Rule 60(1)

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 6019

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 609(1)

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

Inquest into the death of: HILDA JOAN BERG

Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	11 November 2019
Delivered At:	Coroners Court of Victoria
Hearing Dates:	11 November 2019
Counsel Assisting the Coroner:	Hayley Challender

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I, AUDREY JAMIESON, Coroner having investigated the death of HILDA JOAN BERG

AND having held an Inquest in relation to this death on 11 November 2019

at the Coroners Court of Victoria

find that the identity of the deceased was Hilda Joan Berg

born on 6 October 1927

who died at Sunshine Hospital 176 Furlong Road, St Albans, Victoria 3021

from:

1 (a) ASPIRATION PNEUMONIA COMPLICATING ELECTROCONVULSIVE THERAPY FOR TREATMENT OF PSYCHOTIC DEPRESSION

In the following summary of circumstances:

Hilda Joan Berg, a compulsory inpatient at the Sunshine Aged Persons Mental Health Unit (**SAPMHU**),[1] underwent electroconvulsive therapy (**ECT**) to treat her deteriorating mental state. Subsequently, Sunshine Aged Persons Medical Unit staff identified that Mrs Berg was likely to be suffering aspiration pneumonia. Her physical health deteriorated and continued to deteriorate over coming days despite maximal therapy. Palliative care was provided, and Mrs Berg was declared deceased shortly thereafter. The investigation into Mrs Berg's death predominantly relates to the appropriateness of treating Mrs Berg with ECT in the context of her physical health conditions, her mental health presentation, and compliance with relevant health guidelines and the *Mental Health Act 2014* (Vic) [**Mental Health Act**].

BACKGROUND CIRCUMSTANCES

1. Mrs Berg was 89 years of age at the time of her death. She had a medical history of depression, atrial fibrillation, acute myocardial infarction (in 2015), stable chronic renal failure and type 2 diabetes. Mrs Berg's son Peter Berg (**Peter**) stated that, in 2005, his mother was an inpatient at a Ballarat facility due to a decline in her mental health which he termed a "breakdown". Mrs Berg had a possible history of schizophrenia; however, this was unconfirmed.[2] Prior to the events leading to Mrs Berg's death, she had been treated with ECT while under the care of Ballarat Aged Persons Mental Health Service. On 3 October 2015, Peter was appointed as her enduring Power of Attorney for all

[1] Sunshine Aged Persons Mental Health Unit is a service within North Western Mental Health.
[2] Case closure documentation from Ballarat Aged Persons Mental Health Service in 2009 did not mention a history of schizophrenia or other psychotic illness.

personal and financial matters. She had been living with Peter for approximately six months prior to her final admission to hospital. Peter noticed a further deterioration in Mrs Berg's mental health after she suffered a stroke in early 2016.

2. On 15 October 2016, Peter took Mrs Berg to the Werribee Mercy Hospital Emergency Department (**ED**) on the advice of her General Practitioner (**GP**). She was suffering urinary frequency, nausea, confusion, auditory and tactile hallucinations, and paranoid ideation. Mrs Berg had refused to eat for the past three days and had only consumed a small amount of fluids. She was diagnosed with a urinary tract infection and psychosis and was admitted to a medical ward. Later that day, medical ward staff concluded that Mrs Berg was also delirious and dehydrated. While in hospital, she developed and was treated for, aspiration pneumonia.

3. Throughout Mrs Berg's admission, she continued to express fears that her son and the hospital staff were trying to kill her. She refused to eat at various times due to fears that her food was poisoned. She also reported: snakes in her bed, that she had murdered her husband, that she was scheduled to be hanged and that she was in the police headquarters.

4. On 6 December 2016, Mrs Berg was reviewed by psychiatrist Dr Ravi Srinivasaju. During this review, Mrs Berg reported fears that her son would kill her, presented with a restricted range of affect,[3] but was not markedly depressed. She indicated that she had received ECT in the past and that she did not wish to do so again. Dr Srinivasaju documented an impression of "ongoing paranoid psychosis" with a differential diagnosis of "severe depression with psychosis". He documented a plan to transfer Mrs Berg to SAPMHU as a voluntary patient and to consider ECT if her psychosis or depression worsened.

