M were received.

8. I have considered all of their new material, together with the material provided for the previous investigation.

9. Before commencing the substantive part of this finding, I note the heartache and grief palpable in the material produced by Mrs M at the sudden loss of her much loved father. The findings contained hereinafter are not to diminish his life or the precious nature of it.

10. Upon reconsideration, I adopt the accuracy of the original findings of Coroner Spooner as to the identity and cause of death of Mr M and the circumstances surrounding his death as far as they were set out.

11. As a result of the further material and opinions collected, I address the following questions I consider relevant to this re-considered finding.

Circumstances surrounding the fall

12. Mr M was 82 years old at the time of his death. He had a significant number of complex underlying medical conditions including ischaemic heart disease and atrial fibrillation for which he was taking Warfarin.

13. An examination of the material confirms that Mr M had a history of falls and consequently was at risk of further falls. He was assessed at the Kingston Centre upon admission as a "medium risk" for falls.

14. The material provided by Southern Health confirms its acceptance that Mr M on or about 10.20pm on 1 March 2006, not having been provided with the urinal bottle when he required, he tried walking to the toilet unassisted, at which time he fell. It is further not contentious that this fall caused his head injury which was the cause of his sudden death.

15. On reviewing the notes provided by the Kingston Centre, in particular the patient notes attached to the statement of Jan O'Brien (24.7.06), I note that the falls risk assessment completed for Mr M on admission, required nursing staff to ensure that Mr M had the call bell in close proximity to him and that Mr M needed assistance to get to and from the toilet. Therefore, the circumstances surrounding Mr M's fall indicate that the actions assessed as necessary by the Kingston Centre to meet its own requirements were not taken.

Actions in the wake of the unwitnessed fall

16. Mr M was found by a registered nurse, lying on the floor on his left side with his left arm behind his back. There is no evidence that Mr M suffered a loss of consciousness. The clinical notes also record that Mr M was fully orientated on examination with no confusion or amnesia.

17. The evidence is that neurological observations were commenced upon Mr M and the doctor was notified immediately.

18. The doctor attended upon Mr M at 8.45pm that evening, being 25 minutes after Mr M was found. Upon examination Mr M's vital signs were recorded as normal, he had no double vision and his neurological examination was normal, as was his chest and abdominal examination. He was noted to have a small laceration on his left forehead making it clinically apparent that he had hit his head.

19. The clinical notes record that Mr M did not report any chest pain, shortness of breath or dizziness prior to the fall and no nausea or vomiting after the fall. His management plan was for hourly neurological observations and for the doctor to be notified of any concerns in particular nausea and vomiting or increasing headache.

20. The records indicate that these hourly neurological checks requested by the doctor were done and recorded as normal.

21. A further medical review was performed on Mr M the next day, which found normal neurological observations with a treatment plan to check his INR.

22. During a medical review at 2.30pm on the afternoon of 2 March 2006, a doctor found Mr M to have suddenly experienced a decrease in conscious state and he was noted to be severely drowsy. This prompted a concern about intracranial bleeding.

23. The emergency department at Monash Medical Centre was contacted and Mr M was transferred to the Monash Medical Centre. Upon admission, Mr M was found to be "unresponsive".

24. Mr M underwent a CT scan, which found a very large subdural haematoma. Mr M was assessed by neurosurgeons with respect to possible surgical evacuation of the haematoma but after discussion with the family, conservative treatment was decided upon. Mr M was palliated and passed away on 3 March 2006, at 6.45pm.

25. The family of Mr M raised a series of concerns about both the circumstances of the fall and the response of the Kingston Centre in the wake of the fall. I have considered those questions and extracted what I consider to be the remaining relevant issues.

26. Whether or not Mr M lost consciousness was a concern raised by the family in that the fall was unwitnessed and therefore the staff and doctors could not be sure that there was no loss of consciousness. The family was concerned that an assumption was just made about this issue with no consideration beyond that assumption. However, the records make it tolerably clear that this issue was investigated to the extent that Mr M was asked about this and he reported no loss of consciousness and no symptoms consistent with loss of consciousness were noted. Further, Mr M was questioned about other symptoms pre fall and post fall, such as confusion, nausea, vomiting and headaches. Whilst an unwitnessed fall always leaves open the possibility of a loss of consciousness, for an otherwise lucid person to report no loss of consciousness, together with a thorough clinical examination, to conclude there was no loss of consciousness is not "just an assumption" but rather a conclusion based on some examination and investigation. The question of the accuracy of the information obtained must be left to clinical judgment in the circumstances.

Was the examining doctor's conclusion as to Mr M's vital signs reasonable in the circumstances?

27. In the opinion of Doctor Neate, a specialist emergency physician for over 14 years and a former director of emergency medicine training at St Vincent's Hospital for over seven years, (2002 - 2009), the history taken of initial examination performed by the doctor assessing Mr M after his fall, appeared thorough and the conclusions reached were reasonable given his clinical presentation.

28. On the other hand, Doctor Fabinyi considered that whilst the doctor's examination appeared very adequate, it was his view that the doctor did not take into account Mr M's factors, which made him a higher risk for intracranial haemorrhage.

Given Mr M was on Warfarin, should that have caused a different clinical response to his fall?

