IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 0577

FINDING INTO DEATH WITH INQUEST

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

Findings of:	**CORONER JOHN OLLE**
Deceased:	**PAQUITA GOLBERG**, born 16 March 1925
Delivered on:	17 September 2018
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	17 September 2018
Counsel assisting the Coroner:	Remo Antolini

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HER HONOUR:

BACKGROUND

1. Paquita Goldberg was an 87-year-old woman who was born in Spain and who had lived at home alone with a funded package of supports provided by the Jewish Care Kesher, and supported by her children. Mrs Goldberg had been admitted to the Graceland Manor Hostel for respite after discharge from Cabrini Hospital in December 2012. Mrs Goldberg was treated for a chest infection and discharged herself from Cabrini Hospital on 4 January 2013.

2. On 22 January 2013 at 5.00am Mrs Goldberg became distressed and verbally abusive to staff at the hostel. Police were called and according to Constable Andrew Sward, Mrs Goldberg was settled out the front of the hostel but staff reported they believed her capable of physical aggression. She did not settle enough to be assessed for her scheduled appointment with the general practitioner Dr Sevryn Prazkier and Aged Care Assessment Service (ACAS) and was instead taken to the Alfred Hospital for assessment and then admitted to a medical ward at Caulfield Hospital with a possible delirium. Mrs Goldberg did not settle, tried to abscond and two Code Greys were called in response to her behaviours.[1] Consequently, she was made an involuntary patient under the *Mental Health Act 1986* (Vic) and transferred to the secure Baringa Aged Psychiatry Unit.[2]

3. Mrs Goldberg's medical and psychiatric health records document her history as having included chronic obstructive pulmonary disease, shingles, osteoarthritis, paranoia, impulsivity, and dementia and during her admission also diagnosed with behavioural and psychological symptoms of dementia (BPSD).

4. At the time of her death, Mrs Goldberg's routine medications were desvenlafaxine[3], seretide (respiratory) tiotropine (respiratory), celecoxib (anti-inflammatory), oxazepam[4], rivastigmine[5] patch, risperidone[6], and pro re nata medications of oxygen, oxazepam, and olanzapine[7].

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[1] Code Grey is a standardised response to incidents of violence and aggression. https://www2.health.vic.gov.au/getfile/?sc_itemid=%7B3F7728A9-400D-4A32-94FE-42A7D7B5F922%7D&title=Code%20Grey%20Standards

[2] Coronial brief of evidence page 31, 32 & 73.

[3] Desvenlafaxine (Pristiq) is an atypical antidepressant, available as a slow release tablet.

[4] Oxazepam (Serapax, Alepam, Murelax), medium acting benzodiazepine. It is indicated in the treatment of anxiety, panic disorder, sleep disorders, seizures acute behavioural disturbance and acute alcohol, barbiturate or benzodiazepine withdrawal.

[5] Rivastigmine – (Exelon) is an anticholinesterase medication used to treat mild to moderate Alzheimer's disease. It is available in liquid, capsules and as a patch.

[6] Risperidone is an antipsychotic drugs that is used for treating schizophrenia, bipolar mania behavioural issues, dementia and autism.

[7] Olanzapine (Zyprexa) a second-generation antipsychotic indicated in the treatment of schizophrenia and related disorders, and bipolar disorder.

5. Mrs Goldberg was admitted to the Baringa Unit on 23 January 2013 and a family meeting was held the following day with her three sons. Treating psychiatrist Dr Stephen MacFarlane states her family reported she had been dementing for the past 2-3 years (diagnosis made without formal testing), had exhibited paranoia and abuse (including physical) to her neighbours (intervention order had been in place)[8], in the six months prior to her admission to Cabrini Hospital and also to her family.[9] Mrs Goldberg had increasing difficulties self-caring and they "indicated a wish to see her obtain a permanent aged care placement post-discharge."[10]

6. On admission Mrs Goldberg had comprehensive physical and psychiatric assessments (with consultation with family members and GP) and was commenced on rivastigmine patch for her dementia, and low dose oxazepam for her anxiety. The mini mental state examination (MMSE)[11] was 19/30. After 48 hours Mrs Goldberg was more settled but she did stand by the door and wanted to leave the unit.

7. On 24 January 2013 Mrs Goldberg was withdrawn, not speaking with co-patients or staff and refusing interventions in the day time but much better in the evening and she was eating well. Mrs Goldberg's sons Mark, Henry and Aaron attended a family meeting in Baringa Unit with Consultant Psychiatrist Dr MacFarlane, Registrar Dr Long and a social worker. The family told of a history of physical aggression to family and others preadmission and that Mrs Goldberg believed they were trying to lock her away, and the hospital was trying to kill her. The family were described as burnt out and felt guilty at their mother's helplessness. They agreed with the use of injectable medications if required and once she settled, a permanent and suitable placement would be the goal. Mrs Goldberg was assessed by an occupational therapist and she thought herself independent.

