IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2014 / 2170

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: REGINALD JOHN BROOKS

Delivered On:	15 March 2016
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria, 3006
Hearing Dates:	27, 28 and 29 October 2015
Findings of:	PHILLIP BYRNE
Representation:	Mr S Brooks (son of deceased) appeared on behalf of the family Mr J Constable appeared on behalf of South Eastern Private Hospital instructed by Trudy Ararat of Minter Ellison Mr J Goetz appeared on behalf of Dr Jun Shen instructed by Ms D Galbally of Tresscox Mr S Cash appeared on behalf of Mr Patrick Byrne
Police Coronial Support Unit	Leading Senior Constable Andrea Hibbins appeared to assist the Coroner

I, PHILLIP BYRNE, Coroner, having investigated the death of REGINALD JOHN BROOKS

AND having held an inquest in relation to this death on 27, 28 and 29 October 2015
at Southbank, Victoria, 3006
find that the identity of the deceased was REGINALD JOHN BROOKS
born on 6 April 1915
and the death occurred 8 January 2014
at South Eastern Private Hospital, Princes Highway, Noble Park, 3174
from:

1 (a) PNEUMONIA.

in the following circumstances:

BROAD CIRCUMSTANCES

1. Mr Reginald John Brooks, 99 years of age at the time of his death, lived in a supported residential facility, Rosewood Downs, in Dandenong.
2. Mr Brooks' past medical history included short-term memory loss, first degree heart block, osteoarthritis and prostate cancer.
3. Mr Brooks' general practitioner was Dr Trevor Adcock of the Langton Medical Centre. On 20 December 2013, Dr Adcock formed the view that, due to Mr Brooks' increasing frailty and falls, he needed to be assessed by the Aged Care Assessment Service with a view to obtaining permanent care at a higher level. In the interim, Mr Brooks was transferred to The Valley Private Hospital (TVPH).
4. Following assessment at TVPH that day, Mr Brooks was transferred to the South Eastern Private Hospital (SEPH) and admitted under the care of Dr Jun Shen. On arrival, he was assessed by nursing staff who noted that he was coherent and effective in communicating. A falls risk assessment was performed in accordance with SEPH policy and Mr Brooks was considered to be at a high risk of falling. The hospital implemented preventative measures as recommended by their falls policy and Mr Brooks' bed was placed into a low position with a sensor alarm fitted to the bed. As an additional precaution, staff ensured that Mr Brooks was aware of the nurse call button should he wish to get out of bed.

5. At approximately 10.15pm on 20 December 2013, Mr Brooks was located by nursing staff, naked on the floor outside the bathroom.[1] He was reported to be alert and conscious with stable vital signs post fall. He had sustained lacerations to his forehead and left shoulder. Mr Brooks was returned to bed. Having regard to the apparent head-strike, Mr Brooks was monitored and regular neurological observations were taken overnight. Mr Brooks' family were notified of the incident.

6. The following morning, Mr Brooks was reviewed by Dr Shen who observed that he was conscious, mildly confused and orientated to place, but not time. He was also noted to have right-sided hip pain, especially with movement and weight bearing.

7. Dr Shen arranged for a computed tomography (CT) scan of his head as well as x-rays of the pelvis and both hips. Mr Brooks was accompanied to the scan by Nurse Georgia Banks who indicated that Mr Brooks was quite alert and able to converse. She recalls that he recounted a number of stories about his life and appeared at that time to understand what was happening. Ultimately, the CT scan showed no recent intracranial event and the x-ray of both pelvis and hips showed no evidence of acute fracture.

8. On 27 December 2013, Mr Brooks was reviewed by geriatrician Dr Mutlu Haksoz. Dr Haksoz noted Mr Brooks was experiencing restricted mobility because of the right hip pain. Dr Haksoz also performed an Abbreviated Mental Test score, the results of which I set out now in full as they provide a basis upon which to understand Mr Brooks' general mental functioning around this time:

> '*He was able to tell me accurately his age, the approximate time of day, his current location, his date of birth, the end date of World War 2 (which tests long-term memory). He was able to count backward from 20 down to 1 which suggests at that stage there was no inattention due to delirium.*
>
> *He was not able to recall an address given to him after a minute. He was not able to tell me the accurate year, current prime minister nor was he able to tell me what my role at the hospital was accurately.*
>
> *He scored 6/10 in total which indicates some level of cognitive impairment, most in keeping with mild severity. He was alert during the interview. At that stage I was not*

[1] I note that an investigation of Mr Brooks' sensor alarm, which had not activated when he left the bed, was undertaken. Neither SEPH nor the manufacturer of the sensors were able to identify a fault with the mat.

aware that there was a plan for any surgery, so I did not ask any specific questions with regards to this or the capacity to consent for any surgery.

