IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 0980

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of Elizabeth Honor EWART

Delivered On:	29 OCTOBER 2019
Delivered At:	THE CORONERS COURT OF VICTORIA 65 KAVANAGH STREET, SOUTHBANK
Hearing Date:	1-2 OCTOBER 2019
Findings of:	CORONER PHILLIP BYRNE
Counsel Assisting the Coroner:	MR DARREN McGEE
Representation:	MS CHRIS RONALDS ON BEHALF OF MS HEATHER EWART
	MR MICHAEL HAZELL ON BEHALF OF MR ALISTAIR EWART
	MS FIONA ELLIS ON BEHALF OF HEALTHSCOPE OPERATIONS PTY LTD AND MR MARK COOK

I, PHILLIP BYRNE, Coroner, having investigated the death of Elizabeth Honor EWART
AND having held an inquest in relation to this death on 1 October 2019.
at The Coroners Court of Victoria
find that the identity of the deceased was Elizabeth Honor EWART
born on 1 June 1961
and the death occurred 27 February 2017
at The Melbourne Clinic, Church Street, Richmond

The Finding does not purport to all aspects of the evidence obtained in the course of the Investigation. The material relied upon included statements and documents tendered in evidence together with the Transcript of proceedings and submissions of legal representatives/Counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

from:

1(a) UNASCERTAINED

in the following circumstances:

BACKGROUND

1. Elizabeth Honor Ewart (who with the agreement of the family members was referred to at the inquest as Lizzie), was 55 years of age. Normally Lizzie resided at Murambie Downs Douglas Road Wahring, but at the time of her untimely death was a voluntary inpatient at The Melbourne Clinic, Church Street, Richmond. Lizzie was admitted as a voluntary inpatient to The Melbourne Clinic on 14 February 2017 having been transferred from Northern Hospital. Lizzie was previously an inpatient at Northpark Hospital Goulburn Valley Health.

2. Lizzie had a long past mental health history, having been diagnosed with bipolar disorder, anxiety, mood disorder and more recently, a schizoaffective disorder. Interestingly, Lizzie's psychiatric conditions were stable for many years under the care of her private psychiatrist Dr Khanna. However, due to a combination of events, including the death of a family friend, issues with the farm and often poor compliance with her medication regime, Lizzie's condition deteriorated, ultimately resulting in her hospitalisation.

BROAD CIRCUMSTANCES SURROUNDING DEATH

3. At this point I merely provide a timeline of what I see as relevant events during the afternoon of 27 February 2017.

    - Shortly prior to 3pm, Nurse Mark Cook observed Lizzie in the corridor in an "agitated" state, he escorted her back to her room and advised her to rest.
    - At 3:20pm, Lizzie was visually observed by Nurse Siew Lan Tang.
    - At 4:35pm, Lizzie attended the nurses station and asked Nurse Cook for her prescribed Metamucil. Nurse Cook advised Lizzie that this medication was not due to be given until 8pm.
    - Nurse Cook noting Lizzie was "quite agitated" and "disorganised", offered her PRN 2.5mg Olanzapine which was accepted and administered, after which Lizzie returned to her room.

- At about 5:20pm, Ms Heather Ewart, Lizzie's sister, attended at Lizzie's room. Alarmed by Lizzie's condition, Ms Ewart attended the nurses' station immediately and spoke with Nurse Cook.
- Ms Ewart enquired as to what medication had been provided to Lizzie that afternoon. Nurse Cook said Olanzapine and at Heather's request wrote that on a sticky note.
- In the presence of Heather Ewart, at her further request, Nurse Cook rang Dr Meileen Tan, Lizzie's treating psychiatrist. Dr Tan did not answer the call and Nurse Cook left a message. The content of what was conveyed to Nurse Cook by Ms Ewart at this time is a matter of stark contention which, as it is critical, I will address in detail later in this finding.
- Ms Ewart returned to Lizzie's room, had a short conversation with her sister and then returned to the nurses' station and again spoke with Nurse Cook, enquiring as to whether Dr Tan had responded to the message he had earlier left. Ms Ewart asked that if Dr Tan did respond, would he, Cook, ask Dr Tan to call her.
- At 6:10pm, Ms Ewart left The Melbourne Clinic.
- Although it is not entirely clear whether it was shortly before or shortly after Ms Ewart left the hospital, a visual observation check of Lizzie was undertaken by the unnamed Irish nurse who observed Lizzie in her room and recorded Lizzie was sleeping.
- At about 7pm, Dr Tan accompanied by Nurse Tang, attended at the door but did not enter Lizzie's room. Dr Tan called her name but got no response. Dr Tan claims she observed Lizzie lying on the bed with her back to the door, breathing and noting that she was snoring. Dr Tan recorded in the notes that Lizzie was "sleeping, room smelling"!
- Not wishing to wake Lizzie, Dr Tan continued her rounds intending to return later to review her.
- At 7:45pm, Nurse Cook attended Lizzie's room and finding her unresponsive, pressed the emergency alarm. Doctors and nurses attended and CPR was commenced. A call to the 000 emergency number resulted in the timely attendance of MFB personnel and Ambulance Victoria paramedics at 7:54pm including MICA.

- Resuscitation attempts were abandoned as futile at 8:21pm and Lizzie was formally declared deceased at 8:22pm on 27 February 2017.

REPORT TO THE CORONER

4. Lizzie's death was appropriately reported to the coroner. Having regard to the circumstances, having conferred with a forensic pathologist and noting the family did not object to autopsy, I directed an autopsy and ancillary tests. A full autopsy was performed at VIFM by Forensic Pathologist Dr Sarah Parsons. After exhaustive autopsy, including histology and toxicology, Dr Parsons advised she could not determine the cause of Lizzie's death; consequently the cause of death remains

I (a) UNASCERTAINED

I note the case was reviewed by a second pathologist.

