IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 2313

FINDING INTO DEATH WITH INQUEST

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

Findings of:	Simon McGregor, Coroner
Deceased:	**Vanna Vassallo**
Date of birth:	22 May 1948
Date of death:	16 May 2017
Cause of death:	Complications of a right subdural haemorrhage (palliated), sustained in a fall
Place of death:	The Royal Melbourne Hospital, 300 Grattan Street, Parkville Victoria 3050

HIS HONOUR:

INTRODUCTION

1. Vanna Vassallo was a patient at the Broadmeadows Aged Mental Health Inpatient Unit (BAMHIU), NorthWestern Aged Persons Mental Health Program.

2. Prior to her admission to BAMHIU, Ms Vassallo had been living at the supported accommodation, Glenville Lodge located at 36 Lytton Street, Glenroy Victoria 3046.

3. Ms Vassallo died on 16 May 2017 at The Royal Melbourne Hospital, 300 Grattan Street, Parkville Victoria 3050 from complications of a right subdural haemorrhage (palliated), sustained in a fall

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Ms Vassallo's death was reported to the Coroner as it appeared unexpected, unnatural or to have resulted, directly or indirectly, from an accident and so fell within the definition of a reportable death in the *Coroners Act 2008.*

5. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[1] 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 the death occurred.[2]

6. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[4] or to determine disciplinary matters.

7. The expression 'cause of death' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

8. For coronial purposes, the phrase 'circumstances in which death occurred,'[5] 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

[1] Section 89(4) *Coroners Act 2008*
[2] See Preamble and s 67, *Coroners Act 2008*
[3] *Keown v Khan* (1999) 1 VR 69
[4] Section 69 (1)
[5] Section 67(1)(c)

death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

9. 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.

10. Coroners are also empowered:

    a. to report to the Attorney-General on a death;[6]

    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;[7] 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.[8] These powers are the vehicles by which the prevention role may be advanced.

11. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[9] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[10] 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 level of confidence that the person caused or contributed to the death.

12. 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.

[6]Section 72(1)
[7]Section 67(3)
[8]Section 72(2)
[9]*Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152
[10](1938) 60 CLR 336

BACKGROUND

13. Ms Vassallo had a history of schizophrenia that required previous hospitalisations.[11] Her first episode of mental illness is said to have occurred when she was approximately 16-years-old.

14. Reoccurring themes of Ms Vassallo's mental illness included snakes and religion. She is said to have suffered relapses every three to four years. When well, Ms Vassallo has been described as having been a caring and attentive person.[12]

15. Ms Vassallo had several other comorbidities, including type 2 diabetes mellitus, epilepsy, ischaemic heart disease, aortic valve replacement, septal myectomy, mild cognitive impairment, chronic constipation, recent infusion for anaemia, subacute haematoma and hyponatraemia.[13]

16. When unwell, her symptoms included becoming disorganised in behaviour, spending prolonged periods in bed, requiring assistance for daily activities and experiencing hallucinations and delusions. Ms Vassallo's brother, Peter Vassallo told BAMHIU geriatric medicine registrar, Dr Jesse Zanker, that his sister had a history of falls during past relapses of mental illness. During a psychiatric admission in 2003, Ms Vassallo sustained a broken bone.[14]

17. Between 15 March 2017 and 21 March 2017, Mr Vassallo was hospitalised at The Royal Melbourne Hospital with iron deficiency anaemia, lower limb haematoma, postural hypotension, hyponatraemia and subacute subdural haematoma due to falls. On this occasion, Ms Vassallo was reviewed by the neurosurgical team, who determined that surgery was not required.[15]

18. The neurosurgical team suggested a repeat of the CT scan a fortnight from her discharge and to withhold aspirin. At the time of discharge, Ms Vassallo was prescribed antipsychotic medication, including fluphenazine decanoate, risperidone and quetiapine. Ms Vassallo was also taking valproate because of a history of epilepsy and clonazepam.[16]

19. Upon discharge, it was felt that Ms Vassallo was experiencing an exacerbation of her schizophrenia. She was subsequently, discharged back to Glenville Lodge and a referral was made to the Aged Psychiatry Assessment and Treatment Team (APATT) for assessment and