SURROUNDING CIRCUMSTANCES

5. On 9 December 2016, Mrs Berg was transferred to SAPMHU. She was made subject to an Assessment Order under the *Mental Health Act* at 2.40pm due to paranoid ideation and consequent refusal to eat and drink. She was made subject to a Temporary Treatment Order under the *Mental Health Act* at 3.00pm.

[3] "Affect" is used in the study of psychology and psychiatry to describe the way an individual expresses emotion to others.

6. On 11 December 2016, Mrs Berg was transferred to a medical ward at Sunshine Hospital with dehydration and acute kidney injury due to reduced oral intake. Mrs Berg's immediate treatment included: delivery of intravenous fluids, withholding medication known to impair kidney function, and provision of further blood and urine tests.

7. On 12 December 2016, the consultant liaison (**CL**) psychiatry team reviewed Mrs Berg. They concluded that she: had a guarded mental state, was dismissive of her symptoms, was ambivalent about her oral intake, and continued to express concerns that her food was being poisoned. At that point, the team considered the need for ECT remained uncertain and elected to continue with oral psychotropic medication. A food chart to track Mrs Berg's oral intake was requested. The medical team also reviewed Mrs Berg. They noted her renal function was improving but continued intravenous fluid therapy.

8. On 13 December 2016 at 12.30pm, the CL psychiatry team reviewed Mrs Berg; she had declined an earlier review. The team noted that Mrs Berg appeared sedated and that she had made a slight improvement in her oral intake. The team requested continuing observation and documentation of her oral intake; they noted, once again, that ECT may be required if improvement did not continue. Mrs Berg's oral medication doses were not altered.

9. At approximately 5.30pm, the medical officer and medical registrar reviewed Mrs Berg. Her vital signs were normal other than her oxygen saturation which was 85%. This reading was re-checked and found to have normalised (94%). Mrs Berg's breathing was normal, and her chest was clear upon limited examination. During the review, it was noted that Mrs Berg was refusing to engage with the medical team. Her oral olanzapine dose was halved after consultation with the CL psychiatry team.

10. On 14 December 2016, Mrs Berg refused oral intake. The CL psychiatry team reviewed Mrs Berg and noted that she had been drowsy, stayed in bed, pulled out her intravenous cannula, refused to open her eyes or to respond to staff and refused all medications during the previous 24 hours. Her vital signs had been normal. During the review, Mrs Berg refused to open her eyes. At one point she opened her eyes briefly and swore at the doctor. The treating team concluded that Mrs Berg's mental state had worsened, as she was refusing to engage, refusing medications and refusing oral intake. The

psychiatry team requested an anaesthetic review as they considered that Mrs Berg may need ECT.

11. Nursing notes also indicated that Mrs Berg was capable of opening her eyes but was refusing to do so. Mrs Berg's vital signs and blood glucose levels were normal and nursing records confirmed that Mrs Berg had refused all oral intake and medications and had not passed urine.

12. On 15 December 2016, Mrs Berg's heart rate became elevated to 110 beats per minute. This occurred in the setting of Mrs Berg not having taken her heart related medications over the preceding days.

Preparation for ECT

13. On 15 December 2016, the CL psychiatry team had a long meeting with Peter wherein he described his mother's premorbid state in detail. The team updated Peter on Mrs Berg's current condition, including that she was refusing oral intake, nursing care, medications and that her mental state and physical health were deteriorating. They recommended ECT and Peter agreed to the treatment. The team explained the ECT procedure, the expected benefits, and the need to involve the Mental Health Tribunal (**MHT**) as Mrs Berg was a compulsory patient under the *Mental Health Act*.