POSSIBLE CAUSES OF DEATH

5. Dr Parsons, in the comment section of her report discussed a variety of potential causes of death.

> *"The deceased has an enlarged heart. People with an enlarged heart are at increased risk of sudden death presumably due to a cardiac arrhythmia. The most common cause of cardiomegaly in our society is hypertension.*
>
> *Causes of death that cannot be determined at autopsy include cardiac arrhythmic disorders, seizure disorders and metabolic disorders.*
>
> *The deceased does not have a history of seizures; however the deceased did have bite marks to her tongue which can be seen at autopsy following a seizure.*
>
> *Cardiac arrhythmia disorders can cause sudden death. Some cardiac arrhythmic disorders with a long QT syndrome, Brugada and CPVT may run in families and it is recommended that immediate family members are assessed in regards to their cardiovascular health.*
>
> *Toxicological analysis on post mortem specimens has detected Hydrorisperidone and Olanzapine. Neither of these was at significantly raised levels; however they may have a synergetic central nervous system depression affect.*
>
> *At autopsy the deceased has some focal fat and fibrosis whilst the distribution of this is not in keeping with any known cardiomyopathies, fibrosis and fat may act as a*

nidus for a cardiac arrhythmia and this is a possibility, however the history of slurring her words and snoring would not be in keeping with fatal arrhythmia.

C-Reactive Protein and procalcitonin were not raised. C-Reactive Protein is a protein that is produced by the liver in response to infection and inflammation."

6. Dr David Wells, at the request of Ms Ewart, privately provided a report in which he also referred to several possible causes of Lizzie's death, as did Associate Professor Richard Newton, the independent expert who was commissioned by the Court to provide an expert opinion. Possible causes of death were also referred to by the senior clinician in the Health Medical Investigation Team (HMIT) within the Coroners Prevention Unit (CPU).

7. These entities provided interesting hypotheses, but that is all they are. In the final analysis after exhaustive post mortem examinations, the cause of Lizzie's death remains "UNASCERTAINED".

ROLE OF THE CORONER

8. Section 67 of the Coroners Act 2008 provides three core findings I am required, if possible, to make:

    - The identity of the deceased person
    - The medical cause of that person's death
    - The circumstances surrounding the death

    The first core finding is non controversial. In this case, the second core finding is problematic because, as stated earlier, in spite of exhaustive autopsy and ancillary tests, the cause of Lizzie's death remains unascertained; the third core finding is where contention lies. I want it known that the focus of my investigation has been, and remains, on matters proximate to Lizzie's death, not what I refer to as "historical" issues. Consequently, at the formal inquest on 1 and 2 October 2019 virtually the sole focus was upon the adequacy of the care provided to Lizzie during the afternoon/evening of 27 February 2017.

9. In my considered view, the fundamental role of the coroner is often misunderstood within the broader community. Often families in particular are left with an unfulfilled expectation when the performance of the entity they see as responsible for the death of their loved one is not stridently criticised by the coroner.

10. From my perspective, the judgement of Callaway JA in *Keown v Khan* (1999) (VR 69) was a landmark judgement. Adopting a statement in the Brodrick Committee (UK) Report His Honour said:

"In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest required, without deducing from those facts any determination or blame".

and added:

"In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is a difference between a form of proceedings which affords to others the opportunity to judge an issue and one which appears to judge the issue itself."

In *R v South London Coroner: exparte Thompson* [1982] 126 SJ 625 Lord Lane commented:

"It should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning blame".

11. Again in *Keown v Khan* Justice Callaway made a comment which assists in determining whether an act or omission can reasonably be considered a causal or contributing factor, as distinct from a "background circumstance", that is a non-causal factor. In considering this dichotomy His Honour said one should consider whether an act complained of departed from a norm or standard, or an omission was in breach of a recognised duty.

12. Several New Zealand cases assist in explaining the apparent conundrum between concluding an entity has caused or contributed to a death, but not laying, or apportioning blame. See *Louw v McLean* (1998 High Court of New Zealand unreported 12 January 1988) and *Coroners Court v Susan Newton and Fairfax New Zealand* [2006] NZAR 312. The notion is that in finding causation, or contributing to a death the implicit attribution of responsibility is unavoidable.

13. In *Harmsworth v The State Coroner* His Honour Nathan J, broached the subject of the extent of coroners powers, observing that power is not "free ranging", but must be restricted to issues sufficiently connected with the death being investigated. His Honour stated that if not so restricted, an inquest could become wide, prolix and indeterminate.

14. The principle was restated in *R v Doogan; ex parte Lucas Smith and Ors* (2006) 158 ACTR 1. In *Doomadgee & Anor v Deputy State Coroner Clements* (2005) QSC 357, Mr Justice Muir commented that coroners are not "roving Royal Commissioners"; and added:

"It is significant also that rules of evidence do not bind a coroners court and that it may inform itself in any way it considers appropriate. That does not mean that there are no constraints at all on coroners in relation to the gathering of evidence. The

evidence relied on by the Coroner must be relevant to the matters within the scope of the coronial enquiry".

15. Bearing in mind these authorities, as my investigation progressed several issues were raised by Lizzie's brother Mr Alistair Ewart and his daughter, Ms Amelia Ewart, Lizzie's goddaughter, which I indicated I did not propose to pursue. An example is Ms Amelia Ewart's criticism/complaints about events that occurred at The Melbourne Clinic later in the evening of 27 February 2017, after Lizzie's death. Another example is the concerns raised particularly by Mr Alistair Ewart that he and his daughter were refused access to Lizzie while she was an inpatient at The Melbourne Clinic. Although in relation to that issue I had some informal enquiries made and the information gleaned was conveyed to Mr Alistair Ewart, I considered these and some other matters outside the scope of my power of investigation.

COURSE OF CORONIAL INVESTIGATION

16. The investigation in relation to Lizzie's death has followed a tortuous path. After the Autopsy Report was received, I sent copies of the correspondence received from Ms Heather Ewart relating to her concerns about the care/treatment of Lizzie to The Melbourne Clinic seeking a formal statement addressing the general course of management during Lizzie's admission, and the specific concerns raised by Ms Heather Ewart.