I suspect based on history that he had a significant dementia of unclear subtype which had been progressing likely for a prolonged period prior to admission to the hospital. Dementia would not necessarily preclude the ability to consent for surgery or other medical decision making. Capacity to consent to surgery may also change according to time of day or may vary from day to day.

I am unable to comment specifically and definitively as to whether he had capacity for consenting to this surgery. In my experience, most people with the level of cognition he showed at my assessment would be able to make a reasonable decision regarding the risks and benefits of surgery and therefore he would likely have been able to consent.'

9. On 27 December 2013, Mr Brooks complained of an increase in pain to both hips. Dr Shen arranged for a further CT scan which indicated a minimally displaced fracture involving the right greater trochanter. Accordingly, a referral was made to orthopaedic surgeon, Mr Patrick Byrne, who reviewed Mr Brooks the same day. Due to Mr Brooks' age, Mr Byrne initially considered conservative treatment most appropriate.

10. Subsequently, Mr Brooks underwent a Magnetic Resonance Imaging (MRI) scan on 30 December 2013 which confirmed a greater trochanter fracture to the right hip and a further fracture to the left ileum and left sacroiliac joint of the hip bone.

11. In light of that situation, at 7.00am on 31 December 2013, Mr Patrick Byrne explained to Mr Brooks the results of the MRI; in layman's terms that he had a fractured neck of femur. Mr Byrne discussed with Mr Brooks that it was the fracture that was causing him extensive pain and discomfort. Mr Byrne's advice was that Mr Brooks should undergo surgical repair including open reduction and internal fixation. The operation was discussed with Mr Brooks and he was advised that if he attempted to weight bear without surgery, he would have persistent pain and there was also a chance the fracture could displace. Mr Brooks agreed to surgery proceeding at this time and Mr Byrne stated that:

> *'He was orientated at the time [...] I had no reason to find him confused or unable to comprehend what I was saying. Again he was given the opportunity of not proceeding with the operation if he did not desire.'*

12. In the afternoon on 31 December 2013, Mr Brooks was taken to surgery. Pre-operative assessment was conducted by Nurse Rena Arratoon. The 'Pre-operative Checklist' and 'Surgical Safety Checklist' were filled out in full, with the exception of the consent sections which were not ticked. However, the relevant sections were boxed to indicate that consent remained to be obtained by Mr Byrne.

13. On his arrival in the waiting area of the operating suite, Mr Byrne again spoke with Mr Brooks and obtained written consent from him on the 'Consent for Medical Procedure Form.' Mr Byrne stated:

> *'I discussed the operation again with him in the operating reception area. This was in the afternoon of 31 December 2013. He again expressed his desire to proceed with the operation because of the pain in his hip. The consent form was signed.'*

14. Nurse Arratoon stated:

> *'Before Mr Brooks was taken into the operating room Mr Byrne spoke with him about the operation. At this time both Mr Brooks and Mr Byrne signed the consent form.'*

15. The operation proceeded at approximately 2.15pm with internal fixation of the fractured right neck of femur under spinal anaesthetic. Mr Brooks returned to the ward at approximately 4.00pm.

16. On the afternoon of 31 December 2013, Mr Stephen Brooks became aware of the procedure. On the way out of hospital he notified staff that he was unhappy that he had not been consulted prior to this occurring.

17. Later that evening, Nurse in Charge Georgia Banks had communications with Mr Stephen Brooks to seek to resolve his concerns. A number of issues were canvassed, including that Mr Stephen Brooks was his father's Power of Attorney and should have been consulted prior to the surgery. It was agreed that Mr Stephen Brooks would attend the following day to formalise legal arrangements.

18. Unfortunately, on 1 January 2014 at 11.35am, before Mr Stephen Brooks attended as planned, Mr Brooks was found unresponsive by staff on the ward. A Code Blue was called, cardiopulmonary resuscitation was performed and Mr Brooks was revived.

19. Over the following days, Mr Brooks' condition improved slightly and there was discussion with the medical staff and the family in regard to the level of medical management.

However, his condition subsequently deteriorated and he passed away on 8 January 2014 at 4.10am.

