IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2017 005806

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of: KATHLEEN MARY SAVAGE

Findings of:	AUDREY JAMIESON, Coroner
Delivered on:	15 March 2024
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria 3006
Hearing dates:	15 March 2024
Representation:	No representation
Counsel assisting the Coroner:	Ms Anna Pejnovic of the Coroners Court of Victoria
Catchwords:	Disability services; person in care; natural causes; pulmonary thromboembolism; deep vein thrombosis

I, AUDREY JAMIESON, Coroner, having investigated the death of KATHLEEN MARY SAVAGE

AND having held a Summary Inquest in relation to this death on 15 March 2024

at the Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria 3006

find that the identity of the deceased was KATHLEEN MARY SAVAGE

born on 11 December 1949

died on 16 November 2017

at Alexandra District Health, 20 Cooper Street, Alexandra, Victoria, 3714

from:

1 (a) PULMONARY THROMBOEMBOLISM
1 (b) DEEP VEIN THROMBOSIS OF THE LEFT LEG

in the following summary circumstances:

Kathleen Mary Savage, aged 67 years, was discharged from Alexandra District Health (**ADH**) following a 13-day admission for constipation and sepsis. She collapsed as she was walking from her hospital room and died soon after of pulmonary thromboembolism and deep vein thrombosis (**DVT**). Kathleen had significant disabilities and relied on assistance for all aspects of daily living, and at the time of her death was in the care of the Secretary to the then Department of Health and Human Services[1].

BACKGROUND CIRCUMSTANCES

1. Kathleen was born with profound disabilities, later diagnosed as an underdeveloped central nervous system.[2] She also had epilepsy, which was well managed.

2. Kathleen lived at home with her parents until 1974, when her father passed away. She was 25 years old. As her care needs were too high for her mother to manage alone, the decision was made to move her to supported accommodation.[3]

[1] As of 1 February 2021, the Department of Health and Human Services was separated into two new departments: the Department of Health and the Department of Families, Fairness and Housing.
[2] Coronial Brief (**CB**), Statement of Sydney Savage, dated 20 December 2017.
[3] Ibid.

3. In 1974, Kathleen moved to the Beechworth Psychiatric Hospital, known as Mayday Hills. Her brother, Sydney, described Mayday Hills as a 'terrible place, where she was always heavily sedated'.[4] In 1985, Kathleen moved to a group home in Alexandra where she lived for 27 years.

4. In 2012, she moved to the group home in McKenzie Street, Alexandra ("McKenzie Street"), where she lived with five other residents. For over 30 years, Kathleen was also supported by Menzies Support Services, a day service in Alexandra.

5. Kathleen required assistance for all aspects of daily living. She was not toilet trained and was unable to communicate verbally. According to her Behaviour Support Plan, she communicated using a 'personal communication dictionary covering sounds/actions' and by pointing and leading staff by the hand. When she was frustrated or unwell, she would hit and kick walls.

6. Sydney described Kathleen as 'a very awkward person to care for' but stated that the care she received at McKenzie Street was wonderful, and that her carers at both McKenzie Street and Menzies Support Services were 'wonderful people'.[5]

7. Kathleen is remembered as an affectionate, bubbly woman with a mischievous nature. She enjoyed music from the 1950s and 1960s, relaxing in the spa, watching television, going for drives to local outdoor areas, swimming and going out for tea and cake. Her favourite foods included cheese and chocolate.

SURROUNDING CIRCUMSTANCES

8. On 2 November 2017, Kathleen did not eat her dinner, was unable to stand independently and her mood was unusually subdued. McKenzie Street staff sought advice from Kathleen's regular medical clinic who advised overnight monitoring, with checks occurring at 12:30am and 3am.