14. An anaesthetist reviewed Mrs Berg. The review is not dated but appears to have been conducted the day prior to ECT, as recommendations for medication administration prior to ECT were made. The anaesthetist recorded Mrs Berg's: medical history; current medications (including those that had not been taken); change from oral treatment for diabetes to a sliding scale of insulin (in view of refusal of oral medications); history of ECT (and requested records from Ballarat Health regarding this); improving renal function (creatinine levels decreasing from 214 to 178, 141 and 126 umol/L); normal electrolyte values and full blood examination. Mrs Berg had a normal temperature and some coarse crackles in her chest on examination.[4]

15. The anaesthetist called Mrs Berg's son and informed him of her condition, the risks posed by her physical condition, and the risks of drug reaction and aspiration. The anaesthetist prescribed intravenous diuretics and oral medications prior to ECT.

[4] Western Health digital medical record review note by unknown anaesthetist.

16. On 15 December 2016, Mrs Berg attended the MHT for a decision regarding ECT as a compulsory patient. The MHT determined that ECT ought to proceed and nine treatments were directed.

17. On 16 December 2016, the anaesthetist assessed Mrs Berg once more prior to commencing ECT. Her heart rate was elevated at 130 beats per minute. The anaesthetist documented a consultation with the anaesthetic consultant who suggested administering intravenous medication to control Mrs Berg's heart rate. Two drugs were administered to Mrs Berg in small, incremental doses and her heart rate declined to 110 beats per minute. A pre-procedure chest X-ray was not completed.

18. Mrs Berg underwent ECT without any reported complications. Mrs Berg's oxygen saturations were 99-100% throughout anaesthetic sedation and remained so after she was taken to the recovery room.

Post-ECT

19. Mrs Berg did not experience any immediate post-ECT complications. At 3.30pm, a chest X-ray was completed which showed bilateral opacities suggestive of pneumonia.

20. Later the same evening, Mrs Berg's physical health deteriorated, and a Medical Emergency Team (**MET**) call[5] was initiated at 11.11pm. She received further reviews by the medical registrar at 1.15am, 3.00am and 9.00am the following morning. Mrs Berg was suspected to have aspiration pneumonia. An advance care directive was in place with directions for ward, rather than intensive care management. Maximal therapy was provided, including the administration of intravenous antibiotics and medications to control her heart rate, however, Mrs Berg's physical health continued to deteriorate.

21. On 19 December 2016, the medical team reviewed Mrs Berg and cancelled the ECT that had been scheduled for that day. Her Temporary Treatment Order was also revoked. The medical team had several discussions with Peter and conveyed that his mother's condition had deteriorated. They recommended that if there were no improvement in the next 24 hours, palliative care should be commenced.

[5] A Medical Emergency Team (MET) call is a hospital-based system designed for hospital staff to gain a rapid response by medical staff in response to clinical signs of physical health deterioration.

The psychiatry team also spoke with Peter and he consented to a plan for 24 hours of further active treatment and palliative care if her condition did not improve.

22. At 7.30pm on 19 December 2016, Mrs Berg was unresponsive and not breathing; she was declared deceased at 7.44pm.

JURISDICTION

23. Mrs Berg's death was reported[6] because her death occurred in Victoria and occurred '*following a medical procedure*...(and) *may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death.*'[7]

24. Furthermore, Mrs Berg was a compulsory inpatient and 'in care' immediately before her death pursuant to section 3 of the Coroners Act 2008 (Vic) [the Act]. A death which occurs in these circumstances is reportable to the Coroner.[8]

25. Section 52(2)(b) of the Act mandates the holding of an inquest into a death if the death or cause of death occurred in Victoria and the deceased person was, immediately before death, a person placed in care.[9] A Coroner is not required to hold an inquest into a death which occurred in the circumstances set out above if they consider that the death was due to natural causes.[10]

PURPOSE OF THE CORONIAL INVESTIGATION

26. The Coroners Court of Victoria is an inquisitorial jurisdiction.[11] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[12] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and

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[6] Mrs Berg's death was reported by Sunshine Hospital staff via an electronic medical deposition form dated 19 December 2016.
[7] *Coroners Act 2008* (Vic) s 4.
[8] Ibid s 4(b)(ii).
[9] This provision also mandates the holding of an inquest where the death or cause of death occurred in Victoria and a Coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody, or if the identity of the deceased is unknown.
[10] Ibid s 52(3A).
[11] Ibid s 89(4).
[12] Ibid s 67(1).

surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death. [13]

27. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the 'prevention' role.[14] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and 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.[15] These are effectively the vehicles by which the prevention role may be advanced.[16]

28. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

STANDARD OF PROOF

29. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in Briginshaw v Briginshaw. [17] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

- the nature and consequence of the facts to be proved;
- the seriousness of any allegations made;
- the inherent unlikelihood of the occurrence alleged;
- the gravity of the consequences flowing from an adverse finding; and

[13] See for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).
[14] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.
[15] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.
[16] See also sections 73(1) and 72(5) of the Act which requires publication of Coronial Findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a Coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.
[17] (1938) 60 CLR 336.