COURSE OF THE CORONIAL INVESTIGATION

20. The medical officer completing Mr Brooks' death certificate did not believe his death was unexpected, given his age, condition and comorbidities. A death certificate was therefore signed, documenting pneumonia as the cause of death and Mr Brooks' death was not reported to the Coroner at this time. I propose to revisit this issue by way of comment later in the finding.

21. On 8 May 2014, a notification of Mr Brooks' death was received from Mr Stephen Brooks. After undertaking preliminary investigations, I considered that the death was reportable pursuant to section 4 of the Coroners Act 2008, given the proximity of the fall, and I commenced a coronial investigation.

22. In this investigation I have focussed upon four issues:

- Consent to surgery – Power of Attorney (Medical);
- Resuscitation on 1 January 2014 (Not For Resuscitation);
- The internal review (the Waxman Review); and
- The medical management of Reginald Brooks by Dr Jun Shen.

23. In an endeavour to progress the matter, on 26 February 2015 I held a Mention/ Directions hearing to seek to determine the future course of the matter and to define the scope and parameters of my investigation. At that hearing, Mr Stephen Brooks confirmed his concerns claiming that, having regard to his father's declining cognitive state, he, Mr Reginald Brooks, was not able to give an informed consent to surgery. He maintained that consent for surgery should have been referred to him as holder of his father's Enduring Power of Attorney (Medical). Mr Stephen Brooks also was critical of the decision to resuscitate his father after the 'Code Blue' was called late in the morning on 18 January, particularly as he claimed the issue of Not for Resuscitation (NFR) had been discussed with Ms Georgia Banks on the previous evening.

24. Those two issues became the principal foci of my future investigation and the subsequent inquest held on 27-29 October 2015.

25. Ultimately the matter proceeded to inquest. At the formal hearing I heard *viva voce* evidence from the following witnesses:

- Mr Stephen Brooks;
- Dr Jun Shen;
- Dr Mutlu Haksov;
- Mr Patrick Byrne;
- Ms Georgia Banks; and
- Ms Catherine Dans.

Mr Stephen Brooks exercised his prerogative to appear legally unrepresented. Mr J Constable of counsel was granted leave to represent SEPH, Mr J Goetz of counsel was granted leave to represent Dr Shen and Mr S Cash of counsel was granted leave to represent Mr Byrne.

26. In evidence, Mr Stephen Brooks confirmed his earlier complaints about aspects of the medical management of his father.

27. It is not contentious that Mr Stephen Brooks had held his father's Enduring Power of Attorney (Medical) for some years.

CAUSE OF DEATH

28. I am satisfied, and do not think it was contended otherwise, that the fracture sustained in the fall and the subsequent fracture of several ribs occasioned during resuscitation measures on the morning of 1 January 2013 were contributing causal factors in the subsequent development of pneumonia in respect of which Mr Reginald Brooks succumbed in the early hours of 8 January 2013.

CONSENT TO SURGERY

29. Mr Stephen Brooks claimed his father had no moments of clarity as his cognitive decline was such that he could not give an informed consent to the surgical procedure. Before turning to where the weight of evidence lies, I think it important to consider the broad issue of when an Enduring Power of Attorney (Medical) takes effect.

30. An Office of the Public Advocate publication provides valuable information in relation to the issue of informed consent. I include a pertinent excerpt from that publication under the heading of *"When is a Person Incapable of Making Their Own Decisions?"*, it reads:

> *'A person lacks capacity to give consent to medical/ dental treatment if:*
>
> - *They are incapable of understanding the general nature and effect of the proposed procedure or treatment; or*
> - *They are incapable of indicating whether or not they consent to the carrying out of the proposed procedure or treatment.'*

This issue goes to the very heart of the principal focus of my investigation as an Enduring Power of Attorney (Medical) only takes effect when the giver of the power of attorney becomes incompetent to make such decisions due to incapacity.

31. The issue is not without difficulty, primarily because the question then arises as to who determines whether a patient has the capacity to give informed consent. In relation to a surgical procedure, the entity making that sometimes onerous determination is the surgeon. The determination is, I suggest, onerous because, as seen here, the person making the determination may be called upon to justify his/ her position.

32. Unless I form the view that Mr Reginald Brooks was incapable of giving informed consent, the fact that Mr Stephen Brooks held an Enduring Power of Attorney (Medical) and was not consulted is, strictly speaking, somewhat irrelevant. That is not to say it would not have been prudent, if his father agreed, to engage Mr Stephen Brooks in dialogue, or suggest to Mr Reginald Brooks that he discuss the prospect of surgery with his son.