8. Over 25 to 28 January 2013, Mrs Goldberg was settled, eating and engaging with staff. She was recorded as having a low mood and was teary when talking about her sons. Later her room was changed to a shared room and she initially became upset about the noise from a CPAP machine[12] and how she was disturbed by her roommate. On 29 January 2013, Mrs Goldberg was upset after her clothes were taken by another patient and she did not like the clothes given to her by the nursing staff, was agitated and anxious and concerned her sons

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[8] Coronial brief of evidence, page 202.
[9] Coronial brief of evidence, page 202.
[10] Coronial brief of evidence, page 202& 207.
[11] The MMSE tests a number of different mental abilities, including a person's memory, attention and language. In general, scores of 27 or above (out of 30) are considered normal. However, getting a score below this does not always mean that a person has dementia - their mental abilities might be impaired for another reason or they may have a physical problem.
[12] Continuous positive air pressure (CPAP) treatment uses a positive air pressure to hold the airway open during sleep. The positive air pressure is generated by a pump called a CPAP machine, and is applied through a small mask which fits over the nose, or the nose and mouth. It is a mode of respiratory ventilation used in the treatment of sleep apnoea

had not visited her that day. That evening she was pleased to see her son who she believed would take her home.

THE PURPOSE OF A CORONIAL INVESTIGATION

9. The role of a coroner is to investigate reportable deaths to establish, if possible, the identity, of the deceased, the medical cause of death and, with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame, or determine criminal or civil liability.[13]

10. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[14] The *Coroners Act 2008* (Vic) **(the Act)** provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[15]

11. The Act provides that a coroner must hold an inquest into all deaths which occurred while a person is "*in custody or care*",[16] except in those circumstances where the death is considered to be due to natural causes.[17]

12. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[18] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

13. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

14. For coronial purposes, the phrase "*circumstances in which death occurred*," refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

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[13] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.
[14] Section 89(4) *Coroners Act 2008.*
[15] See Preamble and s 67, *Coroners Act 2008.*
[16] Section 52(2)(b) of the *Coroners Act 2008.*
[17] Section 52(3A) of the *Coroners Act 2008.*
[18] *Keown v Khan* (1999) 1 VR 69.

15. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

16. Coroners are also empowered:

(a) to report to the Attorney-General on a death;

(b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

(c) to 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. These powers are the vehicles by which the prevention role may be advanced.

17. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[19] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

18. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

19. On 8 February 2013, Medical Practitioner Dr Stephen McFarlane identified the body of the deceased to be Paquita Goldberg, born 16 March 1925.

20. Identity is not in dispute in this matter and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

21. On 12 February 2013, Dr Michael Burke, Senior Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy upon the body of Mrs Goldberg. Dr Burke

[19] (1938) 60 CLR 336.

provided a written report, dated 2 April 2013 which concluded that Mrs Goldberg died as a result of intentional inhalation of tissue paper.

22. Toxicological analysis of post-mortem specimens detected desmethylvenlafaxine (~0.1 mg/L) and olanzapine (~0.03 mg/L).

23. Dr Burke noted that the post-mortem examination showed tissue paper within the trachea and within the left main bronchus. This tissue paper had been rolled into a "bolus". The inhalation of tissue paper would be expected to lead to upper airway obstruction and a subsequent hypoxic cardiac arrest. The post mortem examination showed no evidence of any traumatic injury that would have contributed to or lead to death and there was no objective evidence to suggest the involvement of any in other person in the incident which lead to death.

24. I accept the cause of death proposed by Dr Burke.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

25. On 30 January 2013 Mrs Goldberg reported having problems sleeping in a room with another person in it and was documented as only having slept for three hours. Her clothes remained missing, she was slightly irritable regarding remaining in hospital, was socializing with other patients, eating meals but described by staff as "confused/puzzled". A clinical review and the recovery plan was completed included an increase in the dose of rivastigmine patch, repeat MMSE, and for Mrs Goldberg's family to look for suitable placements for discharge and for reassessment by ACAS. Nursing staff administered oral oxazepam at 4.05pm because she was anxious, wandering and wanting to go home and olanzapine at 6.14pm because she was paranoid and unsettled. Mrs Goldberg was visited by her family with more clothes but she was anxious they would be stolen and settled after they were locked up. She also stated her room was too big and she did not feel safe.

26. On 31 January 2013 Mrs Goldberg slept for five hours after taking temazepam.[20] She was anxious and again told staff she felt unsafe in the room alone. She participated in cooking group but was upset her underwear had been moved but remained settled, watched television and slept well.

27. On 1 February 2013, Mrs Goldberg participated in the reminiscence group and became upset after talking about her sons. She stated "I wouldn't mind to die tomorrow", but no intent

[20] Temazepam is a benzodiazepine, is habit-forming and used in the short-term treatment of insomnia.

noted and had future plans. Nursing staff recorded her mood as normal but with underlying anxiety. At night she expressed concern about intrusion by co-patients and asked for the door to be locked, and was noted to have settled and observed to be sleeping[21].