17. Subsequently, statements were provided by Consultant Psychiatrist Dr Meileen Tan and Ms Gaylyn Cairns, General Manager, The Melbourne Clinic. That material was provided to Ms Heather Ewart with an invitation to respond if she so wished. Ms Ewart responded, broadly reiterating her concerns. She also lodged a report she obtained from Associate Professor David Wells. Dr Wells' statement was provided on a personal basis, <u>not</u> as a senior clinician at VIFM.

18. It soon became clear that there were areas of contention in relation to the quality/adequacy of the care/management/treatment provided to Lizzie. Consequently, I referred the file to the Coroners Prevention Unit (CPU) for them to seek an independent expert opinion from a suitably qualified, experienced consultant psychiatrist.

19. Associate Professor Richard Newton, Clinical Director, Peninsula Health Mental Health Service agreed to provide an expert opinion. Associate Professor Newton was specifically requested to provide an opinion on the management of Lizzie including commentary on any deficiencies in medical and/or nursing management and possible/potential causes of death. In a timely manner, Associate Professor Newton provided a report dated 30 November 2017.

20. Associate Professor Newton's report was provided to Ms Heather Ewart and Mr Michael Regos of DLA Piper Australia Solicitors, who by that time represented Healthscope Operations Pty Ltd the proprietor of The Melbourne Clinic, again with an invitation to respond if so desired.

21. Associate Professor Newton, at paragraphs 15 and 16 of his report opined that nursing management was what I will call sub-optimal. It is important to understand that Associate Professor Newton's opinions were predicated on what was contained in the statements of Dr Tan together with General Manager Cairns and the material lodged by Ms Heather Ewart. At that point in time a statement had not been sought from Nurse Mark Cook.

22. Having regard to comments by Associate Professor Newton, in late 2017/early 2018 I asked CPU/Health and Medical Investigation Team (HMIT) to review the file with a view to assessing the medical, as distinct from psychiatric, management of Lizzie proximate to her death.

23. In July 2018, I received a Coroners Prevention Unit Advice – Health and Medical. On 8 August 2018 a redacted copy of which was provided to DLA Piper. I include here an excerpt from Mr Darren McGee's, coroner's solicitor, accompanying email of 8 August 2018, he wrote:

> *"Coroner Byrne has indicated that having taken advice from a senior consultant physician in HMIT, there are aspects of the medical management as distinct from psychiatric management, that he may conclude were suboptimal. His Honour wishes to stress that this is his tentative view, which he will revisit after your client has had an opportunity to digest the material and consider whether they would seek to resist/counter any adverse comment regarding the efficacy of medical management."*

24. Again under the hand of Mr Regos, in mid-October DLA Piper responded to my query as to whether The Melbourne Clinic (Healthscope) would seek to resist/challenge an adverse finding or comment with a 10-page response in which, inter alia, the events of the afternoon/evening of 27 February 2017 are canvassed. Most significantly, the response (at paragraph 24) puts what Nurse Cook claims was conveyed to him by Ms Heather Ewart on each of the occasions she approached him at the nurse's station on the afternoon of 27 February 2017. Ms Ewart was also provided with the DLA Piper submission. The versions of those exchanges are diametrically opposed. Mr Regos stated that he was instructed by Nurse Cook that if he had been told what Ms Ewart says she related to him, he would have attended Lizzie's room and taken another set of vital sign observations.

25. In his letter of 16 October 2018, Mr Regos advised that some of the information contained in his letter had come from individuals directly involved in Lizzie's care on the day of her death and was likely not in the medical records, or in the statements already provided, those of Ms Cairns and Dr Tan.

26. At that time I formed a tentative view that unless some concession was made by one or another participant, the contradiction as to what was conveyed could only be resolved by hearing viva voce evidence from both Ms Ewart and Nurse Cook.

27. I had my coroner's solicitor formally request the additional material flagged by Mr Regos. The statements sought were subsequently received on 11 February 2019 and disseminated to the other interested parties two days later. Upon receipt of the additional material it became patently obvious that I would indeed need to list the matter for formal inquest basically on the sole issue of the contradictory positions put by Ms Heather Ewart and Nurse Mark Cook. The parties were advised of the formal hearing.

28. I referred earlier in this finding to the investigation following a "tortuous path". Primarily this occurs due to the process of receiving concerns/complaints, seeking material, receiving the material sought, providing that material to other interested parties, receiving responses to the issues raised in the material, providing those responses and inviting a further response; these exchange processes undertaken to ensure procedural fairness are unavoidable, but necessary.

29. Late in 2018 correspondence was received from Mr Alistair Ewart, brother of Lizzie, querying why he had not been included in these various exchanges of material. Under the legislative hierarchy siblings are considered to be equal senior next of kin where there is no spouse/partner or children. Enquiries made of the Coronial Admissions and Enquiries Office demonstrates the first family contact was made with Ms Heather Ewart, who apparently did not advise she had a brother. Nor apparently did the Coroners Admissions and Enquiries Office call taker make that enquiry. In any event, as a result of Mr Alistair Ewart's concerns I directed that hence forth, he be accepted as equal senior next of kin. Subsequently the accumulated material was provided to him. It is of course regrettable that he was not, from the outset, identified as equal senior next of kin.

MENTION/DIRECTIONS HEARING

30. To assist in determining the future course of the matter, I listed the matter for a Mention/Directions hearing which proceeded in open court on 14 May 2019. At the hearing, both Ms Heather Ewart and Mr Alistair Ewart appeared unrepresented, and Mr Regos of DLA Piper appeared for Healthscope (The Melbourne Clinic).

31. Ms Heather Ewart basically re-iterated her principal concern, the failure to adequately monitor Lizzie during the late afternoon/early evening of 27 February 2017 and the failure of Nurse Cook to take appropriate action after she alerted him to Lizzie's condition. While referring to some matters, which I considered to be at the periphery, Mr Ewart also indicated he had concerns about the management/care of Lizzie on the afternoon/evening of her death.