29. Doctor Neate stated that in her view the decision as to whether or not a CT scan should be performed in these circumstances is "not clear cut". Dr Neate noted that the guidelines for when a CT scan of the brain is required in minor head trauma applying to patients who have lost consciousness or have amnesia or disorientation and Mr M had neither of these three conditions. Dr Neate also noted that these guidelines are for patients presenting to Emergency Departments. Dr Neate noted "Mr M was in a rehabilitation setting where the patient group is different and minor falls and injuries are extremely frequent, and CT scan is not available on the premises and requires hospital transfer. The decision to refer a patient for scan needs to take into account the likelihood of significant injury, the patient's pre-existing condition and general state of health, and an appreciation of the risks and benefits of transfer, scanning and possible surgery. It is not possible or good practice to perform a CT scan on every patient who falls over." It was Dr Neate's opinion that in Mr M's circumstances, in that he had a fall without evidence of loss of consciousness and only minimal evident trauma, with normal Glasgow scale and normal vital signs, the decision not to transfer Mr M immediately for an urgent scan was a reasonable decision, despite the fact that he was taking Warfarin.

30. Dr Neate did go on to observe however, that it would have been prudent to check Mr M's INR as a matter of some urgency, in case it was extremely elevated. Whilst it was organised for the following morning, Dr Neate expressed the view that this could have been done more urgently.

31. On the other hand, Dr Fabinyi the neurosurgeon considered that given Mr M was on anticoagulation treatment, that was an extremely important consideration for CT scanning even for a mild head injury. Dr Fabinyi clearly had a strong view that the protocols which currently apply to emergency departments only for CT scan are poor for patients with head injury on anticoagulation treatment and should apply more widely. He expressed it thus: "I think it is extremely important that the protocol concerning patients with head injury requiring a CT scan be promulgated not only within the emergency department of public hospitals, but more widely. The underlying concern of any injury in a patient on antigoagulant therapy leading to complications must be seriously considered. Where that occurs in a situation where there is no emergency department or facilities for neurosurgical care, one must still think of the possibility and either arrange transfer to such a hospital or carry out a CT scan if one is available."

32. I infer from the overall comments contained in Dr Fabinyi's report that in his view Mr M should have been transferred for CT scan in a timely way post his fall, despite there being no clinical signs of subdural haematoma given that he was over 65, on anti coagulation therapy and had a minor head trauma. Dr Fabinyi makes no comment about the likely timing of the onset of the subdural haematoma and the time during which it would have taken to become observable on CT scan other than in the context of commenting that there was a period of at least several hours

between the head injury and the subsequent rapid deterioration. Dr Fabinyi does not make any reference to the current guidelines for head injury imaging requests supplied by Southern Health.[2]

Would the earlier detection of the subdural haematoma at the time of the initial examination have made any difference to the outcome.

33. On this issue, Dr Neate advises that the rate of bleeding into the subdural space is variable and blood can accumulate slowly. It was Dr Neate's opinion that given that Mr M's conscious state was normal 25 minutes after he was found on the floor, it would be unlikely that a CT scan at that time would have detected any abnormality. It was her view that the accumulation was likely to have occurred over a period of time (unspecified). On the question of whether or not immediate intervention would have made a difference to the outcome, Dr Neate assessed that question as "difficult to judge". She explained this opinion on the basis that given Mr M's underlying conditions, he may have been deemed medically unfit for such a major surgery or had he undergone the surgery he may have not survived post operatively given his underlying medical conditions.

34. On this issue Dr Fabinyi expressed the view in the hours between the fall and the deterioration it is possible that if intervention had been carried out during this period there may have been a satisfactory result. As stated above, he does not give any assessment as to his opinion about when the haematoma may have been observable on CT scan.

Conclusion

35. On balance, I find that Mr M died as a result of the trauma to his head suffered in an unwitnessed fall when he was a patient at Kingston Rehabilitation Centre operated by Southern Health.

Comment

36. Pursuant to section 67 (3) **Coroners Act 2008** I make the following comment in the context of this reconsidered finding. Clearly, there are a range of views across the medical profession about the appropriate response to minor head trauma for patients on anti-coagulation treatment. Dr Neate and Dr Fabinyi, both highly qualified and experienced medical practitioners represent the spectrum of those differing views. In that context, it would not be appropriate to make a recommendation that, in circumstances where an elderly resident, on anti-coagulation therapy in any facility has a fall and strikes his or her head must be transferred for CT scan, held for 24 hours in hospital and scanned again after 24 hours, no matter whether all of their vital signs and neurological signs are intact.

[2] I have been supplied with two sets of guidelines from Southern Health. The one Dr Fabinyi had was the one in place at the time of Mr M's fall. It was made clear in submissions from Southern Health that those guidelines, on review were considered unworkable. The second Guideline is the one, which resulted from a review in 2006 in which Mr M would not have qualified for a CT scan.

37. In my view, clinical judgment must be exercised. However, that clinical judgment must always be exercised appropriately, by an appropriately qualified person to make the assessment as to whether or not a CT scan is warranted in a particular case based on all of the facts and in full knowledge of the perils of anti-coagulation therapy combined with head strikes. Full knowledge of the facts requires not only the neurological and vital sign examination but also appropriate blood monitoring for INR levels.

38. Given the role of the coroner in promoting public health and safety, I consider it appropriate in this case to direct that a copy of this decision be published on the court's website, to assist in highlighting risks associated with anti-coagulation therapy and minor head trauma.

Signature:

Judge Jennifer Coate
State Coroner

28th July, 2011