33. As ultimately it was a matter for Mr Byrne, the surgeon who was to perform the repair procedure, to satisfy himself his patient was able to provide an informed consent, I turn to his evidence. His statement to the Court was a copy of a five page letter sent to the Australian Health Practitioner Regulation Agency (AHPRA), presumably addressing a complaint made to that organisation by Stephen Brooks. Mr Byrne also gave *viva voce* evidence at the inquest hearing. Mr Byrne consistently maintained that he was entirely satisfied that Mr Brooks understood the alternatives, understood in broad terms what the procedure entailed and communicated that he wished the surgery to proceed. Mr Byrne spoke with Mr Brooks on several occasions, 27 December 2013, 30 December 2013, 7.00am on 31 December 2013 and finally in the early afternoon of 31 December 2013 in the

operating suite where the formal consent was signed. In short, in evidence, Mr Byrne re-affirmed his contention that Mr Brooks was capable of and gave a formal informed consent.

34. In relation to the issue, I have to consider where the weight of evidence lies. It is clear Mr Brooks suffered a level of cognitive decline in the previous two years, not particularly surprising in view of his age. An examination of the progress notes demonstrated that Mr Brooks' cognition fluctuated day to day, even within a day. At times, Mr Brooks was variously described as 'confused', 'alert', 'disorientated' and 'orientated.' In evidence, Mr Stephen Brooks maintained that in the days after the admission he did not observe 'any moment of clarity', maintaining that his father did not have the capacity to give informed consent.

35. Mr Byrnes' claim that his patient had the capacity to provide an informed consent for surgery to proceed was supported by the evidence of several witnesses; Nurse Arratoon, Nurse Banks and Dr Haksoz. I accept that Dr Haksoz, geriatrician, made no specific assessment of Mr Reginald Brooks' capacity to give an informed consent to surgery. He did however, for other purposes, undertake an assessment of Mr Brooks, including addressing cognition. Dr Haksoz maintained that, although a patient's cognitive state may fluctuate, that would not preclude being able to provide an informed consent at a particular time. I believe the most important aspect of Dr Haksoz's evidence was in response to a question from Mr Cash. Dr Haksoz agreed that a person with the level of cognition that he observed when he assessed Mr Brooks would be capable of making[2] a reasonable decision regarding the risks and benefits of surgery and would therefore be capable of providing an informed consent to surgery.

36. It is important to carefully examine the evidence relevant to the very time the consent was given. In that regard, the evidence of Nurse Arratoon, who undertook a pre-operative checklist in the theatre suite just prior to surgery proceeding, is significant. Ms Arratoon stated Mr Reginald Brooks was able to provide correct answers to a series of questions and 'did not appear to be confused.' Shortly after that, Mr Byrne conferred with Mr Brooks and obtained the formal consent to proceed.

37. I have also taken into account the fact that the anaesthetist who spoke with Mr Brooks, and who completed the anaesthetic report, made no reference to any concerns about the patient's cognitive state.

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[2] Transcript p. 137.

38. Ms Banks, a Division 1 Registered Nurse, now Director of Clinical Services at TVPH, engaged with Mr Reginald Brooks on a number of occasions and, as such, had the opportunity to gauge his cognitive state at various times. As a senior nurse, Ms Banks had considerable experience of patients with cognitive decline and was, in my view, in a position to make a valid judgement as to issues surrounding capacity. Ms Banks opined Mr Brooks had capacity to consent.

39. In her comprehensive statement, Ms Banks provided from nursing records a helpful broad overview of the observations of nursing staff during Mr Brooks' stay at SEPH from 20-31 December 2013. In broad terms, the overview confirms Mr Brooks' cognitive state fluctuated, importantly demonstrating periods of[3] relative lucidity.

40. Significantly, the nursing records, penned by two separate nurses, noted that on the evening of 30 December 2013 and the morning of 31 December 2013, Mr Brooks was alert and orientated.

41. When examined by Ms Hibbins, assisting, about the various assessments made by Mr Byrne, Dr Haksoz, Nurse Banks and Nurse Arratoon, Mr Stephen Brooks conceded, as he had to, that as he was not there at the relevant time he could not dispute their conclusions as experienced practitioners in their respective fields.

42. Having considered the totality of the evidence, I conclude the weight of evidence, by a considerable margin, supports the conclusion that Mr Reginald Brooks, although confused at times, at the relevant time had the capacity to consent to surgery; his documented consent was in my view, an informed consent.