9. At around 7am on 3 November 2017, McKenzie Street Support Worker Theresa Pichugin entered Kathleen's room. She observed Kathleen to be still in bed, looking very tired with

[4] Ibid.
[5] CB, Statement of Sydney Savage, dated 20 December 2017.

a grey complexion. Ms Pichugin called for an ambulance and Kathleen was transported to ADH.[6]

10. Visiting Medical Officer, General Practitioner **(GP**) Dr Maziar Baghaei admitted Kathleen with a principal diagnosis of constipation and sepsis of unknown origin for which she was treated with intravenous (**IV**) ceftriaxone. Kathleen remained on IV antibiotics for approximately 10 days and responded well.[7]

11. Ms Pichugin visited Kathleen twice during her admission. On the second visit on 15 November 2017, Ms Pichugin noted she 'looked a lot better', though hospital staff informed her that she still had an infection and would not be able to be discharged for 'a couple more days'.[8]

THE CORONIAL INVESTIGATION

Jurisdiction

12. The death of Kathleen Mary Savage was a reportable death under section 4 of the *Coroners Act 2008* (Vic) ("the Act") because it occurred in Victoria and appeared to be unexpected. In addition, immediately before her death Ms Savage was a person placed in custody or care as defined by section 3 of the Act, as she was under the care of the Department of Health and Human Services (**DHHS**).

13. An investigation into Kathleen's death was also conducted under the auspices of the *Disability Services Act 2006* (Vic) ("the Disability Services Act") by the Disability Services Commissioner (**DSC**). DSC investigations have a different scope to that of a coronial investigation, although they can sometimes overlap. The jurisdiction of the DSC provides important oversight of disability services involved in the care of a particularly vulnerable group of persons. The DSC's jurisdiction expands to the services provided to the deceased during their lifetime, whether or not those services are connected with the death. The purpose of the DSC investigation is to identify issues in the services being

[6] CB, Statement of Theresa Pichugin, dated 21 December 2017.
[7] CB, Statement of Dr Maziar Baghaei, dated 20 December 2017.
[8] CB, Statement of Theresa Pichugin, dated 21 December 2017.

investigated and to consider any action that the service provider should take in response to those issues or to otherwise improve the services being investigated.

14. Pursuant to section 7(a) of the Act, a Coroner should liaise with other investigation bodies to avoid unnecessary duplication and expedite the investigation. I have therefore conducted my investigation through a restorative and preventative lens without mirroring the DSC's investigation.[4]

Purpose of a coronial investigation

15. The purpose of a coronial investigation of a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[9]

16. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The circumstances in which death occurred refer to the context or background and surrounding circumstances but are confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[10]

17. The broader purpose of any coronial investigation 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.[11]

18. Coroners are empowered to report to the Attorney-General in relation to 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,

[9] Section 67(1) of the Act.
[10] This is the effect of the authorities – see for example, *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).
[11] The "prevention" role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as "implicit".

including public health or safety or the administration of justice.[12] These powers are effectively the vehicles by which the Coroner's prevention role can be advanced.[13]

19. The Coroners Court of Victoria is an inquisitorial jurisdiction.[14] Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[15]

Inquest into the death of a person in care

20. Pursuant to section 52(3) of the Act, a Coroner must hold an Inquest if a person was a person *who immediately before death* was in the care of the State. However, pursuant to section 52(3A) of the Act, an Inquest is not mandatory as part of the coronial investigation into the death of a person in care, if the Coroner considers the death of a person in care was due to natural causes.

21. The medical cause of Kathleen's death has been ascribed to natural causes. Section 52(3A) of the Act could apply, however, I determined that it is appropriate to hold an Inquest because questions arose during the investigation as to the appropriateness of Kathleen's management at Alexandra District Health.

22. In addition, Coroners have unfettered discretion on whether to hold an Inquest into any death being investigated.[16] Coroners must exercise their discretion on whether or not to hold an Inquest in a manner consistent with the preamble and purposes of the Act. In deciding whether to conduct an Inquest, Coroners should consider factors such as (although not limited to), whether there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process; whether there is a likelihood that an Inquest

[12] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations, respectively.
[13] See also sections 73(1) and 72(5), which requires publication of coronial findings, comments and recommendations and responses respectively; sections 72(3) and 72(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.
[14] Section 89(4) of the Act.
[15] Section 69(1) of the Act. However, a Coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1) of the Act.
[16] See section 52(1) of the Act.

will uncover important systemic defects or risks not already known about and, the likelihood that an Inquest will assist to maintain public confidence in the administration of justice, health services or public agencies.