28. On 2 February 2013 Mrs Goldberg felt unwell in the morning but improved as the day progressed. In the evening she became very agitated during a MET call for a co-patient. She stated she was going to "die here if she wasn't allowed to leave" and tried to enter the nurses' station to speak with the doctor. She was also upset she could not attend her grandson's 18th birthday. She is documented as having settled after making a telephone call.[22] Mrs Goldberg did not sleep more than one hour, refused meds and was wandering and agitated all night voicing paranoid thoughts about family and money.[23]

29. On 3 February 2013 Mrs Goldberg was confused, lacked confidence, was very anxious and her ability to self-care was less. Mrs Goldberg wanted to go home and said she was being intimidated by co-patients.[24] The nursing care plan was reviewed and Mrs Goldberg's risk of aggression was reduced to potential because she had not been aggressive since admission to Baringa. Family reported she felt at risk from other patients, expressed fear and felt she was not safe in the unit. Mrs Goldberg was later documented as anxious and irritable due to intrusive female co-patient."[25]

30. On 4 February 2013 a social worker met with Mrs Goldberg's sons to discuss the ACAS process and the decision to move Mrs Goldberg to a residential unit as respite rather than wait in Baringa for permanent placement. The social worker wrote, "They [family] are concerned for their mother to leave Baringa as soon as possible, being such a noisy, chaotic environment."[26]

31. On 5 and 6 February 2013, Mrs Goldberg had fluctuating presentation with periods of engagement with staff, co-patients and family but also episodes of paranoia and insistence on wanting to call the police because she was in danger, and of wanting to go home and being quite distressed especially when family visit and leave. She was also recorded as becoming anxious when it was near time for her medications. Mrs Goldberg was assessed by ACAS for dementia low level care accommodation and a clinical review was completed. Mark Goldberg contacted the social worker to ask how to hurry the process for getting his

[21] Coronial brief of evidence, page 210.
[22] Coronial brief of evidence, page 210.
[23] Coronial brief of evidence, page 211.
[24] Coronial brief of evidence, page 211.
[25] Coronial brief of evidence, page 212.
[26] Coronial brief of evidence, page 214.

mother out of the unit. The family were distressed and found it hard to visit because of the environment.[27] A clinical review was completed and included the family's request to move their mother to a medical ward because of the environment.

32. On 7 February 2013 Mrs Goldberg was assessed by the psychiatric registrar in the communal areas of the unit because of her level of paranoia and agitation when she clearly stated she did not trust the staff or her family, that she was very scared and cannot trust anyone. She was prescribed risperidone.[28] According to a nurse, Mrs Goldberg was "Telling staff forgot lot past but now remembers. Said "I was raped in a c.camp (concentration) and could not be consoled.""[29] She is recorded as having increasing levels of hostility, verbal abuse to staff, paranoia and refused to take any medications, and was insisting on going home.[30] Mrs Goldberg was aggressive and involved in at least two incidents and refused oral medications and was administered pro re nata (PRN) olanzapine[31] intramuscular injections at 4.35pm and 9.15pm.

33. On 8 February 2013 Mrs Goldberg had reportedly slept for approximately five hours with some waking, however the record by a nurse entered after Mrs Goldberg's death includes "Overnight, patient had had periods of up animation, slamming doors, and intruding into other patients' rooms. Remained paranoid and suspicious of staff and their movements."[32] An unsigned addition has been made to the progress notes after the night staff 5.30am entry on 8 February 2013, "addit – 15/60 [every fifteen minutes] OBS adhered too [sic] as per directive".[33]

34. Mrs Goldberg continued to want to be discharged home and thought she would die if she could not.[34,35] On 7 February 2013, Mrs Goldberg became distressed, had refused all medications and was consequently prescribed but never commenced the antipsychotic risperidone[36] however she refused it.[37]

35. According to the medical records overnight on 7 to 8 February 2013, Mrs Goldberg slept for five hours, was no management problem, but that she was also paranoid and suspicious of staff and had periods slamming doors, of being intrusive however there is no detail

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[27] Coronial brief of evidence, page 219.
[28] Coronial brief of evidence, page 263.
[29] Coronial brief of evidence page 219.
[30] Coronial brief of evidence, page 219.
[31] Olanzapine (Zyprexa) a second-generation antipsychotic indicated in the treatment of schizophrenia and related disorders, and bipolar disorder.
[32] Coronial brief of evidence page 221.
[33] Coronial brief of evidence page 220.
[34] Coronial brief of evidence page 32.
[35] Coronial brief of evidence page 16.
[36] Risperidone is an atypical antipsychotic drug that is used for treating schizophrenia, bipolar mania and autism.
[37] Coronial brief of evidence page 199.

regarding what times this occurred or what hours she was asleep over the duration of the night shift.[38]