32. At the Mention/Directions hearing Mr Regos made two interesting comments, he said:

> *"If the facts were as Heather described, then what should've happened is that Mark Cook or somebody should've attended upon Elizabeth and should've done an assessment. That's accepted completely."*

and similarly:

> *"It would be absolutely conceded that if a family member expressed concern about the physical state there and then of a patient, that somebody ought to attend and conduct the appropriate assessment. On the other hand, if the circumstances happened as Mark Cook says, then the position of the hospital is that they followed the appropriate practices and protocols and what they did was appropriate."*

33. As to that informal concession, with the caveat that it was based upon me accepting Ms Ewart's version of events, it is now of no significance for two reasons, Mr Regos' firm no longer represents Healthscope and in any event I suspect Mr Regos merely responded to the proposition I put to him as distinct from conveying an instruction by his client. I will not be relying on his comment, but considered I should merely air it.

FORMAL INQUEST

34. The matter proceeded to inquest on 1-2 October 2019. At the hearing, Mr McGee appeared to assist, Ms Ronalds, of counsel, appeared on behalf of Ms Ewart, solicitor Mr Hazell appeared on behalf of Mr Alistair Ewart, Ms Fiona Ellis, of counsel, appeared on behalf of Healthscope and Mr Mark Cook.

Viva voce evidence of Ms Heather Ewart

35. Ms Ewart entered the witness box and was sworn. Her statement of 26 March 2017 was, with one minor alteration, formally adopted and received into evidence as exhibit A.

36. In evidence, Ms Heather Ewart in effect maintained the position she had expressed from the outset. She maintains that after observing Lizzie in a parlous state (my expression, not hers), she immediately attended the nurse's station and told Nurse Cook that Lizzie was in a "terrible state", she was "shocked and very worried" and wanted Dr Tan called to

immediately assess Lizzie. In evidence, Ms Heather Ewart conceded she did not convey to Nurse Cook the observations she made of Lizzie which led her to conclude Lizzie was in a "terrible state". It is not in contention that Heather Ewart enquired of Nurse Cook as to what medication he had given Lizzie; nor is it in contention that Nurse Cook advised her he had administered Olanzapine 2.5mg and wrote that on a sticky note which he gave to Heather Ewart. A copy of that note is contained in the brief at page 30. Ms Ellis put to Ms Heather Ewart that if one advised a nurse looking after a patient that his/her patient is in a "terrible state" and one is "very worried" there would be an expectation that the nurse would enquire as to the bases of the serious concerns. Ms Heather Ewart confirmed that Nurse Cook did not enquire as to why she held the serious concerns, stating that the nurse's station was very busy that evening. So in summary, Heather Ewart did not communicate the bases of her serious concerns about Lizzie's physical condition, nor did Nurse Cook enquire as to what they were. Ms Heather Ewart also conceded that after she raised her concerns, she did not ask Nurse Cook to go and look at Lizzie, nor did Nurse Cook, who it is claimed was not aware of Lizzie's condition, suggest they go to the room and assess Lizzie.

37. Ms Ellis examined Heather Ewart about what occurred after she returned to Lizzie's room, again observed her condition, returned to the nurse's station and again spoke with Nurse Cook. Heather Ewart stated that after again observing Lizzie she approached Nurse Cook again and enquired as to whether Dr Tan had responded; she was advised Dr Tan had not responded. It was put to Ms Heather Ewart that as Dr Tan had been slow to respond to previous requests that she call, she would not, at about 6:10pm, have left the hospital without her serious concerns being addressed. I include the following excerpt (lines 23-31 on page 27, and line 1 on page 28 of the transcript) Ms Ellis asked:

> *"-- I suggest to you you wouldn't have left the hospital when you did, that the account that you have given to this court is the result of a careful consideration of what it is that went wrong was different for your sister on 27 February 2017 and that your statement has been effected by your grief and loss, do you agree with that?—"*

Ms Heather Ewart replied:

> *"I disagree entirely. I remember the events that night with absolute clarity, it was the last time I saw my sister and heard her speak, that is not something that I forgot."*

From my perspective, the problem with Ms Heather Ewart's response is that it was a response to two questions, not just a response to why in the circumstances she left the hospital when she did. With the benefit of hindsight, it would have been appropriate if I had put to Ms Ewart the issue of leaving when she did.

Viva voce evidence of Mr Mark Cook

38. Mr Mark Cook entered the witness box and was sworn. His statement, with a short explanation as to a time which is not particularly pertinent, was adopted and entered into evidence as exhibit "B".

39. Ms Ronalds examined Nurse Cook. He accepted that he made his formal statement some 18 months after the events the subject of my investigation and in doing so relied on his memory as to its content. Mr Cook said that other than a "bit of a debrief", a "team meeting" the day after Lizzie's death, he had not discussed the events other than talking to the solicitor in the process of providing his formal statement. He further stated that other than the notes he made at 10:30pm later in the evening of Lizzie's death, he did not believe he made any other handwritten note. That note was received into evidence as exhibit "C".

40. Mr Cook accepted that he provided Lizzie with the PRN dose Olanzapine 2.5mg at about 4:35pm that afternoon as he was authorised to do. It was at this point in his examination by Ms Ronalds that I suggested to Mr Cook that he listen carefully to the questions being put and only then respond. Mr Cook said he had never given evidence in a court before and was a "little bit agitated".

41. Mr Cook acknowledged that he was aware Olanzapine has a sedative effect. He said he observed Lizzie to be a "bit agitated" and provided the Olanzapine to calm her down. It was put to Mr Cook that by Heather Ewart enquiring as to what medication had been given, it was clear she was concerned about Lizzie's condition. Mr Cook denied that Heather Ewart told him Lizzie was curled up in bed, slurring her words and couldn't stay awake. I noted that in viva voce evidence Heather Ewart conceded she did not detail that precise information to Mr Cook, but maintained she told him she was "very worried" because Lizzie was in a "terrible state".