43. Towards the conclusion of the Mention/ Directions hearing, I put a hypothetical question to Mr Stephen Brooks. I asked him, if Mr Byrne had been concerned that Mr Reginald Brooks did not have the capacity to give informed consent to the proposed surgery, would he, Stephen Brooks, as the holder of the Medical Power of Attorney, have given consent to proceed to surgery? Stephen Brooks responded 'yes, absolutely.' Interestingly, the very next day by way of an email to the Court, apparently realising the significance of that response, Mr Brooks sought to retreat from his previous position. The issue was again raised at the formal inquest hearing, at which time Mr Brooks claimed that he would have had to have undertaken some research to satisfy himself Mr Byrne was a competent orthopaedic surgeon

[3] Exhibit J (para 11).

before he would have consented, on behalf of his father, to surgery proceeding. I found that contention somewhat less than persuasive. I firmly believe he would have consented and believe surgery would have proceeded in either event.

44. In short I conclude that, although as demonstrated here it may be prudent to do so, the mere fact a Power of Attorney (Medical) is in existence does not necessarily mean there is a legal obligation on a surgeon to consult the attorney if he/she is satisfied the patient has the capacity to give informed consent.

NOT FOR RESUSCITATION

45. I turn to the issues surrounding NFR. At approximately 11.30am on New Year's Day, 1 January 2013, a Code Blue alert was sounded as Mr Reginald Brooks had suffered cardiopulmonary collapse. Ms Banks attended Mr Brooks' room and, as the senior nurse in attendance, commenced cardiopulmonary resuscitation. Having revived Mr Brooks, Ms Banks phoned Dr Shen who, when advised of the circumstances, directed active treatment and the summoning of an ambulance to transfer Mr Brooks to TVPH.

46. Subsequently, Ms Banks phoned Mr Stephen Brooks to advise him of the collapse and subsequent resuscitation. Mr Stephen Brooks asked that his father be transferred to a large public hospital. He also directed that if a further collapse occurred, his father was not to be resuscitated.

47. Rather than endeavouring to encapsulate what transpired after the telephone discussion between Mr Stephen Brooks and Ms Banks, I include in the finding two relevant excerpts from Ms Banks' statement:

> *'31. Mr Brooks remained stable and comfortable with analgesia. It was suspected he may have fractured ribs due to the resuscitation. The ambulance arrived and the ambulance officers spoke with Mr Stephen Brooks by telephone and recommended that the family allow Mr Brooks to stay at the SEPH for comfort measures and ongoing care and in view of the fact that Mr Stephen Brooks had requested that Mr Brooks not be resuscitated. Mr Stephen Brooks agreed to this course of action.*
>
> *32. Dr Shen was informed that the family wished the patient to remain on the ward and to be kept comfortable. There was then a long discussion with the family, regarding future management. The family requested to speak to Dr Shen regarding a*

NFR order from Dr Shen and documented it in the patient's Major Clinical Alerts form at 1500 hours. Dr Shen subsequently came in for a family meeting.'

48. Consequently, it was early afternoon on 1 January, after cardiopulmonary resuscitation was undertaken, that a formal NFR order from Dr Shen was in place.

49. Mr Stephen Brooks, from the outset, was highly critical of the decision taken to perform cardiopulmonary resuscitation on his father. In evidence, Mr Stephen Brooks said he had at some time previously discussed the issue of NFR with his father, who indicated that in the event of a cardiopulmonary collapse he did not wish to be resuscitated. In answer to a question from Ms Hibbins, Mr Brooks conceded that the 'agreement between father and son' was not formally documented. There was NO formal NFR order in place at SEPH at the time of the resuscitation.

50. Whether there was a discussion regarding NFR in the phone call between Mr Stephen Brooks and Ms Banks on the evening of 31 December 2013 is contentious. In fact, there is contention as to whether there was/were one or two telephonic communications between Ms Banks and Mr Stephen Brooks that evening. Mr Stephen Brooks maintains that he raised the issue of NFR with Ms Banks advising that, in the event of a collapse, his father was not to be resuscitated and that direction was to be formalised the following day when he proposed to go to the hospital to provide a copy (or the original) Enduring Power of Attorney (Medical). Mr Brooks maintains this occurred during a single phone call between the two that evening at around 5:30pm. He was adamant there was only the one telephone call.

51. Ms Banks, on the other hand, maintains there were two telephone calls between her and Mr Stephen Brooks that evening; she too is adamant. Ms Banks stated as she had to make some enquiries to address issues raised by Stephen Brooks in the first phone call, she subsequently rang back. Mr Stephen Brooks conceded in evidence, in discussion with Ms Banks, that he was very upset and emotional.