36. On 8 February 2013 at 6.30am and according to an enrolled nurse, Mrs Goldberg was asleep on her bed. After commencing her shift, a registered nurse glanced into the bedroom and saw Mrs Goldberg lying on her back on her bed at 6.50am.[39] At 7.00am the registered nurse returned to complete physical observations and found Mrs Goldberg non-responsive.[40] A Code Blue was called and staff commenced resuscitation until Ambulance Victoria arrived and took over, but Mrs Goldberg was deceased. According to the attending medical practitioner, he responded to the code blue that was called at 7.10am.[41]

Investigation into medical treatment

Appropriateness of diagnoses

37. Over the course of the investigation into the death of Mrs Goldberg, a number of concerns were raised as to whether her diagnoses were appropriate. She had four provisional and/or final psychiatric diagnoses recorded at the time of her death, delirium, dementia and behavioural changes, depression and anxiety.

38. A delirium is a disturbance of consciousness, attention, cognition, and perception that develops over a short period of time (usually hours or days) and tends to fluctuate during the course of the day. According to the medical records, it was not established if Paquita did or did not have a delirium.[42] A cause for a possible delirium had not been identified which is not uncommon and the presentation of a delirium is complicated by dementia and vice versa.

39. Around 90 per cent of people with dementia experience aggression, agitation and psychosis (delusions and hallucinations) known as the Behavioural and Psychological Symptoms of Dementia (BPSD) that are thought to indicate a person's unmet need and their inability to articulate or communicate it to others.[43] BPSD is described as:

> Symptoms of disturbed perception, thought content, mood, behaviour frequently occurring in patients with dementia. BPSD include aggression, agitation, wandering, social and sexual disinhibition, verbal outbursts,

[38] Coronial brief of evidence page 221.
[39] Coronial brief of evidence page 20.
[40] Coronial brief of evidence page 18.
[41] Coronial brief of evidence page 29.
[42] Australian Commission on Safety and Quality in Health Care. Delirium Clinical Care Standard. Sydney: ACSQHC, 2016, page 22.
[43] Australian Government, Senate Standing Committees on Community Affairs, 2014. Care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia (BPSD).

> delusions, hallucinations, and anxiety. Such behaviour is usually only considered "challenging" and therefore a "problem" when it affects other people, causes harm to, or indicates distress of the people with dementia themselves. BPSD are recognized as potential complications throughout the course of any form of dementia because they are unpredictable, often stressful and sometimes dangerous. The burden of care in domestic situations and care institutions is increased by BPSD.[44]

40. These behaviours can be very distressing for the person with dementia, their family and carers.[45] With age as the major non-modifiable risk factor, the prevalence of dementia approximately doubles every five years beyond the age of 65 and for those aged 85 and over, the prevalence is approximately one in every four persons.

41. Depressive symptoms are common in older people but major depressive episodes are more common in those with dementia and can exhibit similar symptoms. Suicidal ideation is listed as an area of potential risk in patients with dementia. [46]

42. Anxiety is normal and helps people feel alert, focused and perform well, however high levels of anxiety, or constant anxiety or a low tolerance for anxiety is disabling and can affect and disrupt daily activities and interpersonal relationships and is often accompanied by panic and a sense of impending doom. Disorders of anxiety include generalised anxiety disorder, phobias, obsessive-compulsive disorder, and panic disorder.

43. Based on the available information, the diagnoses for Mrs Goldberg were appropriate and supported by the medical records.

Safety of the new medications prescribed

44. At the Mention Hearing, Mrs Goldberg's family requested a review of the new medications prescribed for their Mother. Dr Stafrace addressed their concerns in his statement and based on the available information, the investigation found no concerns regarding the selected medications and doses that requires further investigation.

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[44] Australian Government, Dementia behaviour Management Advisory Service (DBMAS) http://dbmas.org.au/want-to-know-more/defining-bpsds/ International Psychogeriatric Association Taskforce on BPSD. <https://www.ipa-online.org/publications/guides-to-bpsd>

[45] Alzheimer's Society United Kingdom. <http://www.alzheimers.org.uk/bpsdguide>

[46] Depression in dementia. NPS MedicineWise; Dec 2015. <https://www.nps.org.au/australian-prescriber/articles/depression-in-dementia>

Why was Mrs Goldberg assessed as a threat?

45. Mrs Goldberg had a history of aggression from 2008, which in the main was associated with her paranoia.[47] Her aggression was usually verbal however there are clearly documented instances of physical violence (to family, neighbours and staff) in the information available. The two instances in the medical ward at Caulfield were severe enough to result in a Code Grey; requiring attendance by the Caulfield Hospital site security; a change to involuntary treatment, and transfer to Baringa Unit. Mrs Goldberg frequently tried to leave the units, wanting to go home with her family or by herself. Alfred Health could not sustain her detention against her will without the use of the *Mental Health Act 1986* (Vic) and its use ensured.[48]

46. If a patient is affected by a mental illness to that degree the response to any violence and aggression is guided by legislation, regulated and monitored and staff are trained. Staff, regardless of how old or frail the patient appears to be, are not expected to tolerate any violence as part of their job, especially physical. The source of violence is irrelevant. The definition of violence includes where an employee is abused, threatened or assaulted while doing or from circumstances arising from their employment.[49]

Risk assessments and nursing observations

47. There is no doubt the mental health service was trying to find a more appropriate facility for Mrs Goldberg and that her family were anxious to remove her from Baringa Unit. Regardless, the statements from family members and the medical records suggest the environment was not considered to be calm by Mrs Goldberg's family or Mrs Goldberg herself who is documented on repeated occasions as telling staff she was frightened and did not feel safe, all of which cannot reasonably be dismissed as symptoms of her illnesses.