- if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

30. The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

INVESTIGATIONS PRECEDING THE INQUEST

Identity

31. On 19 December 2016, Peter Frederick Berg completed a statement of identification for his mother Hilda Joan Berg. On 20 December 2016, Coroner Peter White completed a Form 8 *Determination by Coroner of Identity of Deceased* pursuant to the *Coroners Court Rules 2009 (Vic)* rule 32.

32. The identity of Hilda Joan Berg is not in dispute and requires no further investigation.

Medical Cause of Death

Post Mortem Examination

33. Dr Mathew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), performed an external examination upon the body of Hilda Joan Berg, reviewed a post mortem computed tomography (**CT**) scan, referred to the electronic medical deposition form and to the Victoria Police Report of Death, Form 83. Dr Lynch commented that CT scanning identified calcific coronary artery disease, mitral valve annulus calcification and increased lung markings. He reported that the results of the examination were consistent with Mrs Berg's known clinical history.

Forensic pathology opinion

34. Dr Lynch ascribed the medical cause of Mrs Berg's death to aspiration pneumonia complicating electroconvulsive therapy for treatment of psychotic depression.

Coronial Brief

35. Constable James Johnston was the Victoria Police Coronial Investigator assisting me in my investigation into the death of Hilda Joan Berg. I directed Constable Johnston to provide me with a full coronial brief in this matter, including:

a. Details of clinicians involved in Mrs Berg's mental ill-health treatment, recent diagnosis and ECT treatment;

b. Details of Mrs Berg's most recent admissions to hospital;

c. Details of the reasons for Mrs Berg's Temporary Treatment Order made under the *Mental Health Act*;

d. Details of Mrs Berg's ECT treatment, and

e. Statement(s) from Mrs Berg's family or friends regarding her background.

36. Constable Johnston requested information from health services on a number of occasions but was ultimately only able to collate statements from Mercy Health geriatrician Dr Linda Appiah and Mrs Berg's son Peter, in addition to his own statement. After discussion with the Police Coronial Support Unit, Constable Johnston was advised to provide the brief as it was for further direction from me.

37. Peter's statement delineated Mrs Berg's background and provided information about her medical history. Dr Appiah's statement provided a summary of Mrs Berg's admission to the Mercy Hospital in Werribee between 15 October 2016 and 9 December 2016; it did not canvass Mrs Berg's admission to Sunshine Hospital Aged Persons Mental Health Unit and subsequent management of her physical and mental health. My investigator's statement served to document his attendance at the hospital after Mrs Berg's death and that he had ruled out any suspicious circumstances. Upon review of the statements, I determined that the brief did not fully address my requests for material nor adequately address the relevant issues in this matter. I determined that further information would be requested directly by the Court, in an effort to stem any further delays.

Coroners Prevention Unit

38. I subsequently requested that the Coroners Prevention Unit (**CPU**)[18] review the circumstances of Mrs Berg's death. Specifically, I requested a review of the decision to treat Mrs Berg with ECT based on her mental health presentation and compliance with

[18] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

the *Mental Health Act*. I also requested that the CPU consider whether it was appropriate to treat Mrs Berg with ECT in the context of her physical health conditions.

39. In completing their review, the CPU examined the coronial file and brief of evidence. At my direction, the CPU also obtained Mrs Berg's Mercy Health medical records and Mrs Berg's Western Health medical records.

