IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003048

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	HJ
Date of birth:	3 February 1945
Date of death:	12 June 2021
Cause of death:	1(a) Undetermined
Place of death:	Western Health, Western Hospital, 160 Gordon Street, Footscray, Victoria, 3011

INTRODUCTION

1. On 12 June 2021, HJ was 76 years old when she died at Footscray Hospital. At the time of her death, HJ lived in Point Cook with her son.

THE CORONIAL INVESTIGATION

2. HJ's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). HJ's death was reportable as she was a person placed in care, being a patient detained in a designated mental health service within the meaning of *Mental Health Act 2014* immediately prior to her death.[1] Deaths of persons in care are reportable to ensure independent scrutiny of the circumstances surrounding their deaths. If such deaths occur as a result of natural causes, a coronial investigation must take place, but the holding of an inquest is not mandatory.

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. This finding draws on the totality of the coronial investigation into the death of HJ, including evidence contained in her medical records from Western Health. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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1 Section 4(2)(c).

2 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.

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

Circumstances in which the death occurred

6. On 24 May 2021, HJ's family contacted emergency services as she had been experiencing abdominal pain, increased vomiting and a poor appetite for several weeks. Ambulance Victoria paramedics attended and transported HJ to Footscray Hospital, where treating clinicians were advised she had not seen a doctor since around 2005.

7. A computed tomography (**CT**) scan on admission revealed a bilateral large adnexal mass and a small bowel obstruction. The results of a pelvic ultrasound suggested a solid mass on the right-hand side and cystic mass on the left. HJ's family expressed concerns that she would "*shut down*" on receipt of a diagnosis and would "*decline all medical help and assistance*" as she was reportedly "*paranoid*" of health care professionals due to historical trauma. The surgical team spoke with HJ in the presence of her children, with the assistance of a Somalian interpreter, at which time HJ was unwilling to engage in conversation and declined a nasogastric tube (**NGT**) to assist with feeding.[3]

8. A psychiatric referral was made to assess HJ's competency and she was reviewed by the clinical psychology team with the assistance of an interpreter on 26 May 2021. She reported several delusional beliefs, including that a previous doctor was trying to kill her in 2018 when she underwent a previous NGT insertion, and that the medical establishment was working for a distant family member who had tried to poison her. HJ also expressed a belief that "*God looks after her and her health is in God's hands*".[4]

9. Her treating clinicians formed the view that she had poor insight into the severity of her medical condition. They determined that if HJ attempted to leave the hospital, they would treat her involuntarily. Arrangements were made for her to undergo a cardiology review and outpatient stress testing to address atrial fibrillation and mildly elevated troponin levels.

10. On 27 May 2021, discussions took place within the general surgical team in relation to HJ's lack of insight into her condition. She was reportedly unable to communicate why she wanted to leave the hospital and her family reported "*worsening erratic behaviour*", including being overly friendly with strangers and giving away her belongings.[5]

[3] e-Medical deposition completed by ICU Registrar Dr David Wang dated 12 June 2021.
[4] e-Medical deposition completed by ICU Registrar Dr David Wang dated 12 June 2021.
[5] e-Medical deposition completed by ICU Registrar Dr David Wang dated 12 June 2021.

11. On 28 May 2021, HJ underwent a further capacity assessment with the assistance of an interpreter and family. The psychiatric registrar and consultant formed the view that HJ did not have decision-making capacity and formed a diagnosis of "*chromic psychotic disorder*" with features of "*systematised belief system with paranoid delusions and likely delusions of reference*".[6]

12. HJ was then made the subject of an Inpatient Temporary Treatment Order (**TTO**) pursuant to the *Mental Health Act 2014* (Vic) of 28 days duration, unless earlier revoked. Having reviewed the medical records, I am satisfied that the Inpatient TTO had not been revoked as at the time of her death.

13. On 2 June 2021, HJ underwent a further CT scan, the results of which indicated bronchiectatic changes, calcified pleural plaque, and evidence of a suspected previous infection with pleural injury. She was commenced on antibiotics Augmentin DF and doxycycline.