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[47] Coronial brief of evidence page 126.

[48] *Mental Health Act 1986* (Vic) Section 8 criteria, all must apply: (a)the person appears to be mentally ill; and (b)the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; and (c)because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and (d)the person has refused or is unable to consent to the necessary treatment for the mental illness; and (e)the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

[49] Zero tolerance or no tolerance to violence in the workplace is supported by WorkSafe Victoria, the Department of Health and Human Services and unions.
WorkSafe Victoria A handbook for workplaces Prevention and management of aggression in health services Edition No. 1 June 2008, <https://www.worksafe.vic.gov.au/__data/assets/pdf_file/0012/10209/Aggression_in_health_care.pdf>
Preventing occupational violence in Victorian health services A policy framework and resource kit October 2007. Authorised by the Victorian Government, 50 Lonsdale St, Melbourne October 2007 (0010707)
<http://www.health.vic.gov.au/__data/assets/pdf_file/0015/101643/nurse_safe_policy-Final.pdf>
Australian Nursing & midwifery Federation Victorian Branch 2001 updated 2003, 2006, 2010, and 2014. Prevention of occupational violence and aggression policy. <https://www.anmfvic.asn.au/news-and-publications/publications?type=policies>

48. There were also incidents in the last days of her admission when Mrs Goldberg is recorded as being aggressive to staff/co-patients and also documented as being settled, participating in activities and of being effectively redirected by staff in the Baringa Unit. Baringa Unit as an acute psychiatric unit for older persons also accommodates people who have high acuity of illness but expect to have a proportion of their patients with dementia and BPSD.[50] Mrs Goldberg was subject to the *Mental Health Act 1986* (Vic). She was also experiencing a possible delirium, and dementia, BPSD and paranoia which contributed to her vulnerability in an unfamiliar environment. The evidence is unequivocal that hospitals are not the most suitable environments for people with dementia and Alfred Health acknowledges this in their submission.[51] Managing a person with BPSD in this environment is difficult.

Bedroom door locks

49. Mrs Goldberg is documented on more than one occasion as having wandered into other bedrooms and at other times of being upset about others wandering into her room. There are also at least two occasions when she was upset her clothes had been taken. She had also requested her bedroom door to be locked and on the one occasion staff have recorded it, Mrs Goldberg is noted by the registered nurse as, "Anxiety was relieved. Warm and reactive."[52]

50. Alfred Health was asked about the ability to lock the Baringa Unit bedroom doors at the time of Mrs Goldberg's admission and stated the doors could only be locked by nursing staff but the patient could exit freely. The Alfred Health submission states the door locks and handles were changed in mid-2014 to remove ligature points and the fact that a patient could now lock their bedroom door was an additional bonus and not related to Mrs Goldberg's death.

Incident Reporting

51. Alfred Health was asked to provide the incident reports for Mrs Goldberg for her admission to the Caulfield Hospital, including the Baringa Unit. The four incident reports relevant to Mrs Goldberg (confirmed by Alfred Health as all of the incident reports) consist of three dated 23 January 2013, are recorded as having occurred in the Aged Medical Unit at Caulfield Hospital, and resulted in her transfer to Baringa Unit. All three were related to

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[50] Alfred Health Services and Clinics. <https://www.alfredhealth.org.au/services/aged-inpatient-mental-health>

[51] Submission by Alfred Health dated 19 September 2016, page 6.
Australian Government, Senate Standing Committees on Community Affairs, 2014. Care and management of younger and older Australians living with dementia and behavioural and psychiatric symptoms of dementia (BPSD).
NHMRC: Guideline Adaptation Committee. Clinical Practice Guidelines and Principles of Care for People with Dementia. Sydney. Guideline Adaptation Committee; 2016.

[52] Coronial Brief of Evidence page 210.

Mrs Goldberg's verbal and physical aggression and the need for staff to call a Code Grey. The remaining incident report is related to Mrs Goldberg's death on 8 February 2013.

