IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 5479

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Simon McGregor, Coroner
Deceased:	VA
Date of birth:	21 July 1945
Date of death:	30 October 2018
Cause of death:	**1(a) Combined effects of congestive cardiac failure, coronary artery atherosclerosis and cardiomegaly**
Place of death:	Broadmeadows Hospital 25 Johnstone Street, Broadmeadows, Victoria

HIS HONOUR:

THE CORONIAL INVESTIGATION

1. VA was a 73-year-old woman who was an inpatient at the Broadmeadows Aged Persons Mental Health Unit at the time of her death. She was subject to a Temporary Treatment Order under the *Mental Health Act 2014*.

2. VA's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as she met the definition of a '*person placed in custody or care*' due to her Temporary Treatment Order.[1]

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. The Coroner's Investigator, Senior Constable Chloe Guerin, prepared a coronial brief in this matter. The brief includes statements from witnesses, including the forensic pathologist, treating clinicians and the investigating officer.

6. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

7. I have based this finding on these materials. In the coronial jurisdiction facts must be established on the balance of probabilities.[2] Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

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1 *Coroners Act 2008* s 4.

2 This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

8. In considering the issues associated with this finding, I have been mindful of VA's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

9. VA had a long history of mental health issues, including Borderline Personality Disorder and Schizoaffective Disorder. This had led to a number of admissions to inpatient psychiatric services including the Broadmeadows Aged Persons Mental Health Unit (**BAPMHU**) located at Broadmeadows Hospital.[3] She also had a history of pulmonary hypertension, Type 2 diabetes mellitus and congestive cardiac disease.[4]

10. On 12 October 2018 VA presented to the BAPMHU demanding admission and threatening to harm herself if she was not admitted. However, she then asked to leave and requested a taxi voucher to return home. Due to the danger she posed to herself, she was made subject to a Temporary Treatment Order under the *Mental Health Act 2014*.[5]

11. While at the BAPMHU, VA suffered diarrhoea, hypotension and fever. On 15 October she was taken to the Northern Hospital Emergency Department and then transferred to the Intensive Care Unit (**ICU**) due to her hypotension requiring vasopressors.[6]

12. She was diagnosed as suffering from *C. difficile* colitis and given an infusion of metaraminol which was then weaned. She was transferred to a medical ward the next day, 16 October.[7]

13. While on the medical ward she refused to take oral antibiotics for her infection. However, her diarrhoea resolved without this treatment and she was transferred back to the BAPMHU on 23 October, and again made subject to a Temporary Treatment Order.[8]

14. During this admission to the BAPMHU, VA was noted to be dismissive of nursing care, frequently isolating herself in her bedroom and often refusing to have her vital signs taken.[9]

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[3] Mental Health Assessment dated 23 October 2018, Medical Records.
[4] Statement of EN Heather Robertson, Coronial Brief.
[5] Statement of EN Heather Robertson, Coronial Brief; Statement of PSEN Ann Cassell, Coronial Brief.
[6] ICU Admission Summary dated 15 October 2018, Medical Records.
[7] ICU Discharge Summary dated 16 October 2018, Medical Records.
[8] Mental Health Assessment dated 23 October 2018, Medical Records.
[9] Statement of EN Heather Robertson, Coronial Brief; Statement of PSEN Tinny Alexander, Coronial Brief.

15. On the morning of 30 October 2018, VA was reportedly '*up and about, speaking with nurses*' but refused her breakfast.[10]

16. When, later in the day, nurses attempted to convince VA to partake in afternoon tea, she refused their offer of a drink and stated she was dizzy. As she appeared pale, nurses brought her to a treatment room where she was assessed by Dr Jenny Yu.[11]

17. Dr Yu found that VA was unresponsive to a sternal rub and had very cool peripheries, although a carotid pulse was still present initially and she was taking intermittent breaths. She was placed onto an examination bed, but her pulse ceased and Dr Yu could not hear a heartbeat so she called a 'Code Blue' (medical emergency) and began CPR.[12]

18. Despite attendance by other doctors, further CPR and injection of adrenaline, VA did not recover. She was declared deceased at 3.51pm.[13]

Identity of the deceased

19. On 30 October 2018, Father PD visually identified VA, born 21 July 1945.

20. Identity is not in dispute and requires no further investigation.

Medical cause of death

21. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine **(VIFM)**, conducted an autopsy on VA and provided a written report of her findings. Post mortem examination revealed blocked coronary arteries (atherosclerosis) and an enlarged heart (cardiomegaly), among other signs of cardiac illness.

22. Dr Archer concluded that a reasonable cause of death was:

    1(a) Combined effects of congestive cardiac failure, coronary artery atherosclerosis and cardiomegaly

23. Dr Archer noted that VA had recently had *C. difficile* colitis, but that autopsy confirmed the clinical impression that this was resolving.

[10] Statement of Dr Jenny Yu, Coronial Brief.
[11] Statement of Dr Jenny Yu, Coronial Brief.
[12] Statement of Dr Jenny Yu, Coronial Brief.
[13] E-Medical Deposition of Dr Jenny Yu dated 30 October 2018.

24. She formed the opinion, based on the information available to her, that VA's death was due to natural causes.

25. I accept Dr Archer's conclusions as to cause of death.

26. Pursuant to sections 52(3A) and 52(3B) of the Act, I am satisfied that I am not required to hold an inquest into her death.

FINDINGS AND CONCLUSION

27. Pursuant to section 67(1) of the Act I make the following findings;

    (a) the identity of the deceased was VA, born 21 July 1945;

    (b) the death occurred on 30 October 2018 at Broadmeadows Hospital, 25 Johnstone Street, Broadmeadows, Victoria from the combined effects of congestive cardiac failure, coronary artery atherosclerosis and cardiomegaly; and

    (c) the death occurred in the circumstances described above.

28. I convey my sincere condolences to VA's family for their loss.

COMMENTS

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

29. It appears that the medical care provided by the Northern Hospital and the Broadmeadows Aged Persons Mental Health Unit was appropriate, and that the death could not have been prevented.

Pursuant to section 73(1B) of the Act, I direct that this de-identified form of my finding be published on the Internet.

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

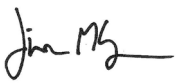
Mr TA, Senior Next of Kin.

Senior Constable Chloe Guerin, Coroner's Investigator.

Mr Peter Kelly, NorthWestern Mental Health.

Dr Neil Coventry, Office of the Chief Psychiatrist.

Signature:



SIMON McGREGOR

CORONER

Date: 6 November 2020

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act