42. Ms Ronalds then took Mr Cook to pages 72-74 of exhibit "C" in the Progress Notes, his handwritten note of 10:30pm referred to earlier described variously as "retrospective" and "contemporaneous". Mr Cook conceded that the note was silent as to details of the conversation he had with Ms Ewart at the nurse's station, although he accepted that he made a note "sister" noted she was sleepy. He further accepted that in his formal statement, made some 18 months later, he made no reference to Ms Ewart noting Lizzie was sleeping. Mr Cook also accepted that if Lizzie was sleeping at that time of the day it would likely be due to the PRN administration of Olanzapine to settle her down. Again Ms Ronalds put to Mr Cook that Ms Ewart said to him that Lizzie was "curled up in her bed and was having trouble speaking and staying awake". On this occasion Mr Cook replied, "*I don't recall* [her] *saying*

that" (my emphasis). I am not sure what, if any, significance I can place on that precise reply; it is unclear to me if he meant to convey that he "could not recall" Ms Ewart stating that. If he did, that reply is not as unequivocal as his earlier denial that precise information was conveyed. However several questions later Mr Cook again maintained that Ms Ewart didn't raise those precise concerns. However, it is to be recalled that Ms Ewart conceded in evidence she did not advise Mr Cook of precisely what she says she saw.

43. Ms Ronalds put to Mr Cook that even on the information he was aware of, as distinct from the additional information Ms Ewart says she conveyed, he had an obligation to exercise a professional judgement to review Lizzie. Mr Cook did not accept that proposition.

44. When examining Mr Cook, Ms Ellis established Mr Cook's qualifications and experience as a nurse particularly his experience as a psychiatric nurse. In relation to that issue, and I do not believe it is in issue, I accept that Mr Cook is an appropriately qualified, highly experienced psychiatric nurse both in psychiatric hospitals and to a lesser extent in community based treatment/management of psychiatric patients.

45. Ms Ellis examined Mr Cook as to the principal/focal issue of what was conveyed to him by Ms Ewart and asked that if a family member came to him, advised that a patient he personally had care of at the time was in a "terrible state", the family member was worried and wanted a doctor to be called, what would he as an experienced psychiatric nurse do. Mr Cook responded that he would ask what was wrong, attend upon the patient and make an assessment including taking vital signs and if thought necessary, call a doctor to review the patient and/or, if considered appropriate, call an ambulance. Mr Cook completed his evidence and was excused. Before he actually exited the courtroom, in submission, Mr Hazell, for Mr Alistair Ewart, raised an issue in relation to Dr Tan, when she attended Lizzie's room, detecting a smell. I thought it appropriate to enquire of Mr Cook whether, when he entered Lizzie's room at 7:45pm and noted she was unresponsive, he smelt anything. He returned to the witness box and said when he entered the room he did not notice a smell.

SUBMISSIONS

46. At the completion of viva voce evidence I entertained oral submissions by Mr Hazell, Ms Ronalds, Ms Ellis, and counsel assisting, Mr McGee. As it was against her clients that adverse findings or comments were sought, I allowed Ms Ellis to go last.

Initial submission by Mr Hazell

47. Mr Hazell indicated he did not propose to make submissions in relation to the narrow issue upon which I heard evidence. That was not surprising because he could be reasonably assured

Ms Ronalds would be making submissions on the issue which was the family's fundamental concern from the outset. He did however wish to make submissions on the issue of Dr Tan noting a smell when she attended at, but did not enter, Lizzie's room at 7pm. I had indicated that as Dr Tan had noted she smelt something I was prepared to accept she did, but ruled that its significance did not, in my view, warrant calling her to give oral evidence. However, bearing in mind I have broad discretion as to how I can obtain evidence, I took the somewhat unusual step of suggesting I would have my assistant Mr McGee endeavour to contact Dr Tan and enquire as to what it was she smelt. With the assistance of Ms Ellis' instructing solicitor a contact number for Dr Tan was provided. Mr McGee made contact with Dr Tan on the following morning. She was prepared to discuss the issue. Dr Tan confirmed she did smell something, but could not recall, or did not know what it was she smelt.

48. In his submission Mr Hazell also raised the issue of whether either the unidentified Irish agency nurse who undertook the 6pm visual inspection, or indeed Dr Tan, were aware Lizzie had been given the 2.5mg PRM Olanzapine. I indicated that with the benefit of hindsight I would have preferred to know the answer to that question. However, I said it was more significant for me to consider the adequacy of the visual inspections undertaken by each. I indicated that my tentative view was that the issue was not of such significance to warrant re-opening the investigation at the 11th hour.

49. Both Ms Ronalds and Ms Ellis indicated they would rather wait till the following morning to make their oral submission when the transcript of the day's evidence would be available.

50. On the morning of the second day of the inquest, Wednesday 2 October 2019, Mr McGee relayed what he was told by Dr Tan in relation to both what she smelt and whether she was aware Lizzie had been given 2.5mg of Olanzapine during the afternoon, I confirmed with Mr Hazell my tentative position of the previous day not to call Dr Tan.

Submission made by Ms Ronalds

51. Ms Ronalds commenced her submission by stating:

> *"So as is well accepted, Elizabeth struggled with mental health issues all her adult life, but this doesn't provide an explanation for her physical condition, or her death. She was in the care of experts, in a specialist psychiatric hospital in the middle of Melbourne. She was entitled, we say, to receive optimum care. Not only for her mental illness, but also for any physical issues, whether arising from medication she was taking, or any other issue.*

This didn't occur here. We say that her care can best be described as casual and without any proper foundation in either policy or practice of the Melbourne Clinic, which is a private hospital and part of the Healthscope Operations Pty Ltd."

That broadly goes to the crux of the case put by the family of Lizzie, both Ms Heather Ewart and Mr Alistair Ewart. There is however one aspect of that statement with which I feel obliged to take issue. It is claimed Lizzie was "entitled" to "optimum care". While one would hope "optimum care" would be achieved, and would like to think they are the same, in considering the efficacy/adequacy of care provided to Lizzie, I believe I have to consider whether in relation to both mental and physical health the care provided to Lizzie achieved a reasonable and appropriate level.

52. Early in her submission, Ms Ronalds made a couple of comments which puzzled me. She said:

"We say that there's an important dichotomy in this matter, which is that we make and seek no findings against Mr Cook. It is about the operation of The Melbourne Clinic itself and not any individual who is merely going about doing his job as he understood it, from his own evidence—"

and;

"We don't believe, in these circumstances, that it is appropriate to vilify an individual when he was doing the best he could—"

While I acknowledge that sentiment, I commented to the effect that IF I accepted Heather Ewart's version of events as to what was conveyed to Mr Cook, I would have to make an adverse finding against him. That's not to say one could not also make an adverse finding or comment in relation to the adequacy of the clinic's policies/practices/guidelines, to borrow Ms Ronalds' expression, "the operation of the clinic"; In the event, I thought it appropriate at that stage to raise the issue with Ms Ronalds.