52. Mr Stephen Brooks maintains the issues of both Enduring Power of Attorney (Medical) and NFR were discussed, claiming that he advised Ms Banks that his father was NFR. Ms Banks, on the other hand, is adamant that NFR was not canvassed at all, the discussion solely related to issues surrounding the Power of Attorney. Counsel for SEPH asked Mr Brooks if he was suggesting Ms Banks had fabricated the claim of a second call. Mr Brooks responded, no he was not suggesting that, but maintained Ms Banks was 'mistaken.' Ms Banks stated she noted the second call in the Progress Note at 9.30pm as an update. Had Ms

Banks been advised Mr Brooks was NFR, I believe she may have been somewhat conflicted as to what action she should take when she attended the Code Blue.

53. Unfortunately, the cardiopulmonary resuscitation of Mr Reginald Brooks resulted in a number of fractured ribs. In evidence, in response to a question put by Mr Stephen Brooks as to why she stated she was sorry she had to resuscitate his father, Ms Banks replied:

> *'I was faced with a man visually presented before me on that morning who was 99 and three quarters; who was frail; who was post-operative and who was now collapsed and as an experienced nurse who has performed CPR before I knew what – what the complications of that CPR probably would be and in fact were and I was distressed by having to perform CPR on a frail, elderly gentleman with a risk of fractured ribs.'*

Ms Banks accepted that it would have been preferable if an NFR order had been in place; as she stated she, as an experienced nurse, was acutely aware of the prospect of fractured ribs and what often flows from that in the elderly.

54. From my point of view, it is not critical whether there was/were one or two phone conversations that evening. The more important issue is what was discussed in the calls. The question of whether NFR was discussed that evening, while significant, is not determinative or conclusive; the fact is no formal NFR order was in effect when Mr Brooks was resuscitated.

55. On balance, I conclude it is Mr Stephen Brooks, very upset, angry and emotional at the time, who is mistaken; I believe there was a second call.

56. It is incontrovertible in my view that in the circumstances that prevailed at about 11.30am on 1 January 2013 upon the Code Blue, Ms Banks was obliged to attempt to resuscitate Mr Reginald Brooks. Not to do so, in the absence of a formal NFR order, would not have been appropriate; as Ms Banks said 'full resuscitation measures are to be undertaken in those circumstances.'

57. Ultimately, it is primarily a matter for the patient, or if that person is incapable, the holder of the Medical Power of Attorney, to decide if resuscitation is to be undertaken in the event of a cardiopulmonary arrest. The fact that there was a lack of communication, as conceded on behalf of the hospital, does not alter that fact. Having said that, if appropriate communication with family had occurred, I believe that although surgery would have proceeded, an NFR order may have been addressed and formalised. That, however, would

have been a matter for Mr Reginald Brooks, who in all likelihood would have discussed the issue with his family. I do not accept Mr Stephen Brooks can successfully seek to deflect to others the ultimate responsibility to formalise an NFR.

58. Interestingly, in his final submission, Mr Stephen Brooks indicated his 'major argument' was the lack of communication between doctors, hospital staff and family. I suggest Mr Brooks' focus shifted somewhat from his initial complaint that he, as Medical Power of Attorney, not his father, should have determined whether the surgical procedure to repair the fractured neck of femur should have proceeded and whether resuscitation should have occurred. I suspect as the evidence unfolded he gleaned that the weight of evidence supported Mr Byrnes' conclusion that Mr Reginald Brooks was capable of giving informed consent and that after his fathers' collapse on the morning of 1 January 2013, Ms Banks was obliged to resuscitate Mr Reginald Brooks as no formal NFR was in place.

59. Mr Stephen Brooks placed great reliance on the fact that Healthe Care revised important documents in relation to both NFR and Medical Powers of Attorney. However, in this case, the Medical Power of Attorney refinements, if in place at the time, would not have been determinative, because I have found that a Medical Power of Attorney would not have been activated as Mr Reginald Brooks had the capacity to give an informed consent to surgery.

60. In relation to an NFR order, one was not formalised and, furthermore, I have found Mr Stephen Brooks did not convey that his father was NFR.

THE WAXMAN REVIEW/ REVISED PRACTICES AND PROCEDURES

61. The third important focus of my investigation and inquest relates to recommendations that came from the comprehensive internal root cause analysis review undertaken under the chairmanship of Associate Professor Bruce Waxman, Director of Medical Services, SEPH/TVPH.