52. According to the medical records of Baringa Unit, Mrs Goldberg was involved in at least two incidents of verbal and physical aggression to staff and/or co-patient on 7 February 2013. This resulted in two intramuscular injections of the antipsychotic olanzapine being administered by nursing staff five hours apart after Mrs Goldberg had refused all oral medications. There is a lack of detail of what the triggers were for these incidents including the actions of the co-patient and/or staff. It is unclear if the intramuscular injection was given because staff were concerned regards Mrs Goldberg's mental state and she had refused her oral medications or if they were given as a direct result of the incidents. The PRN stickers in the medical records contain the following as reasons for administration;

> "Aggression, paranoia +++, Refusing meds.[53]
>
> Aggression towards co-patient, paranoia +++.[54]"

53. It is unclear how the intramuscular injections were administered. There is no detail suggesting Mrs Goldberg was agreeable to having the injections and was compliant with having them or that physical restraint by staff was required to administer the injections.

54. The lack of details limits the assessment of Mrs Goldberg's care on 7 and 8 February 2013. It also raises concerns that an incident of aggression involving a co-patient and/or staff and the need to administer intramuscular antipsychotic medications was not considered by staff to be an incident and therefore reported.

55. According to the Submission on behalf of Alfred Health, "Consistent with that policy[55], only those of Mrs Goldberg's interactions with other patients fell within the definition of incident, and were therefore reported."[56] In addition, Dr Simon Stafrace states in his statement that:

> "A clinical (patient) incident is described as an event or circumstance that could have, or did, lead to unintended and/or unnecessary harm to a person receiving care. Clinical incidents include adverse events, near misses and hazards in the environment that pose a clinical risk.[57]
>
> At Baringa, incidents include: falls (whether witnessed/unwitnessed); aggression or violence; use of seclusion; medication errors; calls for medical assistance (known as

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53 Coronial Brief of Evidence page 219.
54 Coronial Brief of Evidence page 220.
55 Alfred Health Incident Management Guidelines.
56 Submission by Alfred Health dated 19 September 2016, page 6.
57 Statement by Dr Simon Stafrace dated 19 September 2016, page 6 of 7.

MET calls or Code Blues); any injuries or near misses involving patients and/or staff; patients absconding; and other adverse events."[58]

56. The requirements of the Alfred Health Incident Management Guideline supplied by Alfred Health after the Mention Hearing and referred to by Dr Stafrace and in the Alfred Health submission, did not apply at the time of Mrs Goldberg's death as it was approved in December 2015.[59]

57. It is concerning that staff viewed these types of incidents as usual and raises the possibility of their not recognising the significance of such incidents on a patient who had a possible delirium, with dementia, BPSD, and paranoia who had in the previous 24 hours told staff she recalled being raped in a concentration camp, had repeatedly stated she was frightened, believed staff would kill her, felt unsafe, did not trust staff and at times her family, and wanted to go home which was no longer a possibility.[60]

58. There is conflicting information suggesting Mrs Goldberg was a holocaust survivor or that she married a survivor[61] but regardless she lived in France from 1936 and did not move to Australia until 1951 or 1961 (unclear), so at a minimum she was a Jewish woman who had lived through the Second World War in occupied France. The implications for re-traumatization in the context of her recalling the rape on the day prior to her death and telling staff does not appear to have been considered by staff as contributing to a change in level of risk.[62]

59. It also raises the possibility of the staff not having a clear understanding of zero tolerance for workplace aggression or an understanding of their responsibilities for reporting incidents.

Risk assessment and Nursing Observation

60. There are two guidelines provided by Alfred Health and referred to as part of the investigation:

Risk Assessment and Management – Baringa, approval date 2012; and

Psychiatry – All inpatient Nursing Observation and Patient Engagement – approved June 2013.

61. The guideline that applied at the time of Mrs Goldberg's death was the 2012 Risk Assessment and Management – Baringa. Risk assessments and mental state examinations

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58 Statement by Dr Simon Stafrace dated 19 September 2016, page 6 of 7.
59 Alfred Health Incident Management Guideline, approval date December 2015.
60 Coronial Brief of Evidence page 220.
61 Conflicted reports in the brief, pages 170, 177, 195 & 277.
62 Paratz, B & Katz, B, 2011. Ageing Holocaust survivors in Australia. Medical Journal Australia. Volume 194, Number 4 pages 194-197.

were documented, as were clinical multidisciplinary reviews and family engagement in planning Mrs Goldberg's care.

62. Mrs Goldberg was admitted to Baringa Unit following three episodes of aggression necessitating two Code Greys on 23 January 2013. Following her admission to Baringa Unit, the progress notes show her to be paranoid; intimidated by other patients;[63] anxious and agitated at times but not aggressive until 7 February 2013.[64] Mrs Goldberg is noted to have settled at different times with staff interaction and distraction, visits from her family and the use of regular and PRN oral medications. It is also noted on 6 February 2013 by the ACAS assessor "Nursing staff report that she is easy to engage, not wandering or intrusive."[65]

63. On 7 February 2013, Mrs Goldberg is noted to have been increasingly agitated and anxious, telling the registrar she was frightened and did not trust anyone;[66] refusing her oral medications; disclosing she remembered she had been raped in the concentration camp and could not be consoled;[67] and increasingly agitated; hostile and aggressive to staff and co-patients, requiring two intramuscular injections of olanzapine over five hours.

