FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 3976/07

Inquest into the Death of PAUL ALEXANDER GOODWIN

Delivered On:	
Delivered At:	Lonsdale Street, Melbourne
Hearing Dates:	31st May, 2010
Findings of:	JOHN OLLE
Representation:	Ms Erin Gardner for West Gippsland Healthcare Group Ms Felicity Cockram for Dr Tang
Place of death:	West Gippsland Hospital, Victoria
SCAU:	Senior Constable Tania Cristiano

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 3976/07

In the Coroners Court of Victoria at Latrobe Valley

I, JOHN OLLE, Coroner

having investigated the death of:

Details of deceased:

Surname: GOODWIN
First name: PAUL
Address: Gracevale Lodge Nursing Home,
133 Normanby Street, Warragul 3820

AND having held an inquest in relation to this death on 31 May 2010
at Latrobe Valley Coroners Court
find that the identity of the deceased was PAUL ALEXANDER GOODWIN
and death occurred on 5th October, 2007

at West Gippsland Hospital, Victoria

from
1a. RUPTURED ABDOMINAL AORTIC ANEURYSM

in the following circumstances:

1. Mr Paul Alexander Goodwin was aged 85 years at the time of his death. He lived at Gracevale Lodge, Warragul.

2. A comprehensive inquest brief has been prepared. A summary of evidence compiled by the coronial investigator, Senior Constable Spackman, fully addresses the circumstances of death of Mr Goodwin:

> *"The deceased in this matter is Paul Alexander GOODWIN, formally a resident of Gracevale Lodge Nursing Home, 133-199 Normanby Street, Warragul. The deceased died at the age of 85 years and is survived by his daughter Heather MICHAU and son Neil GOODWIN.*
>
> *The deceased had a past history of chronic obstructive airways disease, multiple cerebrovascular accidents, congestive cardiac failure, dementia, urinary incontinence, hypertension and an inoperable abdominal aortic aneurysm.*

On the 19/9/07 the deceased was admitted to the West Gippsland Hospital for treatment of an acute infective exacerbation of his chronic obstructive airways disease, as requested by Dr Michael THOMPSON.

On admission to the West Gippsland Hospital extra medication lists belonging to two other patients of the Gracevale Lodge Nursing Home were included on the deceased's medication chart by Dr Kim Wing TANG. These included Hexamin, Gabapentin and Clopidogrel.

Dr Kim Wing TANG noted that in 2004 that the deceased had a Not For Resuscitation order, this matter was discussed with the deceased's daughter, Heather MICHAU. The order was reinstated as a result of the discussion.

Dr Michael THOMPSON attended to the deceased over the following days and his health improved to the point that on the 25/9/07 his discharge options were being considered.

On the 26/9/07, Dr Michael THOMPSON noted that the deceased had poor co-ordination, and was drowsy which was unusual for the deceased. Blood tests were ordered for the deceased.

On the 27/9/07 the deceased remained drowsy and his speech was slurred, a chest X-ray and urine test were ordered by Dr Michael THOMPSON.

By the 29/9/07, Dr Michael THOMPSON noted that the deceased had deteriorated markedly in the past three days. Dr Michael THOMPSON also noted that the deceased was received extra medications including Gabapentin which was a possible cause of the deceased's sedation. Dr Michael THOMPSON ordered his oral medications to be ceased and for him to commence intravenous fluids and amoxicillin.

On the 30/9/07 the deceased was more alert and speaking, Dr Michael THOMPSON noted that he may have basal pneumonia and ordered that he continue his intravenous fluids and amoxicillin. His condition continued to improve and on the 04/10/07 he was alert and conversing, his intravenous fluids and antibiotics were ceased. At approximately 11.30pm that night, Registered Nurse, Kerry O'TOOLE checked on the deceased, he was in bed and appeared to be sleeping. At approximately 1:00am on the 05/10/07, she checked the deceased again, he was sitting beside the bed, but could not say why, he was helped back to bed. He was checked again at 1:30am and appeared comfortable, then again at 2:00am when he was found unresponsive.

Dr Hooman ARBABIAN certified death at 2:15am on the 05/10/07 at the West Gippsland Hospital."[1]

The evidence of Dr Tang

3. At inquest I had the evidence of Dr Tang. Dr Tang was an impressive witness. He acknowledged the error which led to incorrect administration of medication to Mr Goodwin.

4. The medication error was not a cause of death of Mr Goodwin.

---

[1] Summary of Evidence Inquest Brief

5. At the time of Mr Goodwin's admission, Dr Tang was in the early stage of his internship. Evidence has revealed Dr Tang was a meticulous medical practitioner. In all other respects, his management of Mr Goodwin's admission was exemplary.

6. He consulted Mr Goodwin's general practitioner and subsequently a cardiologist. His dealings with the family were indicative of his thorough approach.

7. His entries in the medical file were succinct and clear.

8. The medication error was brought to his attention some months after the death of Mr Goodwin. His practice and his supervision of interns thereafter reflects the seminal lesson learnt by him.

9. Dr Simon Fraser, Latrobe Regional Hospital sets out the valuable lessons learnt and steps initiated at the hospital to ensure medication errors are not repeated.[2]

Post Mortem Medical Examination

10. On the 9th October, 2007, Dr N. Sonenberg, Pathologist at Gippsland Pathology performed an autopsy.

11. Dr Sonenberg found the cause of death to be ruptured abdominal aortic aneurysm.

12. Dr Sonenberg stated:

> *"MODE OF DEATH*
> *Ruptured abdominal aortic aneurysm unrelated to the extra medications administered.*
>
> *MANNER OF DEATH*
> *Natural Causes."*

13. Finally, I offer my condolences to the family of Mr Goodwin.

Finding

I find that Paul Alexander Goodwin died of ruptured abdominal aortic aneurysm.

Signature:

John Olle
Coroner
Date: 16th June, 2010

[2] Statement Dr Fraser