Psychiatric management regarding ECT

Appropriateness of ECT with regard to Mrs Berg's mental state

40. The Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) clinical psychiatry guidelines *on the administration of electroconvulsive therapy* ("the guidelines"), [19] state that the primary indication for ECT is major depression, especially with melancholia, psychotic features and/or suicide risk. Mrs Berg was experiencing depression with psychosis, and while she was not considered to be at risk of suicide, she was at risk of harm to herself by restricting her oral intake. The guidelines state that ECT may be particularly appropriate treatment of the elderly given the increased incidence of psychomotor changes and psychotic features in old age depression, and potential difficulty tolerating antidepressant medication.

41. The *Mental Health Act* states that:

> *An authorised psychiatrist may make an application to the Tribunal to perform a course of ECT on a patient who is not a young person if:*
>
> *a) the patient does not have capacity to give informed consent to the performance of a course of ECT on himself or herself and;*
>
> *b) the authorised psychiatrist is satisfied in the circumstances that there is no less restrictive way for the patient to be treated.*[20]

Requirements of ECT as a compulsory patient

42. In determining whether there is no less restrictive way for a patient to be treated, section 93(2) of the *Mental Health Act* states that the authorised psychiatrist must, to the extent that is reasonable in the circumstances, have regard to all of the following:

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[19] Weiss, Hussain, Ng et al., 'Professional Practice Guidelines for the Administration of Electroconvulsive Therapy' (2019) 53 *Australian and New Zealand Journal of Psychiatry* 609-623.
[20] *Mental Health Act 2014* (Vic) s 93(1).

a) *the views and preferences of the patient in relation to ECT and any beneficial alternative treatments that are reasonably available and the reasons for those views or preferences, including any recovery outcomes the patient would like to achieve;*

b) *the views and preferences of the patient expressed in his or her advance statement;*

c) *the views of the patient's nominated person;*

d) *the views of a guardian of the patient;*

e) *the views of a carer of the patient, if authorised psychiatrist is satisfied that the decision to perform a course of ECT will directly affect the carer and the care relationship;*

f) *the likely consequences for the patient if the ECT is not performed;*

g) *any second psychiatric opinion that has been obtained by the patient and given to the psychiatrist.*[21]

43. The guidelines state that the specialist psychiatrist may decide to proceed with ECT without the consent of the patient in certain emergency situations. An "emergency situation" may include an illness causing serious risk to the patient or others (including seriously impairing self-care). In such situations, ECT is deemed the most appropriate treatment. If the patient is of compulsory status under the *Mental Health Act*, the psychiatrist should involve the family in the decision-making process and seek the opinion of at least one other senior colleague.

44. Mrs Berg was asked about her views and she expressed a preference not to receive ECT, however her reasons for this preference were unclear. On 15 December 2016, psychiatrist Dr Kusuma contacted Peter and discussed the option of ECT. Peter was advised of his mother's refusal of oral intake and nursing care, the concerns for her deteriorating physical and mental health, the process of ECT and its anticipated benefits. Peter agreed to the procedure on his mother's behalf. He was initially concerned about the need to involve the MHT given he had medical Power of Attorney, however no further concerns appear to have been raised after the requirements for

[21] Above n 16 s 93(2).

compulsory ECT under the *Mental Health Act* were explained. There is no evidence in the medical record of a nominated person[22] or an advance statement.[23]

45. There was evidence in the medical records of reviews by three consultant psychiatrists: Dr Ravi Srinivasaju, Dr Louise Kerr and Dr Cathrin Kusuma. On 6 December 2016, Dr Srinivasaju documented that ECT should be considered if Mrs Berg's mental state worsened.[24] On 9 December 2016, Dr Kerr documented that ECT '*was to be considered*'.[25] On 12 December 2016, Dr Kusuma reviewed Mrs Berg with psychiatry registrar Dr Boyd. Dr Boyd documented that the need for ECT was unclear at that time.[26] On 14 December 2016, Dr Kusuma reviewed Mrs Berg with an unknown psychiatry registrar. The psychiatry registrar documented that Mrs Berg may need ECT and requested an anaesthetic review.[27] On 15 December 2016 Dr Kusuma reviewed Mrs Berg with psychiatry registrar Dr Boyd. Dr Boyd documented a plan to apply to the MHT to administer ECT to Mrs Berg as a compulsory patient.[28]

46. The only evidence in the medical record of a consultant psychiatrist documenting a definitive need for Mrs Berg to receive ECT was the documentation by Dr Boyd of Dr Kusuma's review on 15 December 2016. Neither Dr Srinivasaju nor Dr Kerr documented a definite need for Mrs Berg to have ECT. While Mrs Berg was reviewed by psychiatric registrars on several occasions, the RANZCP guidelines specify that the psychiatrist seek the opinion of a senior colleague. There was no documentation in the medical record indicating that a second opinion regarding ECT was completed.