64. Dr Stafrace's statement includes reference to the guideline that revision of risk assessment occurs "At any time risk factors are perceived to have changed."[68] Dr Stafrace also states that the hourly rate of visual observation was appropriate when considered in the context of other activities and duties undertaken by nursing staff over a shift when they would come in contact with Mrs Goldberg. In addition, Dr Stafrace records the high risk factors that would have indicated the need for more frequent observations as per the guideline were suicidality, history of violence (as opposed to mere aggression[69]), absconding, deliberate self-harm, period following step-down from a special to frequent observations, super-high falls risk and substance withdrawal,[70] and states "There is no evidence that Mrs Goldberg displayed any of these traits, at any time during her admission at Baringa."[71]

65. Both Drs MacFarlane[72] and Stafrace[73] include in their statements the entry in the progress notes on 8 February 2013 that observations had been completed fifteen minutely was a mistake that was made by an agency nurse. Dr Stafrace also includes that although the entry is incorrect, it shows the nursing staff can increase the frequency of observations if needed.

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63 Coronial Brief of Evidence page 211.
64 Coronial Brief of Evidence page 218.
65 Coronial Brief of Evidence page 217.
66 Coronial Brief of Evidence page 218.
67 Coronial Brief of Evidence page 219.
68 Statement by Dr Simon Stafrace dated 19 September 2016, page 3 of 7.
Alfred Health 2012 Guideline - Risk Assessment and Management – Baringa, page 4 of 5.
69 Statement by Dr Simon Stafrace.
70 Statement by Dr Simon Stafrace dated 19 September 2016, page 2 of 7.
71 Statement by Dr Simon Stafrace dated 19 September 2016, page 3 of 7.
72 Statement by Dr Stephen MacFarlane dated 7 April 2016.
73 Statement by Dr Simon Stafrace dated 19 September 2016, page 3.

There has been no statement provided by the agency nurse confirming the entry was a mistake or confirming or excluding that the observation frequency had been increased in response to perceived risks.

Procedure for completing and recording observations

66. According to the rostered enrolled nurse on 8 February 2013 she observed Mrs Goldberg asleep on her bed at 6.30am. The ward nurse glanced into the bedroom at 6.50am and saw Mrs Goldberg lying on her back on her bed.[74] At 7.00am the ward nurse noted Mrs Goldberg was unresponsive.

67. The Alfred Health 2013 Psychiatry – All Inpatient Nursing Observation and Patient Engagement Guideline provides greater guidance for staff regarding their accountabilities and responsibilities. Dr Stafrace includes the following:

> "Nursing staff are required to visually sight all patients at the required time and must be satisfied that the patient is safe and free from harm. When patients are sleeping the nurse should satisfy themselves that the patient is alive by checking their breathing (visual, audible and tactile if necessary). Nursing staff must record all observations at the time they are made.[75]"

68. According to the both guidelines, "An observation worksheet must be completed for each client by a member of the nursing staff" and the guidelines expand on the procedure.[76] The 2012 Guideline - Risk Assessment and Management – Baringa guideline required only that the patient be observed, rather than the need to establish is a person was breathing or asleep[77] and although Dr Stafrace's position is best practice, it is not articulated in either of the guidelines provided by Alfred Health.

69. Based on the available information and that the nurses involved stated they glanced through the door and observed Mrs Goldberg to be on her bed, there is nothing to support they attempted to establish if she was alive as described by Dr Stafrace and establishing respiration and colour of a patient from the doorway of a bedroom would reasonably be considered unreliable.

70. A review of the three copies of the Alfred Health medical records, did not contain observation sheets completed after 24 – 25 January 2013.[78] It is therefore unclear what time prior to 6.30am Mrs Goldberg was last observed and if this too, was established from the

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74 Coronial brief of evidence page 20.
75 Statement by Dr Simon Stafrace dated 19 September 2016, pages 3 & 4.
76 Alfred Health 2012 Guideline - Risk Assessment and Management – Baringa, page 4 & 5.
Alfred Health 2013 Psychiatry – All inpatient nursing observation and patient engagement, page 4.
77 Alfred Health 2012 Guideline - Risk Assessment and Management – Baringa, page 4 & 5.
78 8/2/2013; Copy included in the Coronial Brief of Evidence & copy obtained 23 January 2015.

bedroom doorway. In addition, sleep and behaviour charts had also been ceased, leaving the statements of the nurses and progress notes as the source of evidence as to how Mrs Goldberg spent the night 7 to 8 February 2016. The statements provide no information about what occurred prior to 6.30am and the Nursing progress note entries have a degree of conflict:

> RIB @ COS and attained appox 5hrs of sleep presentation due to intermittent waking aspects – relaxed and settled @ TOR. Overall nil management concerns encountered.[79]
>
> Overnight, patient had had periods of up animation, slamming doors, and intruding into other patients rooms. Remained paranoid and suspicious of staff and their movements. Challenging but manageable behaviour.[80]