53. Ms Ronalds accepted my stated position in relation to the cause of death remaining "unascertained". The events of the day up until Ms Heather Ewart attended at the nurse's station are non-controversial, but thereafter is the controversy, the diametrically opposed versions of events.

54. Ms Ronalds further submitted another reason for me not to accept Mr Cook's version of events is the fact that there are inconsistencies in the content of what I will call the semi contemporaneous progress notes he made on 27 February 2017 after Lizzie's death, and the formal statement he made some 18 months later. Bearing in mind he made that statement

without reference to his earlier note, or for that matter any other note, I do not consider that matter determinative but will take it into consideration.

Additional submission by Mr Hazell

55. Mr Hazell commenced his additional submission by concurring with the submissions made by Ms Ronalds. He further submitted that there were a number of "smaller events" which on the face may seem "insignificant" but in combination may enable me to come to firm conclusions. The first was the smell noted by Dr Tan when she attended at the door of Lizzie's room. The second was that "nobody was aware" of the 2.5 PRN administration of Olanzapine at 4:35pm, or more importantly, Mr Cook did not advise Dr Tan of that fact. The third matter claimed by Mr Hazell to be considered was that Mr Cook did not give evidence to suggest he was aware of the change in the dosage of PRN Olanzapine provided in the days before 27 February. Mr Hazell argued that Mr Cook should have conferred with Dr Tan prior to providing the 2.5mg of Olanzapine on the afternoon of 27 February. I queried with Mr Hazell the relevance of this issue. He stated that it would be pertinent to an opinion provided by Dr David Wells that what occurred on the afternoon was "suggestive of a progressive determination in Lizzie's conscious state". However, Mr Hazell conceded that the cause of the claimed progressive deterioration cannot be definitively identified. I have had regard to Mr Hazell's submissions in this regard, but I commented on a number of occasions that the cause of death remains unascertained.

56. Having regard to Mr Hazell's submission on these issues I think it appropriate to at this point include an important excerpt from the report of the independent expert Associate Professor Richard Newton; at paragraph 19 he opined:

> *"There appears to be a time relationship between her being given her PRN Olanzapine 2.5mg and becoming drowsy and developing slurred speech suggesting that the Olanzapine may have caused these effects. However this is a small dose of Olanzapine that she had previously had with no adverse effects. It is possible that some other event or some unknown medication caused the drowsiness and slurred speech."*

In relation to the prospect, Lizzie's death was related to the medication administered, it is to be recalled the CPU reviewing clinician came to a similar view.

Furthermore, at paragraph 4 of his CPU advice, the reviewing consultant physician advised that the doses of the medications, including the PRN dosage, taken by Lizzie were within the normal prescribing range and post mortem toxicology did not demonstrate any to be present

in concentrations greater than therapeutic, or known to be toxic. I will return to the possible causes of death when I reach my conclusions.

57. Mr Hazell was critical of what he described as "gaps in the records" and the levels of coordination and communication between those involved in Lizzie's care on the afternoon of 27 February 2017, in effect broadly claiming the formal policies and practices of The Melbourne Clinic were lamentable. I will discuss the relevant policies later in this finding. Referring to the deficiencies he claimed in care/management of Lizzie, Mr Hazell ended his submission with the following:

> *"I don't suggest in any way, shape or form that any of these events that I've referred to is on its own proximate or causative of the death of Lizzie but there is little doubt in my mind that a number of these smaller failure along each step of the way when combined ultimately led, at the very least a failure to intervene earlier to prevent her death."*

58. Not surprisingly, Mr Hazell concluded his additional submission by concurring with the submissions made by Ms Ronalds.

Submissions made by Ms Ellis

59. Ms Ellis advised that her instructor had provided to the Court and other parties copies of the February 2016 policy and the revised August 2017 policy in relation to Risk Assessment and Observation Levels. This material was discussed at the Mention/Directions hearing where a request was made of Mr Regos to provide copies. However, due to the engagement of new solicitors, the policies were not made available to the interested parties or indeed the Court until several days before the hearing when they were provided directly by Ms Ellis' instructor.

60. Ms Ellis pointed out that the policy in relation to visual observations, which are pertinent in this matter, was revised/refined by the 2017 version. Ms Ellis stated that under the 2016 policy the nurse undertaking the observation was required to chart the time the patient was sighted, the patient's risk level, where the patient was sighted and what the patient was doing at the time of sighting. Ms Ellis then took me to the definitions in the revised August 2017 policy. The revision is substantial; visual observation requiring "*full faced unequivocal identification and screening of the patient for changes in presentation condition of behaviour*". Ms Ellis maintained that the visual observations at 3:20pm and 6pm were charted and in the absence of knowledge of slurred speech or physical deterioration was in accordance with the policy as it was at that time.

61. Ms Ellis stated that although Associate Professor Newton suggested these type of policies generally require consideration of a patient's wellbeing, his view on the matter was qualified; it was. In submitting that the 6pm observation was in accordance with the policy in place at the time, Ms Ellis suggested that noting a patient was sleeping, snoring or not, did not demonstrate a depressed conscious state, nor an adverse response to medication, requiring a check on that person's physical wellbeing.

62. Ms Ellis also reminded me that the CPU senior clinician who reviewed the material stated in his report that he was unable to find a guideline in Victoria that covers the medical care and standard of assessment. The reviewer did however go on to say:

> *"The Chief Psychiatrist's guidelines are available online, but the one that addresses 'general medical health needs' does not cover or prescribe a standard of medical observation or assessment for patients who may be developing a medical condition."*

63. Ms Ellis then turned to address me in relation to the principal issue, the focus of the inquest, referring to the issues I have referred to earlier in this finding at paragraphs 41-42 when discussing Mr Cook's viva voce evidence.