47. The decision by the MHT to grant an Electroconvulsive Treatment Order is based on the legislative requirements of the *Mental Health Act.* That Act does not consider the patient's medical fitness for ECT. The MHT consists of three Tribunal members; a

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[22] Section 24 of the *Mental Health Act* states that a person may nominate another person to be a nominated person for himself or herself. Section 23 of the *Mental Health Act* states that the role of a nominated person is-- (a) to provide the patient with support and to help represent the interests of the patient; and (b) to receive information about the patient in accordance with this Act; and (c) to be one of the persons who must be consulted in accordance with this Act about the patient's treatment; and (d) to assist the patient to exercise any right that the patient has under this Act.

[23] According to section 19 of the *Mental Health Act*, an advance statement is a document that sets out a person's preferences in relation to treatment in the event that a person becomes a patient.

[24] Mercy Health medical record, second admission, progress note by Dr Srinivasaju dated 6 December 2016.

[25] Western Health digital medical record progress note by Dr Kerr dated 9 December 2016, page 267 of 351.

[26] Ibid by Dr Kusuma dated 12 December 2016, page 114 of 351.

[27] Ibid by unknown psychiatry registrar dated 14 December 2016, page 121 of 351.

[28] Ibid by Dr Kusuma dated 15 December 2016, page 127 of 351.

legal member, a psychiatrist or registered medical practitioner member[29] and a community member. There is no requirement for the MHT to include a medical professional who can provide an appropriate assessment of the patient's medical fitness for ECT. While a review by an anaesthetist is required prior to commencing ECT, this is not required to be completed prior to the MHT decision to grant an Electroconvulsive Treatment Order. As such, at the time of granting an Electroconvulsive Treatment Order, the MHT may not be aware of the patient's medical fitness for ECT.

Medical management regarding ECT

48. On 11 December 2016, Mrs Berg was admitted to the general medical ward at Sunshine Hospital due to decreased oral intake, dehydration and acute kidney injury. Although she was 89 years old and had several medical co-morbidities, at this point, her condition was considered reversible and appeared related to a mental illness. It was therefore appropriate to attempt to reverse the dehydration and acute kidney injury with intravenous fluids.

49. The psychiatry and medical teams reviewed Mrs Berg daily. After an initial mild improvement, the psychiatry team determined that her mental state was deteriorating, and her refusal of food and oral medications was threatening her life. This was evident as her refusal to take her medication, together with dehydration, had resulted in uncontrolled atrial fibrillation. The teams decided to proceed with ECT to attempt to address the mental illness.

50. Prior to commencing ECT treatment, the anaesthetist conducted a thorough assessment and considered it safe to proceed in the circumstances. Medications were administered before and during the anaesthetic to address the medical issues associated with elevated heart rate. There was no evidence of obvious aspiration during the anaesthetic.

51. Mrs Berg's condition deteriorated following ECT despite maximal therapy to treat atrial fibrillation and the pneumonia that had developed. Of note, although aspiration was considered the likely cause of the pneumonia, changes of pneumonia were only evident on the X-ray performed several hours after the ECT; it is possible these changes were present and evolving prior to the anaesthetic.

[29] A registered medical practitioner member must have knowledge of, and experience in relation to, the treatment of mental illness.

Further Investigation

52. In light of the outcome of the CPU review, I requested additional information from North Western Mental Health Service (**NWMHS**) to clarify whether a second opinion by a senior psychiatrist was sought in relation to the administration of ECT to Mrs Berg. If NWMHS considered that a second opinion was obtained, I requested provision of supporting documentation for the initial and secondary consultations.