14. On 3 June 2021, HJ was intubated to undergo a gastroscopy, which was uneventful. Post-operatively, her treating clinicians were unable to extubate her and she was transferred to the intensive care unit (**ICU**). HJ was commenced on ceftriaxone (a post-operative antibiotic). In the ICU, she experienced type 2 respiratory failure.

15. On 5 June 2021, HJ was successfully extubated but became hypotensive. A central venous catheter was inserted and she was commenced on noradrenaline.

16. On 6 June 2021, HJ's treating clinicians observed she was having difficulty tolerating non-invasive ventilation. She was reviewed by the surgical team, who concluded that she was not suitable for surgical management due to her poor tolerance of gastroscopy.

17. On 10 June 2021, HJ was commenced on a palliative pathway in ICU and measures were implemented for her comfort. She was subsequently pronounced deceased at 4.30am on 12 June 2021.

Identity of the deceased

18. HJ's identity and date of birth was confirmed by visual identification on 12 June 2021.

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

[6] e-Medical deposition completed by ICU Registrar Dr David Wang dated 12 June 2021.

Medical cause of death

20. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 14 June 2021 and provided a written report of his findings dated 17 June 2021.

21. Dr Lynch reviewed a post-mortem CT scan, which revealed bilateral pleural effusions, evidence of bronchiectasis, a large fibroid uterus, left adnexal mass, but no evidence of ascites or omental modules indicative of metastatic ovarian cancer. Dr Lynch did not observe any evidence of metastatic disease within the chest or abdomen.

22. Dr Lynch suggested that in order to identify the primary site of malignancy, an autopsy would be required. HJ's family indicated they were satisfied if an internal examination did occur.

23. Toxicological analysis of post-mortem samples identified the presence of hydroxyrisperidone, olanzapine, and ondansetron. These medications are consistent with the treatment HJ received in hospital.

24. Dr Lynch provided an opinion that the medical cause of death was 1(a) Undetermined. Despite being unable to identify a definitive cause of HJ's death, Dr Lynch considered that her death was due to natural causes.

25. I accept Dr Lynch's opinion.

FAMILY CONCERNS

26. While speaking with Coronial Admissions and Enquiries, HJ's son expressed concerns surrounding the appropriateness of her undergoing surgery in light of her condition. They also raised concerns regarding physical restraints and verbal abuse directed at HJ while in hospital.

27. HJ's family were encouraged to submit their concerns in writing but no such correspondence was received by the Court. I note that the family have not raised further concerns since being advised that the matter would be closed by way of findings without holding an inquest.

REVIEW OF CARE

28. Having reviewed HJ's medical records, I have not identified any evidence of inappropriate use of physical restraint or abuse directed towards HJ by hospital staff. It is clear that HJ experienced ongoing agitation and confusion associated with her psychosis, which medical

staff considered required the use of soft restraints for her safety. Due to the use of physical restraints, HJ appropriately underwent regular skin assessments.

29. With respect to the gastroscopy on 3 June 2021, I am satisfied that HJ's treating clinicians had no reason to suspect complications following the procedure. I am also satisfied that the procedure was necessary, in circumstances where the results of the CT and ultrasound warranted further investigation and her treating clinicians did not have available to them HJ's complete medical history.

30. Having reviewed all the available evidence, I am satisfied that the care HJ received at Footscray Hospital was reasonable and appropriate, in the context of her lack of insight into the severity of her condition. I have not identified any opportunities for prevention in connection with HJ's death and am therefore satisfied that no further investigation is required.

31. As noted above, HJ's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before her death, she was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that HJ died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an inquest into her death.

FINDINGS AND CONCLUSION

32. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was HJ, born 3 February 1945;

    b) the death occurred on 12 June 2021 at Western Health, Western Hospital, 160 Gordon Street, Footscray, Victoria, 3011, from undetermined causes; and

    c) the death occurred in the circumstances described above.

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

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Senior Next of Kin

Narelle Watson, Western Health

Constable Michael Rinvenuto, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 17 November 2021

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.