71. It is unclear if Mrs Goldberg had slept the five hours in a single stretch, had a disturbed and broken sleep that collectively was five hours or for example, if she slept from 10.00pm on 7 February 2013 until 3.00am on 8 February 2013 and was up, slamming doors, intruding into other's rooms up until 6.30am when she is recorded as having been last seen by the Nursing staff.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

72. Mrs Goldberg was only admitted to Baringa Unit after her behaviour made it untenable that she remain in the medical unit at Caulfield Hospital. It is acknowledged that Baringa Unit and Mrs Goldberg's family were trying to find an appropriate residential facility in which to place her and had to wait for the ACAS assessment process and for the family to find an appropriate facility when a bed became available. It was also being discussed with her family that it might be possible to transfer Mrs Goldberg to a respite bed in an appropriate unit while awaiting a permanent room.

73. Alfred Health acknowledges the possible impact of the environment on Mrs Goldberg but the fact that she had to adjust to the environment is part of the problem when her and her family's documented experience was of a unit that was chaotic, noisy and in which she did not feel safe. In the context of Mrs Goldberg's diagnoses, her capacity to adjust to the environment was compromised. Dismissing her concerns as a product of the dementia and delirium alone and not as a reasonable response to the ward environment in the context of her vulnerabilities, may have undermined the assessment of any risks associated with her continued feelings of distrust and being unsafe.

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79 Coronial Brief of Evidence page 220.
80 Coronial Brief of Evidence page 221.

74. Patients have a right to privacy and to feel safe in a hospital regardless of the type of ward/unit. Privacy and an appropriate level and frequency of observation are not mutually exclusive. The Alfred Health 2012 Guideline - Risk Assessment and Management – Baringa lists the high risk factors but does not exclude other indicators that a more frequent observation period may be required. Distinguishing between violence and aggression must include the context in which it occurs and it is unclear what level of aggression in the context of Mrs Goldberg being an 87 year old woman with dementia, BPSD, who had two Code Greys called some two weeks earlier, was again aggressive to staff and other patients and was subject to the *Mental Health Act 1986* (Vic) could be considered violent enough to alert staff to a change in clinical presentation.

75. Mrs Goldberg had an increased level of distress over 7 and 8 February 2013 and had exhibited aggressive behaviours to staff and other patients that were new, in the actual admission to Baringa Unit. The assessment by the Psychiatric Register noted her as, "Admits she's very scared and can't trust anyone"[81], so much so that a second antipsychotic was prescribed.

76. It is difficult to draw a causal link directly between the absence of recorded observations, a detailed and reliable record of the events of the 7 to 8 February 2013 and Mrs Goldberg's actions. It is also unreasonable to expect the staff to have predicted Mrs Goldberg would die from tissue inhalation. Nonetheless, it is reasonable to expect that staff in an older person's acute psychiatric unit would be aware of the possibility of suicide or other risk (for example harm to others) in a woman with Mrs Goldberg's circumstances in the context of a recent and marked change in behaviours. Holocaust survivors report high levels of suicidal ideation and are up to twice as likely to attempt suicide.[82] The change in behaviours included an escalation in level of distress and Mrs Goldberg clearly articulating fear which resulted in the prescribing of a second antipsychotic, her refusal to take medications, and disclosure to staff of her sudden recall of a previous sexual assault trauma in the context of a concentration camp. It is reasonable for staff to have considered more frequent observations.

77. In the context of Mrs Goldberg's diagnoses, level of distress and paranoia, it is likely her capacity to think through the consequences of her actions and form intent was compromised.

78. The changes in guidelines since Mrs Goldberg's death include the Alfred Health 2013 Psychiatry – All inpatient nursing observation and patient engagement which now applies at

[81] Coronial Brief of Evidence page 220.
[82] Paratz, B & Katz, B, 2011. Ageing Holocaust survivors in Australia. Medical Journal Australia. Volume 194, Number 4 pages 194-197.

Baringa Unit and is contemporary and the Alfred Health 2015 Incident Management Guideline which is much clearer regarding staff accountabilities and responsibilities.

FINDINGS AND CONCLUSION

79. Having investigated the death and having held an Inquest in relation to her death on 30 July 2018, at Melbourne, I make the following findings pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Paquita Goldberg, born 16 March 1925;

    (b) the death occurred on 8 February 2013 at Baringa Ward, Caulfield Hospital 260 Kooyong Road, Victoria, from intentional inhalation of tissue paper; and

    (c) the death occurred in the circumstances described above.

80. I convey my sincerest sympathy to Mrs Goldberg's family.

81. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

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

(a) Mrs Goldberg's family, senior next of kin;

(b) Investigating Member, Victoria Police; and

(c) Interested Parties.

Signature:

CORONER JOHN OLLE

Date: 17 September 2018