62. The review resulted in a number of additions/ amendments/ refinements to the relevant hospital policies and procedures being made to address deficiencies identified in the Waxman Review. One of the major deficiencies identified related to communication, or more significantly, lack of communication with the family of Mr Reginald Brooks. This was a major issue of Mr Stephen Brooks. He, as the holder of the Medical Power of Attorney, was not advised of the proposed surgical intervention and was not even aware it had occurred until after the event. I have formally found that the decision to proceed to surgery

was a matter for the patient, Mr Reginald Brooks. However, in light of his age, frailty, cognitive decline and fluctuating confusion, discussion with family about the course of medical management after the fractured neck of femur was confirmed would have been prudent; some might say imperative. One can understand Mr Stephen Brooks' frustration at not being at least consulted.

63. I do not propose in this finding to go into fine detail about the revised/ refined practices, procedures and protocols. The relevant documents were tendered in evidence through Ms Banks as exhibits 'K', 'L', and 'M' and form part of the formal record of this proceeding. I propose, however, in somewhat broad terms, to refer to several of the revised policies and procedures, especially those relating to Enduring Power of Attorney (Medical) and NFR orders.

64. There is now in place a revised Clinical Assessment Form prepared at the time of admission which contains, *inter alia*, a specific provision relating to existence of Medical Power of Attorney (see attachment GB3 to Ms Banks' statement). The Patient File Front Sheet has also been revised, dealing with the issue of awareness of powers of attorney and guardianship orders in place (see attachment GB4 of Ms Banks' statement). Significantly, the Major Clinical Alerts policy and the Major Clinical Alerts card have been revised, copies of the revised documents were tendered (see attachments GB5 and GB6 of Ms Banks' statement). The revised documentation, GB4, 5 and 6 constitutes exhibit 'K.'

65. Probably the most important revised document is the Major Patients Alerts Card, wherein the issue of Medical Power of Attorney is highlighted in red. That document is contained 'front and centre', to adopt Ms Banks' terminology, in the bedside folder literally at the bedside to ensure practitioners are immediately alerted to the existence of a Medical Power of Attorney and to turn their minds to whether the attorney should be consulted.

66. It is clear there were shortcomings in communication, such is conceded. I am satisfied the changes made following the Waxman Review, if in place at the time would, in all likelihood, have resulted in consultation with Mr Stephen Brooks at the relevant time as to the future course of management.

67. Ms Banks gave evidence concerning ongoing training and 'extensive education' of staff, both in-house and through State Trustees and the Office of the Public Advocate, surrounding the issue of powers of attorney and guardianship orders, together with hospital wide orientation. This is an important refinement.

68. I am satisfied the refinements represent, in effect, best practice. Having formed that view, I do not see the need for specific recommendations to address the consultation deficiencies demonstrated in this coronial investigation and inquest. I accept Ms Banks' contention that:

> *'... the amendments made should prevent incidents such as occurred during Mr Brooks' admission.'*

DR JUN SHEN'S MEDICAL MANAGEMENT OF REGINALD BROOKS

69. Dr Shen was the primary physician under whom Mr Reginald Brooks was admitted to SEPH. He first spoke with Mr Brooks on the morning after he was admitted. Dr Shen maintained that the issue of NFR was not raised with him by the family (or anyone else for that matter) until after the arrest and resuscitation. Mr Stephen Brooks was critical of Dr Shen for not proactively broaching the issue of NFR with the family. When his counsel Mr Goetz asked Dr Shen whose responsibility he believed it was to raise the issue of NFR, Dr Shen replied that it was a 'shared responsibility' between family and the relevant medical practitioner. I found that interesting because the patient him/ herself was not included in the equation. I would have thought that in most circumstances the patient would be the primary person to whom the issue should be addressed. However, in my not inconsiderable experience, NFR is an issue that some medicos are somewhat reluctant to broach; the topic is often 'danced around' (to use the vernacular) as too difficult/ sensitive to raise. In my view, it is a topic that should generally be faced head on because, as in this case, if not addressed it can subsequently be problematic. I note that in evidence Mr Stephen Brooks stated he did not raise the issue of NFR with Dr Shen because he did not anticipate that NFR would be relevant. He argued that was a reasonable position bearing in mind he was not, at that time, aware surgery was to occur. This is another manifestation of the failure to adequately communicate. I add communication is a two way process; with a 99 year old patient in hospital, known to have suffered a fall, it could be argued that it may have been prudent for the family to proactively raise the issue.