[11] Statement of Angelo Ferraro dated 25 October 2017, Coronial Brief.
[12] BAMHIU Clinical Review note dated 3 May 2017, p160 of Medical Records, Coronial Brief.
[13] Statement of Vanessa Sharples dated 3 November 2017, Coronial Brief.
[14] Statement of Angelo Ferraro dated 25 October 2017, Coronial Brief.
[15] Ibid.
[16] Ibid.

management of her mental illness. At the time, she was taking clonazepam 0.5 milligrams daily, fluphenazine decanoate 25 milligrams fortnightly, quetiapine 100 milligrams nightly, risperidone 2 milligrams nightly and valproate 700 milligrams twice a day. Neurosurgeon, Dr John Laidlow, recommended that urgent medical attention be sought in the event that Ms Vassallo developed nausea, vomiting, new neurological signs or an alteration in conscious state.[17]

20. Ms Vassallo was seen on several occasions by the APATT staff over the preceding month. No changes to her medications were made.[18]

21. On 28 April 2017, it was determined that Ms Vassallo was not improving, so she was admitted to the BAMHIU with an exacerbation of chronic schizophrenia. Consultant psychiatrist, Dr Angelo Ferraro, assessed Ms Vassallo as experiencing hallucinations and delusions. As she had been treated with three different antipsychotics since her time at The Royal Melbourne Hospital without any clinical improvement, it was decided to cease fluphenazine decanoate and adjust the doses of risperidone and quetiapine to treat her psychotic symptoms.[19] Admission records dated 28 April 2017, list Ms Vassallo as being 'high falls risk'.[20]

22. Dr Ferraro details that out of these three medications, fluphenazine decanoate would be the most likely to contribute to falls.[21]

23. A NorthWestern Mental Health, Integrated Care Pathway form details that an engagement record and patient safety plan was completed, as well as consideration to risk, trauma history and gender of Ms Vassallo before bedroom allocation was made. The client manual handling risk assessment was also completed on this day.[22]

24. On 30 April 2017 at approximately 3.00pm, Ms Vassallo sustained a fall and struck her head. She was found in the dining area, sitting on the floor.[23] Ms Vassallo reported that she had felt dizzy and slipped on the floor.[24]

25. Ms Vassallo was reviewed by Dr Zanker. A full examination revealed normal blood pressure, no nausea or vomiting, no changes in her conscious state and no focal neurological signs.

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[17] Ibid.
[18] Ibid.
[19] Ibid.
[20] BAMHIU Admission Record 0656696, pp 150-152 of Medical Records, Coronial Brief.
[21] Statement of Angelo Ferraro dated 25 October 2017, Coronial Brief.
[22] NorthWestern Mental Health, Integrated Care Pathway NWMH254 dated 28 April 2017, pp 164-172, Coronial Brief.
[23] Statement of Vanessa Sharples dated 3 November 2017, Coronial Brief.
[24] Statement of Angelo Ferraro dated 25 October 2017, Coronial Brief.

During the period of her admission at BAMHIU, the facility did not have a CT scanner on site. The decision was made to transfer Ms Vassallo to the emergency department of The Royal Melbourne Hospital to undergo a CT scan.[25]

26. The scan showed no abnormality, including any evidence of the previously reported subdural haematoma. This indicated that it had resolved.[26] Ms Vassallo was returned to BAMHIU on 1 May 2017, with the direction to assess her for a decrease in the Glasgow Coma Scale and to notify the doctor immediately if she showed signs of vomiting.[27]

27. On the same day at approximately 8.00am, Ms Vassallo suffered another unwitnessed fall.[28] She reported that she tried to get out of bed and began to slide down the side. Ms Vassallo told staff that she struck her head on the left frontal side. Staff noted that the reported mechanism would have been unlikely.[29] She was again reviewed by Dr Zanker. Dr Zanker felt that Ms Vassallo had not sustained any injuries.[30] Ms Vassallo did not report any pain or dizziness. Direction was given to monitor Ms Vassallo for vomiting or a drop on the Glasgow Coma Scale and to immediately notify the doctor if either of these occurred.[31]

28. Medical notes from 1 May 2017, detail that Ms Vassallo was placed on half hourly neurological observations.[32] Medical notes from 2 May 2017 detail that Ms Vassallo was on 15-minute site observations.[33] Additional progress notes detail that Ms Vassallo was placed on routine observation.[34] On 9 May 2017, she was noted has having an 'okay' gait.[35]