23. In all the circumstances, it was appropriate to hold an Inquest.

Sources of evidence

24. This Finding is based on the totality of the material produced by the coronial investigation into the death of Kathleen Mary Savage. That is, the Court File and Coronial Brief of evidence compiled by Leading Senior Constable Ian Hamill. I have also had the benefit of reading the *Investigation Report into disability services provided by DHHS and Menzies Support Services to Ms Savage* ("Investigation Report") issued on 1 November 2019 by the DSC.

25. The Brief and the Investigation Report will remain on the Court File, together with the Inquest transcript.[17] In writing this Finding, I do not purport to summarise all the material and evidence but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

Standard of proof

26. 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*[18]. 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;

[17] From the commencement of the Act, that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

[18] *Briginshaw v Briginshaw (1938)* 60 C.L.R. 336 esp. at 362-363: *"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 issues had been proved to the reasonable satisfaction of the tribunal. In such matters, "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…".*

- the seriousness of any allegations made;
- the inherent unlikelihood of the occurrence alleged;
- the gravity of the consequences flowing from an adverse finding; and
- 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.

IMMEDIATE CIRCUMSTANCES OF DEATH

27. At around 12:30pm on 16 November 2017, Dr Baghaei reviewed Kathleen at ADH. Registered Nurse Cassandra Fraser informed Dr Baghaie that Kathleen was able to walk with the supervision of one person and had been sitting in a chair as well as resting in bed. Dr Baghaei approved her discharge back to McKenzie Street.[19]

28. Ms Pichugin received a call from the hospital informing her that Kathleen would be discharged at 2pm that day. Ms Pichugin arrived at the hospital to find Kathleen still in bed. Ms Pichugin and a nurse changed Kathleen's clothing, before Ms Pichugin assisted her to walk out of the hospital.[20]

29. Ms Pichugin described Kathleen as 'a bit wobbly on her feet' and 'a bit grey'. Approximately 10-15 metres from Kathleen's room, she collapsed. Ms Pichugin believed that she had hit her head on the carpet.[21]

30. Nurse Fraser immediately attended upon Kathleen who was lying on her side, making attempts to get up from the floor. Nurse Fraser examined her and noted that she was conscious, her eyes opened spontaneously, and she was restless. There was no evidence of a head strike, lacerations or haematoma and no evidence of any fractures.[22]

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[19] CB, Statement of Cassandra Fraser, dated January 2018.
[20] CB, Statement of Theresa Pichugin, dated 21 December 2017.
[21] Ibid.
[22] CB, Statement of Cassandra Fraser, dated January 2018.

31. Registered Nurse Hayley Wales arrived with a wheelchair and Nurse Fraser and Nurse Wales assisted Kathleen into the chair and returned her to her room. Nurse Fraser observed her to be pale with cold, clammy skin. Kathleen was transferred back to bed with assistance.[23]

32. Nurse Fraser contacted Dr Baghaie, who instructed her to re-admit Kathleen and conduct a full blood screen. Her blood pressure and oxygen saturation levels were low, and she was restless and resistant to oxygen administered by both nasal cannula and oxygen mask.[24]

33. Nurse Fraser noted Kathleen was deteriorating, had stopped resisting and looked 'a little frightened'. She instructed a student nurse to press the emergency bell. Nurse Fraser instructed the attending nurses to get the 'crash trolley' while she reviewed Kathleen's file for her resuscitation statement.[25]

34. The resuscitation statement in Kathleen's care plan was unclear, so Nurse Fraser contacted both Dr Baghaie, requesting his immediate attendance, and Kathleen's next of kin, Sydney.[26] Sydney advised that he did not wish for his sister to be resuscitated, as she had 'already had a terrible life and for her to be further incapacitated would be cruel to her and her carers.'[27]

35. Kathleen's condition deteriorated rapidly. Sadly, she ceased breathing and ceased to have a heartbeat at 2:47pm and was declared deceased.

[23] Ibid.
[24] Ibid.
[25] Ibid.
[26] Ibid.
[27] CB, Statement of Sydney Savage, dated 20 December 2017.