70. The other criticism levelled against Dr Shen was that he did not adequately brief Mr Byrne prior to surgery. In respect of that claim, the fact is, no matter what information was or was not conveyed to Mr Byrne, the decision as to consent to surgery was a matter for Mr Reginald Brooks himself and Mr Byrne's assessment of the capacity of his patient.

71. Dr Shen's medical management of Mr Reginald Brooks after the collapse and resuscitation has been called into question. Mr Brooks' condition fluctuated so that the level of treatment varied to accommodate that fluctuation.

72. Initially, after a lengthy consultation on the afternoon of 1 January 2014, the family's position was to provide comfort care only, without further active treatment. Subsequently, on the morning of 3 January 2014, Mr Brooks' condition to some extent improved. Again, in consultation with the family, 'ward medical management', including antibiotic therapy, was instituted; Mr Brooks remained relatively stable.

73. On 7 January 2014, at the behest of the family, geriatrician Dr Irene Wagner reviewed Mr Brooks and recommended a return to palliative care, with a cessation of intravenous fluids and antibiotics.

74. In the progress notes, Dr Wagner wrote that Mr Brooks' death was likely to occur in the 'not too distant future' and the 'time has come to palliate Mr Brooks.' A further meeting with Mr Warwick Brooks (brother of Stephen Brooks) was held late in the afternoon of 7 January 2014 to discuss Dr Wagner's recommendations. At that meeting, Mr Warwick Brooks indicated intravenous fluid/ antibiotic therapy be continued for a further 48 hours with a view to a further assessment thereafter. That decision was conveyed to Dr Wagner who, having conferred with Dr Shen, agreed to that medical management. In evidence, Mr Stephen Brooks claimed that his brother relayed to him a different version of those events. He did, however, concede he could not challenge Dr Shen's claim that after his discussion with her, Dr Wagner agreed to proceed with partial treatment.

75. I have concluded Mr Stephen Brooks' criticism of Dr Shen in relation to his management of Mr Reginald Brooks is not warranted. Dr Shen was obviously getting mixed messages. I accept Dr Shen was doing what he professionally thought was in the best interests of his patient. An adverse finding against Dr Shen is not warranted.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. By way of comment, I refer to the issue of a Death Certificate. Mr Brooks' treating physician, Dr Shen, issued a Death Certificate on 8 January 2013, certifying the cause of death to be:

   I (a) PNEUMONIA.

   There was NO reference on the Death Certificate to the fall on 20 December 2013, which resulted in injuries, including a fractured right neck of femur; nor was there reference to the rib fractures occasioned during resuscitation. Dr Shen obviously believed the death was not 'reportable' within the meaning of the Coroners Act 2008. Having regard to the matters referred to in paragraph 27 of this finding, I believe the death should have been reported to the Coroner. It was not, in my view, appropriate for Dr Shen to issue a Death Certificate.

2. I make the following observation in the broader context of this matter. It should not be overlooked that patients, even elderly patients, are entitled to make their own decisions in relation to medical treatment; assuming they have the capacity to do so, this entitlement should be respected. In these circumstances, I suggest, doctors and others involved in the medical/ clinical management of a patient are obliged to respect the privacy of their patient and are bound by the notion of confidentiality. Ms Dan, the DVA Liaison, Discharge, Planner, confirmed this situation by stating:

   'Many patients of the DVA era actually like to keep their own control...'

3. In his submission, Mr Stephen Brooks urged me to adopt as a recommendation a suggestion he formulated. He suggested:

   > *'Healthy Care (sic) implement multi-disciplinary care meetings to facilitate the flow of information and by that to enhance the implementation of policies and procedures already developed. Such meetings would enable members of the health care team to collaborate and make treatment recommendations that facilitate co-ordinated quality patient care and promote communication in consultation with family.'*

   I see merit in the suggestion, although, with respect, it is not entirely novel. Furthermore, I do not think this matter is the appropriate vehicle to warrant adoption of Mr Brooks' suggestion as a formal recommendation. If indeed Healthe Care do not have in place such a practice they would do well to introduce one, but much would depend on the circumstances surrounding the particular patient. In light of that caveat, I do not adopt it as a formal recommendation, but include Mr Brooks' suggestion as a useful comment.

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

Mr Stephen Brooks;

Ms Trudy Ararat;

Dr Jun Shen;

Mr Patrick Byrne; and

Dr Mutlu Haksoz.

Signature:

PHILLIP BYRNE
CORONER
Date: 15 March 2016