53. Director of Clinical Services NWMHS Aged Persons Mental Health Program Dr Brett Coulson provided a statement on behalf of North Western Mental Health. Attached to his statement, Dr Coulson provided:

    a) the MHT 6 Electroconvulsive Treatment Report – Adult Patients form, completed by Dr Simon Boyd dated 15 December 2016, and

    b) the Determination Regarding ECT Application (Adult Patient) form, dated 15 December 2016 in which the MHT approved nine ECT treatments over the next three weeks.

54. Dr Coulson stated that Mrs Berg was seen by:

    a) The Werribee Mercy consultation liaison psychiatry service at Werribee Mercy Hospital and it was documented that she had psychotic depression and "probably" needed ECT;

    b) SAPMHU consultant psychiatrist Dr Louise Kerr and she documented that ECT was likely to be required, and

    c) Dr Catherin Kusuma who documented a need for ECT, requested an anaesthetics review and an urgent MHT hearing.

55. Dr Coulson believed that the requirements of the RANZCP guidelines were satisfied as three different psychiatrists[30] had considered ECT treatment necessary and approval for compulsory ECT from the MHT was obtained. The medical record does document reviews by three consultant psychiatrists. However, only the final review (by Dr Catherin Kusuma on 15 December 2016) indicated a definite need for ECT. Previous reviews indicated that psychiatrists were aiming for conservative management

[30] Dr Coulson's statement refers to Dr Kerr's review and Dr Kusuma's review. It is unclear whether the third psychiatrist that Dr Coulson was referring to was the clinician from the Werribee Mercy CL psychiatry service (though Dr Coulson initially did not specify whether this person was a psychiatrist) or psychiatric registrar Dr Boyd, who reviewed Ms Berg with Dr Kusuma.

of Mrs Berg before re-considering ECT treatment. The MHT 6 *Electroconvulsive Treatment Report – Adult Patients* stated that a second opinion had not been obtained, but it was noted that two psychiatrists, (Dr Louise Kerr and Dr Catherin Kusuma), were '*concordant with a diagnosis of psychotic depression and likely need for ECT if her physical health deteriorated further*'. There was no reference in the medical record to any of these reviews being a second opinion.

56. In April 2019, RANZCP published new Professional Practice Guidelines to provide practical guidance for psychiatrists prescribing and administering ECT.[31] With regard to a second opinion for compulsory patients being treated with ECT, the new guidelines state:

a) In patients where the medical risk of ECT is increased, which included those with other severe medical conditions, a second opinion should be obtained from a psychiatrist experienced in ECT practice, as well as from anaesthetist and other relevant specialists. There should be a specific plan documented by the psychiatrist to address the management of medical comorbidity during ECT, which may include appropriate specialist medical support.[32]

b) Older people are likely to have more medical comorbidities and are at possible increased risk of delirium during a course of ECT. Health issues such as frailty, ischaemic heart disease, hypertension, stroke, hyperkalaemia and anticoagulant use should be considered and managed, and appropriate specialist consultation, if required, should be sought. The guidelines do not indicate a routine need for a second opinion when providing ECT to older people.

c) For patients who are unable to consent to ECT and/or are compulsory patients, psychiatrists must comply with local and national legislation in relation to ECT. The guideline does not indicate a routine need for a second opinion when providing ECT to compulsory patients.[33]

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[31] Above n 17.

[32] Verbal was advice sought from the CPU who advised that acute kidney disease on the background of chronic kidney disease (as Ms Berg was documented to have been admitted for) would be considered a serious medical condition.

[33] The guideline also makes recommendations about obtaining a second opinion in situations that are not relevant to the circumstances of Mrs Berg's death (i.e. when considering ECT for child or adolescent patients).

COMMENTS

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

1. Mrs Berg's treating teams were faced with the difficult decision of whether to compulsorily treat a patient who was deteriorating physically from a mental illness; whilst treating her with an anaesthetic and ECT was not without risk, the alternative was to provide palliative care in circumstances where their patient was refusing to eat or drink due to her mental illness.