INVESTIGATION PRECEDING THE INQUEST

Identification

36. On 16 November 2017, Kathleen Mary Savage, born 11 December 1949, was visually identified by her brother, Sydney Savage, who completed a Statement of Identification.

37. The identity of Kathleen Mary Savage is not in dispute and requires no further investigation.

Medical cause of death

38. On 20 November 2017, Forensic Pathologist Dr Gregory Ross Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Kathleen Mary Savage.

39. Dr Young reviewed the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, E-Medical Deposition Form from Alexandra District Hospital and medical records of Alexandra District Health and the Myrtle Street Clinic and provided a written report of his findings dated 8 December 2017.

40. At autopsy, Dr Young identified pulmonary thromboemboli throughout both lungs and in the pulmonary trunk. He further identified deep vein thrombosis in the left lower leg. Dr Young explained that pulmonary thromboemboli are dislodged blood clots that pass into the lung's blood circulation, resulting in blockage of the blood vessels in the lungs.

41. Dr Young also noted that the left kidney showed a cortical infarct, possibly due to a septic embolus, and the right kidney showed chronic pyelonephritis. There was no clear source of the sepsis. Chronic findings were seen in the urinary tract and lungs which Dr Young commented may indicate previous infection.

42. There was no evidence of any injuries which may have caused or contributed to the death.

<u>Toxicology</u>

43. Toxicological analysis was not undertaken.

Forensic pathology opinion

44. Dr Young concluded that Kathleen's death was due to natural causes and ascribed the medical cause of death to: 1 (a) pulmonary thromboembolism; 1 (b) deep vein thrombosis of the left leg.

DISABILITY SERVICES COMMISSIONER INVESTIGATION[28]

45. Upon completion of its independent investigation into the disability services provided by DHHS and Menzies Support Services, the Commissioner provided the Court with an Investigation Report[29]. Upon provision of the report, the Commissioner requested that I comply with the conditions for further use and disclosure of the same.

46. As part of its investigation, the DSC considered documents relating to the provision of services to Kathleen, as well as documentation provided by the Court.

47. The DSC found that overall, Kathleen was treated with warmth, care and respect. Staff used appropriate professional tools and strategies to best understand Kathleen's communication style, and DHHS and Menzies Support Service had a constructive and cooperative partnership to the benefit of Kathleen.

48. However, the DSC identified deficiencies in the support provided to Kathleen by DHHS while she was hospitalised, and made the following findings:

    a. DHHS did not provide Kathleen with appropriate support during her hospital admission; and

    b. DHHS did not appropriately inquire into and/or escalate its concerns about the hospital treatment provided to Kathleen.

[28] Disability Services Commissioner, Investigation Report into disability services provided by DHHS and Menzies Support Services to Ms Savage, dated 1 November 2019.
[29] Pursuant to section 132ZB of the Disability Amendment Act.

49. On 8 October 2019, the DSC provided a draft copy of its investigation report, including a draft of the proposed Notice of Advice to DHHS to provide an opportunity to respond.[30]

Finding 1: DHHS did not provide Kathleen with appropriate support during her hospital admission.

50. The DSC advised that the Residential Services Practice Manual (**RSPM**) outlined the expectations of group homes in the event that a resident was hospitalised. This included providing the hospital with comprehensive information about the resident, supporting hospital staff to understand how best to communicate with the resident, and visiting the resident regularly.

51. McKenzie Street staff provided the hospital with a significant amount of information in the form of management plans, summaries and charts. There was however no evidence that DHHS provided the hospital with Kathleen's 'personal communication dictionary'.

52. McKenzie Street staff visited Kathleen on 4, 13, 15 and 16 November 2017. During the 15 November visit, a McKenzie Street staff member showed the nursing staff how to administer Kathleen's medication, though it is unclear why this was necessary on this occasion.

53. At the time of Kathleen's death, the DHHS had a guide 'Hospitalisation of people living in disability supported accommodation services', which stated that group home staff were to 'assist the hospital staff to communicate with the resident and visit regularly to ensure the resident is comfortable'. Noting that McKenzie Street staff did not visit between 5 and 12 November 2017, Kathleen was left at the hospital without visitors for a period of eight days.