29. On 9 May 2017 at approximately 2.00pm, Ms Vassallo was seen near the nursing office crawling on her hands and knees. When questioned, Ms Vassallo said that she had been making her bed when she saw snakes. She said she was crawling to the nursing office for assistance.[36] Ms Vassallo reported falling approximately ten centimetres from the floor. She also reported that a python had helped her up, before changing her story to a woman named Claudia. Ms Vassallo denied having any injuries.[37]

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[25] Ibid.
[26] Ibid.
[27] Statement of Vanessa Sharples dated 3 November 2017, Coronial Brief.
[28] Statement of Angelo Ferraro dated 25 October 2017, Coronial Brief.
[29] BAMHIU Clinical Review note dated 1 May 2017, p158 of Medical Records, Coronial Brief.
[30] Statement of Angelo Ferraro dated 25 October 2017, Coronial Brief.
[31] Statement of Vanessa Sharples dated 3 November 2017, Coronial Brief.
[32] BAMHIU Clinical Review note dated 1 May 2017, pp173-174 and of Medical Records, Coronial Brief.
[33] BAMHIU Clinical Review note dated 2 May 2017, p156 of Medical Records, Coronial Brief.
[34] BAMHIU Clinical Review note dated Various, Medical Records, Coronial Brief.
[35] BAMHIU Clinical Review note dated 9 May 2017, p157 of Medical Records, Coronial Brief.
[36] Ibid.
[37] Statement of Angelo Ferraro dated 25 October 2017, Coronial Brief.

30. She presented as psychotic, disorganised and confused,[38] also stating that she saw a killer python but could not kill it because she wasn't tall enough.[39] Dr Zanker concluded that Ms Vassallo probably hadn't suffered a fall and nil injury was recorded. The plan was to monitor Ms Vassallo's gait and mental state.[40]

31. On the same day, Ms Vassallo's antipsychotic medication, risperidone, was increased from 4 milligrams daily to 6 milligrams daily because of continuing psychotic symptoms. No changes and or problems were noted with her gait.[41]

32. During her admission, Ms Vassallo was *not* noted as experiencing nausea, vomiting or significant changes in her Glasgow Coma Scale up until the time of her last fall.[42]

33. From the time of her admission, Ms Vassallo was assessed as being at a high risk of falls. Nursing management strategies were in place to address the risk.[43]

34. Strategies were regularly reviewed and included routine sight observations, with two hourly rounding. In addition, BAMHIU follows the *Melbourne Health, Falls Minimisation Procedure*[44] and the *Precinct Preventing Falls and Harm from Falls Policy*[45] to screen and manage falls. These policies include the requirement to regularly review patient risk of falls using a falls risk assessment tool (FRAMP). Ms Vassallo's FRAMP was completed and up to date at the time of her last fall.[46]

35. Additional BAMHIU falls prevention strategies include daily discussions with multi-disciplinary teams about patients' mental and physical states, perceived falls risk, medications and blood pressure management. Referrals, physiotherapy and occupational therapy are also considered. Where considered appropriate, BAMHIU also use crash mats, low beds, rounding, assistance, various equipment, anti-slip socks, safety huddles and regular falls meetings.[47]

36. NorthWestern Mental Health state that all required equipment to manage falls are serviced, in good working order and available on the ward. NorthWestern Mental Health further note that,

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[38] Statement of Vanessa Sharples dated 3 November 2017, Coronial Brief.
[39] BAMHIU Clinical Review note dated 9 May 2017, p162 of Medical Records, Coronial Brief.
[40] Statement of Vanessa Sharples dated 3 November 2017, Coronial Brief.
[41] Statement of Angelo Ferraro dated 25 October 2017, Coronial Brief.
[42] Ibid.
[43] Ibid.
[44] iPolicy No. : MH02. 02. 03
[45] iPolicy No. : MH31
[46] Statement of Vanessa Sharples dated 3 November 2017, Coronial Brief.
[47] Ibid.