2. My investigation has identified that the decision to apply to the Tribunal to perform a course of ECT on Mrs Berg as a compulsory patient was appropriate in light of: Mrs Berg's clinical presentation, relevant provisions of the *Mental Health Act*, and the RANZCP guidelines. There was also evidence that the views of Mrs Berg's Power of Attorney were appropriately sought and considered.

3. Mrs Berg had expressed fears that hospital staff were trying to kill her and therefore her ability to consent to treatment was impaired. Due to Mrs Berg's age, medical comorbidities and refusal of oral intake, she required a higher level of observation and care while receiving ECT than could be provided in a less restrictive environment.

4. Contemporaneous RANZCP guidelines stated that the treating psychiatrist ought to seek a second opinion from at least one other senior colleague prior to proceeding with ECT. While Mrs Berg's medical record included reviews by three consultant psychiatrists, only one of these reviews indicated a definite need for ECT. There was no reference in the medical record to a second opinion; my investigation has identified that one was never sought. However, the guidelines exist to facilitate best practice and are not instructions on what must be done. Additionally, the guidelines in place at the time of Ms Berg's death were significantly outdated and have since been amended.

5. Mrs Berg did not have a chest X-ray prior to the ECT procedure. She did have medical reviews with the anaesthetist the day prior and immediately prior to the procedure and she was deemed fit to undergo ECT. However, it is not possible to determine whether a pre-procedural X-ray would have detected any changes that may have delayed or stopped the ECT procedure.

INQUEST

1. The material obtained during the course of my investigation has obviated the need to hear from any witnesses. I note that Mrs Berg's family have not raised any specific concerns to the Court. However, the investigation has identified that Mrs Berg's death was not due to natural causes; an Inquest into the death of Hilda Joan Berg is mandated pursuant to section 52 of the *Coroners Act 2008* (Vic). As such, I deemed it appropriate to hold a Summary Inquest into the death of Hilda Joan Berg on 11 November 2019.
2. On 5 September 2019, written notice of the Summary Inquest was sent to Peter Berg, NorthWestern Mental Health Director of Operations Peter Kelly, and Dr Coulson. I did not receive a response from the NorthWestern Mental Health Service in relation to their attendance at the Summary Inquest. Consequently, I sought clarification and was informed that the health service did not intend to appear at the Hearing but requested that my Findings be provided to them and to their legal counsel.

FINDINGS

The investigation has identified that, at the time of her death, Mrs Berg's mental state had significantly deteriorated and she was refusing all oral intake, resulting in substantial deterioration in her physiological health and threatening her life.

On the evidence available to me, I find that the North Western Mental Health Service's overall provision of care to Mrs Berg was reasonable and appropriate, albeit not adherent to the requirement to seek a second psychiatrist's opinion pursuant to the contemporaneous Royal Australian and New Zealand College of Psychiatrists clinical psychiatry guidelines. Additionally, the investigation has identified that Mrs Berg was not provided with a pre-procedural chest X-ray, as she ought to have been.

I am unable to find that rectifying the identified shortcomings in Mrs Berg's medical management would have prevented the provision electroconvulsive therapy to Mrs Berg. Moreover, I am unable to find that rectifying the identified shortcomings would have prevented Mrs Berg's death. In all the circumstances, I make no further adverse comments in relation to the NorthWestern Mental Health Services' provision of care and treatment to Mrs Berg.

I accept and adopt the medical cause of death as ascribed by Dr Mathew Lynch and I find that Hilda Joan Berg died from aspiration pneumonia complicating electroconvulsive therapy for treatment of psychotic depression.

To enable compliance with section 73(1) of the Coroners Act 2008 (Vic), I direct that the Form 37 *Finding into Death with Inquest* of Hilda Joan Berg will be published on the internet.

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

Peter Berg

Dr Brett Coulson, Director of Clinical Services, Aged Persons Mental Health Program (NWMHS)

Peter Kelly, Director of Operations, Melbourne Health (NWMHS)

Jan Moffatt, Legal Counsel for NWMHS

Office of the Chief Psychiatrist

Constable James Johnston

Signature:

AUDREY JAMIESON

CORONER

Date: **11 November 2019**