[30] Section 132ZF of the Disability Act 2006 (Vic) requires that if a DSC Investigation Report makes an adverse comment on or gives an adverse opinion of an individual or a service provider, at least 14 days before giving the report, the DSC must give a copy of the relevant part of the report to the individual or service provider and give a reasonable opportunity to comment on the adverse comment or opinion.

Finding 2: DHHS did not appropriately inquire into and/or escalate its concerns about the hospital treatment provided to Ms Savage.

54. On 10 July 2019, DSC staff visited McKenzie Street as part of the investigation. A staff member expressed concerns that Alexandra District Health appeared to have a limited understanding of the impact of Kathleen's intellectual disability and complex communication needs, which potentially impacted on the quality of hospital care they received. They did not raise a complaint with the hospital or with the Health Complaints Commissioner.

55. The RSPM notes that if group home staff have any concerns about the hospital care a resident is receiving, they should raise these with DHHS management and consult with the Nurse Unit Manager and the key hospital contact.

56. Although hospital services are outside of the scope of DSC investigations, the DSC's review of Kathleen's hospital progress notes indicated that she remained in bed for 10 days from her admission on 3 November 2017 until her appointment with a physiotherapist on 13 November 2017. On 9 November she was 'restless' and 'rolling from side to side' in bed and on 11 November she was 'turning herself as needed'.

57. The DSC noted that it was unclear if Kathleen was administered medication or other supports to reduce her risk of DVT, or if any attempts were made to mobilise Kathleen prior to her physiotherapist appointment.

58. Notes from her physiotherapist assessment state that Kathleen was able to mobilise for 20 metres with assistance and recommended one or two staff assist with mobilisation. Following her physiotherapist appointment, her progress notes indicated that she was able to shower assisted and was taken for a walk with two staff members.

FURTHER INVESTIGATION

59. While the DSC exercises an important function in investigating the delivery of disability services, in the case of Kathleen, many of the issues identified by the DSC were not causal to her death and therefore outside of my investigative purview as a Coroner.

60. I remained concerned by two issues regarding Kathleen's care at ADH – namely, that it did not appear that Kathleen had been assessed for venous thromboembolism risk (**VTE**) whilst a patient at the hospital, nor had she received VTE prophylaxis. I note that hospitalisation is a major risk factor for VTE, with bed rest contributing to this, and appropriate use of VTE prevention methods is ranked as one of the top intervention hospitals can make to improve patient safety.[31]

61. Accordingly, I sought further information from ADH regarding the medical management of Kathleen, in particular any measures implemented to minimise the risk of her developing DVT. Claire Palmer, Director of Clinical Services at ADH provided a statement on 3 April 2020.

62. Ms Palmer conceded that Kathleen was not assessed for VTE risk and did not have VTE prophylaxis prescribed during her admission to hospital.[32]

63. She further conceded that while the referral to physiotherapy was made on the fourth day of her admission, Kathleen was largely on bed rest throughout her admission, until she was seen by the physiotherapist on the tenth day, 13 November. At the assessment, advice was provided to mobilise Kathleen. Ms Palmer noted that Kathleen would often become agitated and uncooperative with staff who were attending to her care needs, compounded as she was non-verbal.[33]

Restorative and preventative measures

64. Ms Palmer advised that following the death of Kathleen, ADH conducted an in-depth clinical case review and root cause analysis (**RCA**). The case was presented to the Health Services Mortality and Morbidity Committee and was reviewed by an external expert. Several recommendations flowed from the in-depth case review and RCA.

[31] Australian Commission on Safety and Quality in Health Care, Venous Thromboembolism Prevention Clinical Care Standard, January 2020.
[32] Statement of Claire Palmer, Director of Clinical Services, received 3 April 2020.
[33] Ibid.

65. Jane Poxon, Chief Executive Officer of ADH, provided a statement explaining the restorative and preventative measures implemented, and the reviews undertaken by ADH to assess the efficacy of the measures implemented.

VTE risk assessments[34]

66. ADH amended their VTE policies and procedures to reflect the Australian Commission of Safety and Quality in Health Care VTE prevention Clinical Care Standard[35] and the New South Wales Clinical Excellence Commission on VTE prevention[36]. All adult patients admitted to ADH are to be assessed for VTE risk.