64. At paragraph 175 of the transcript, Ms Ellis made an interesting comment. She said she did not invite me to find that neither Ms Ewart or Mr Cook were not "witnesses of truth". As observed in relation to Ms Ronalds and Mr Hazell's comments along similar lines in relation to Mr Cook's evidence, I consider it unavoidable to do other than consider the credibility and/or the reliability of both witnesses in seeking to determine, if I can, which of the contradictory versions of events represents the truth.

65. Towards the completion of her submission, Ms Ellis took issue with some of the bases upon which Mr Hazell's submission proceeded, particularly in relation to Mr Cook providing the PRN dosage of Olanzapine without conferring with Dr Tan, Dr Tan not being aware of that administration earlier in the afternoon and the different dosage provided on previous days. In relation to those matters I merely state I hear what she said.

DISCUSSION

66. When Associate Professor Newton was engaged to provide an <u>independent</u> expert report, he was invited to provide an opinion on the management of Lizzie from her admission to The Melbourne Clinic on 14 February 2017 until her death on 27 February 2017, including commentary on any deficiencies of nursing or medical management. Associate Professor Newton identified some issues which he considered sub-optimal management.

67. At paragraph 12 of his report, Associate Professor Newton wrote:

"During most of her inpatient stays her treatment and care was mainly as one would expect with minor deficiencies in process or practice of clinical care and with a number of gaps that are identifiable but are common in the provision of care in any hospital setting."

In broad terms, leaving aside for the moment some issues he considered sub-optimal, Associate Professor Newton concluded, and I accept his opinion, that the management of Lizzie's mental health issues reasonable and appropriate in the circumstances.

68. At paragraph 19 of his report, Associate Professor Newton addressed the issue of Lizzie's deterioration and the prospect her death was related to the medication administered at 3:35pm.

69. As to some other unidentified event being the cause of Lizzie's death the CPU reviewer speculated as to several possible causes, but noting the cause remained undetermined, stated:

"It would appear that Ms Ewart has died from a relatively acute but unascertained event."

As stated on several occasions earlier in this finding, I am unable to determine the cause of Lizzie's death, which unfortunately remains unascertained.

70. As to the core issue of the adequacy, or otherwise, of Mr Cook's response to what was conveyed to him by Ms Heather Ewart, the views expressed by both Associate Professor Newton and the CPU reviewer, both of whom opined that the concerns conveyed should have been a prompt for an immediate in-depth nursing assessment, have to be viewed in context. Associate Professor Newton wrote:

"The nurse was informed that the sister was concerned about her sister's state more generally and this should also have been a prompt for an in depth nursing assessment of Ms Ewart."

The CPU reviewing clinician wrote:

"The CPU considers that a general physical assessment, including the taking of a set of observations and checking the patient's general state would be a prudent response to concerns expressed by a patient's relatives in any clinical setting."

71. Unfortunately those opinions were predicated on the basis that Ms Ewart related to Mr Cook all, or at least most of her observations of Lizzie – the contentious issue that I sought to resolve at inquest.

72. I believe I do not require further expert advice on the core issue because if I accept what Ms Heather Ewart says she told Mr Cook, even if she did not convey the precise detail of her

observation upon which her grave concerns were founded, it seems so obvious that a formal assessment should have been undertaken. That was the very basis upon which I sought a concession from Mr Regos at the Mention hearing in May.

Visual observations

73. I propose to address the issues surrounding visual observations of Lizzie undertaken after 3pm on the afternoon of 27 February. At that time the policy and procedure in place was Policy 9.07 Risk Assessment and Observation Levels – Patient dated February 2016. A copy of this policy (and the revised August 2017 policy) was provided to the Court. The patient's level of risk is pertinent to the level of observation. Bearing in mind we are here talking about patients in a psychiatric facility, it seems the focus of the policy is on establishing whether a patient is what I will call "present and accounted for", in effect to establish that a patient has not absconded, or is at risk of doing him or herself a mischief, not to generally gauge the patients' psychical wellbeing. To that end an observation from a doorway is probably reasonable, but certainly not sufficient to make a judgement as to the patients' physical condition.

74. As I noted earlier, in her submission Ms Ellis put that the policy in place at the time did not explicitly mandate a check or a physical wellbeing, and appearing to be sleeping did not necessarily indicate a depressed conscious state.

75. On the basis of the policy in place at the time of the formal visual observations of Lizzie, the doorway observations undertaken at 3:20pm and 6pm, at which it was noted she was breathing, were compliant with the policy in place at the time.

76. However, the obvious deficiency in the 2016 policy was recognised, possibly due to the events the subject of this matter, and a revised Healthscope policy on the issue of visual observations was promulgated in 2017. Had this policy been in place on 27 February 2017 the visual doorway observation would have been non-compliant.

77. The revised policy, requiring a visual full faced unequivocal identification and screening, would hopefully establish the medical status of the patient.

78. I note Associate Professor Newton at paragraph 15 of his report which was written after August 2017 said:

> *"I did not have access to the Melbourne Clinic visual observation policy however it is usual for such policies to consider the need to consider the physical well-being of the person explicitly as part of routine visual observation."*

However, as it was unclear to me whether the levels of visual observation required are consistent throughout the industry, I propose to formulate a recommendation to the effect that

the Chief Psychiatrist issue some form of directive to psychiatric facilities to develop policies along the lines of the 2017 Healthscope visual observation policy.

CONCLUSIONS

The contradictory versions of conversions between Ms Ewart and Mr Cook

79. In spite of the positions put by Ms Ronalds and Mr Hazell as to Nurse Cook, I have sought to resolve the conflict in the versions of what was conveyed by Ms Ewart to Nurse Cook at the nurses station after she had seen Lizzie.

80. I have found this exercise extremely difficult. It may come as a surprise to some, but in my not inconsiderable experience as a judicial officer I find coming to a conclusion on the balance of probabilities, especially in cases where the evidence is "one to one", is often more difficult than coming to a conclusion on the basis of proof beyond reasonable doubt; The very basis of taking viva voce evidence is to observe witnesses under the pressure of giving evidence in open court, generally in the presence of the other protagonist and being examined and cross examined by counsel. I believe most people find it a daunting task. I have assiduously considered the viva voce evidence of both Ms Ewart and Mr Cook, examined the written material provided by both, and considered the submissions made on behalf of both.