Ms Vassallo did not require everyday use of lifting equipment because she was ambulant. Ms Vassallo was immediately assessed post-falls in line with their relevant policy.[48]

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

37. On 16 May 2017, Peter Vassallo visually identified the body of his sister, Vanna Vassallo, born 22 May 1948.

38. 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

39. On 18 May 2017, Dr Gregory Young, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination of Ms Vassallo's body. Dr Young reviewed the Police Report of Death for the Coroner, E-Medical Deposition Form from The Royal Melbourne Hospital and a post mortem computed tomography (CT scan). Dr Young provided a written report dated 19 May 2017, in which he formulated the cause of death as '*I(a) Complications of a right subdural haemorrhage (palliated), sustained in a fall*'.

40. Toxicological analysis of post mortem samples was not performed as it was not indicated.

41. Dr Young commented that the postmortem CT scan confirmed the presence of a right subdural haemorrhage (haematoma) with associated mass effect on the brain. A subdural haemorrhage is where blood collects in the space surrounding the brain, usually from bleeding due to trauma (such as that sustained in a fall). This may lead to headache, confusion and eventual loss of consciousness and death when there is compression of essential centres in the brain. Decreased consciousness and mobility also predisposes to development of chest infections, deep vain thrombosis and pulmonary thromboembolism, which may also eventually lead to death.

42. Dr Young further commented the heart showed coronary artery calcification and an aortic valve replacement, and increased markings were seen in the lungs. No other *significant* pathology was identified.

43. I accept Dr Young's' opinion as to cause of death.

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[48] Ibid.

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

44. On 14 May 2017 at approximately 7.30pm, Ms Vassallo suffered an unwitnessed fall.

45. After staff heard a loud noise coming from the corridor, they immediately responded and found Ms Vassallo lying on the floor in an altered state of consciousness.[49] Blood was noted coming from Ms Vassallo's head and mouth. Ms Vassallo was disoriented and pale in appearance. A code blue was called.[50] Ambulance Victoria were called and Ms Vassallo was taken to the emergency department of The Royal Melbourne Hospital.[51] She arrived at approximately 8.10pm.[52]

46. It was reported that Ms Vassallo had sustained a massive intracranial bleed and would not survive. She was subsequently transferred to the palliative care ward.[53]

47. Ms Vassallo died on 16 May 2017.[54]

FINDINGS AND CONCLUSION

48. I am satisfied with the level of care afforded to Ms Vassallo both at BAMHIU and The Royal Melbourne Hospital.

49. I make note of Mr Vassallo's submissions at the summary inquest hearing. He suggested, amongst other things, that the use of closed-circuit television (CCTV) cameras be implemented in psychiatric wards to monitor patient movements. Mr Vassallo believes that going forward, implementation of CCTV will better facilitate falls prevention for high risk patients.

50. In my view, the constellation of devices and other management systems deployed by BAMHIU were sufficient in this case, but in support of developing a community wide culture seeking continuous improvement in relation to preventable deaths, I record his suggestion for the consideration by the facility at any appropriate future forum.

51. Having investigated the death of Vanna Vassallo and having held an Inquest in relation to her death on 16 May 2017, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

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[49] Statement of Angelo Ferraro dated 25 October 2017, Coronial Brief.
[50] Statement of Vanessa Sharples dated 3 November 2017, Coronial Brief.
[51] Statement of Angelo Ferraro dated 25 October 2017, Coronial Brief.
[52] Statement of Vanessa Sharples dated 3 November 2017, Coronial Brief.
[53] Ibid.
[54] Ibid.

a. The identity of the deceased was Vanna Vassallo, born 22 May 1948;

b. The death occurred on 16 May 2017 at The Royal Melbourne Hospital; 300 Grattan Street, Parkville Victoria 3050 from complications of a right subdural haemorrhage (palliated), sustained in a fall; and

c. The death occurred in the circumstances described above.

52. I convey my sincerest condolences to Ms Vassallo's family for their loss.

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

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

a. Mr Peter Vassallo, senior next of kin.

b. Mr Peter Kelly, Melbourne Health (NorthWestern Mental Health), interested party

c. Ms Kellie Gumm, Trauma Program Manager, The Royal Melbourne Hospital, interested party

d. Mrs Jan Moffatt, Grindal & Patrick on behalf of NorthWestern Mental Health Service and Staff, interested party

e. Dr Neil Coventry, Office of the Chief Psychiatrist, interested party

f. Constable Aaron Magnuson, Coroner's Investigator, Victoria Police.

Signature:

SIMON McGREGOR

CORONER

Date: 19 September 2019