81. It must be said that giving evidence, Ms Ewart seemed assured and measured; having regard to her background that did not surprise. On the other hand I think it fair to say Mr Cook was patently nervous, apparently unassured, to use my expression, to some extent "all over the place", not helping himself by often proffering answers before the question had been fully put. However, that comparison of performance does not necessarily carry the day. I remind myself that I am required to consider not only the credibility of a witness, whether they are telling the truth or not, but their reliability. I have done both. What I have also sought to do is, in examining the body of evidence, see if there is material which while not determinative, may tend to bolster one version or the other.

82. I feel it incumbent upon me to elaborate on the issue of the appropriate standard of proof I am required to bring to bear. In *Briginshaw v Briginshaw* (1938) 60 CLR 336 Dixon, J. at p. 362.3 explained the standard:

> *"...Except upon criminal issues to be proved by the prosecution, it is enough that the affirmative of an allegation is made out to the reasonable satisfaction of the tribunal. The reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequences of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a*

given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction; should not be produced be inexact proofs, indefinite testimony, or indirect inferences."

The Supreme Court of Victoria has emphasised that in coronial matters the test expounded in *Briginshaw v Briginshaw* should apply to findings of causation and contribution where the questions relate to individuals or other entities acting in their professional capacity (see *Anderson v Blashki* (1993) 2 VR 89; *Health and Community Services v Gurvich* (1995) 2 VR 69 and *Chief Commissioner of Police v Hallenstein* (1996) 2 VR 1). Consequently, if in fact Ms Ewart advised Mr Cook she was "very worried" that Lizzie was in a "terrible state", enquired as to what drug Lizzie had been given some short time earlier, and requested to speak with Dr Tan, and Mr Cook did not enquire as to precisely what were the bases of her concern, and if advised, did not attend and assess Lizzie, I would suggest, as an experienced professional nurse that would be a serious breach of his duty to his patient.

83. Approaching the task on the basis of the matters referred to in the previous few paragraphs, and in spite of giving the matter my earnest assiduous consideration, I find myself unable to reach a comfortable level of satisfaction as to which of the contradictory versions represents the truth. I have also considered the matter from another perspective and am not comfortably satisfied that I can reasonably reject either versions. The result remains the same.

84. I have also considered, leaving aside the contradictory versions, whether even on the information Mr Cook conceded was conveyed to him by Ms Ewart, together with the fact he provided the PRN dose of Olanzapine, a fact that cannot be viewed in a vacuum, whether that should have been a prompt for him to enquire as to what it was that troubled Ms Ewart about Lizzie's condition.

85. Considering the matter on that basis and again applying the principles enunciated in *Briginshaw*, as applied in *Blashki*, *Gurvich* and *Hallenstein*, I am not comfortably satisfied what was conveyed was sufficient to require Mr Cook to act on that information.

86. I have concluded there was no act or omission by Mr Cook which would enable me to say he caused or contributed to Lizzie's death. Having reached that conclusion, where does one go from here?

87. In relation to the treatment/care/management of Lizzie's mental health it is to be recalled that with some "minor deficiencies in process or practice of clinical care and with a number of gaps that are identifiable but are common in the provisions of care in any hospital setting",

Associate Professor Newton opined that Lizzie's treatment and care "was what one would expect". None of the interested parties sought to challenge/counter Associate Professor Newton's opinions by submitting competing expert opinions on this issue.

88. I conclude the treatment/care provided to Lizzie, in relation to her physical wellbeing, whilst perhaps not optimal, was reasonable and appropriate in the circumstances.

89. The significance of not being able to determine the cause of death cannot be overstated. By definition, if the cause of death remains "unascertained", which in this case it has, how can one seek to determine whether an act or omission by any entity has been a causal or contributing factor in the death? I suggest one cannot!

90. My inability to reach a conclusion in relation to seeking to determine which of the contradictory versions of the conversations between Ms Heather Ewart and Nurse Mark Cook is not as significant as it would be in other circumstances. This is so because while an adverse finding against Nurse Cook would be, of itself, a significant matter, I could not go as far as saying it was a causal or contributing factor in Lizzie's death whilst the cause of her death remains undetermined.

FINDING

91. I formally find Elizabeth Honor Ewart died at The Melbourne Clinic, 130 Church Street, Richmond between 7pm and 7:45pm on 27 February 2017. The cause of her untimely death remains unascertained.

RECOMMENDATION

92. In the Coroners Prevention Unit Advice – Health and Medical the CPU clinician stated:

> *"CPU is not able to find a guideline that covers the medical care and standard of assessment in Victoria. The Chief Psychiatrist guidelines are available on line, but the one that addresses 'general medical health needs' does not cover or prescribe a standard of medical observation or assessment for patients who may be developing a medical condition."*

If that is still the position, I make the following recommendation:

The Chief Psychiatrist formulate a directive to prescribing a standard protocol/practice in all inpatient facilities that visual observation of a patient include not only full faced unequivocal identification but, to ensure the physical wellbeing of the patient, a screening for any changes in presentation that may indicate an acute or developing medical condition.

93. Pursuant to section 73 (1) of the *Coroners Act 2008* I direct that a copy of this finding be published on the Coroners Court of Victoria website.

DISTRIBUTION OF FINDINGS

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

- Ms Chris Ronalds, Senior Counsel, on behalf of Ms Heather Ewart, Senior Next of Kin;
- Mr Michael Hazell, Macpherson Kelley Lawyers, on behalf of Mr Alistair Ewart, Senior Next of Kin;
- Ms Libby Riekert, Minter Ellison, on behalf of Healthscope Operations Pty Ltd, the proprietor of The Melbourne Clinic and Mr Mark Cook.
- Dr Neil Coventry, Chief Psychiatrist, Office of the Chief Psychiatrist.

Signature:

PHILLIP BYRNE
CORONER
Date: 29 October 2019