67. ADH implemented a VDH Risk Assessment Tool in 2018. The Tool is a two-page form to be completed by the Medical Officer within 24 hours of admission, and provides for a comprehensive assessment of all patients. The key elements of the tool include:

    a. Patients at risk of VTE are identified.

    b. VTE risk is assessed and documented.

    c. Appropriate prophylaxis is prescribed.

    d. The patient is engaged in their care.

    e. Risk is regularly reassessed (at least every 7 days, as the patient's clinical condition changes, after surgery and at transfer of care).

68. The VTE risk assessment criteria is now laminated and placed in patients' bedside folders to assist with assessment, and nursing handover procedures and forms were amended to highlight VTE assessment requirements, including a physical handover of charts and assessments at the bedside.

[34] Statement of Jane Poxon, Chief Executive Officer, dated 18 September 2023.
[35] https://www.safetyandquality.gov.au/standards/clinical-care-standards/venous-thromboembolism-prevention-clinical-care-standard
[36] https://www.cec.health.nsw.gov.au/keep-patients-safe/medication-safety/vte-prevention

69. Further, the ‘patient journey board’ at the nurse’s station was amended to insert a column for checking off VTE risk assessments as completed. This was done to provide a visual aid for all staff and highlights that VTE risk assessments are an all-staff responsibility.

Referral to Allied Health[37]

70. ADH has implemented policies and procedures regarding assessment, referrals, documentation and tracking time from the time of admission to referral to Allied Health services, such as physiotherapy, and from referral to completion of assessment.

Education[38]

71. ADH has instituted a comprehensive education campaign on VTE risk. Throughout 2018 and 2019, an in-service program around VTE prevalence and prevention, the importance of risk assessment and the introduction of the risk assessment tool was delivered to all medical and nursing staff working across the acute ward and perioperative services.

72. Learning modules detailing VTE prevention, the documentation of risk assessment and prescribing of prophylaxis to at risk patients have been added to the ADH Learning Management System. These are updated as necessary and are mandatory for all clinical staff, reflected in the ADH Learning and Development Framework.

73. ADH also ensured education is provided to patients, with information on the risks, prevention and signs and symptoms of VTE provided to all patients on admission. VTE prevention is also highlighted in the ADH ‘partners in care’ information booklet.

Efficacy of restorative measures[39]

74. VTE prevention was assessed as per the ADH Risk Management Framework and was rated as a high clinical risk. This was placed on the risk register and monitored at the Operational and Board Governance Level with the Board of Directors receiving regular briefing reports regarding the completion of the action plan against recommendations.

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[37] Statement of Jane Poxon, Chief Executive Officer, dated 18 September 2023.
[38] Ibid.
[39] Ibid.

75. ADH completed regular compliance audits, the results of which were monitored at the Drugs and Therapeutics Committee every two months over a two-year period. The results demonstrated improvement over a 12-month period the second year shows changes were imbedded into clinical practice at ADH.

THE INQUEST

76. Having carefully reviewed the available evidence, I considered that Alexandra District Health had made appropriate concessions and provided adequate responses to my outstanding concerns, obviating the need to hear *viva voce* evidence from witnesses.

77. I determined that this matter would be appropriately finalised by way of a Summary Inquest and Form 37 *Finding into Death with Inquest*. Interested parties were informed of my determination by way of a formal notice for a Summary Inquest to be held on 15 March 2024.

FINDINGS AND CONCLUSION

Having applied the applicable standard to the available evidence, I make the following Findings pursuant to section 67 of the *Coroners Act 2008* (Vic):

1. I find that Kathleen Mary Savage, born 11 December 1949, died on 16 November 2017 at Alexandra District Health, 20 Cooper Street, Alexandra, Victoria, 3714.
2. I accept and adopt the medical cause of death ascribed by Dr Gregory Ross Young and I find that Kathleen Mary Savage died from pulmonary thromboembolism arising from deep vein thrombosis of the left leg.

3. AND, I find that the decision of Alexandra District Health to not assess Kathleen Mary Savage for venous thromboembolism risk and to not administer appropriate prophylaxis represents an opportunity lost to provide her with appropriate medical care. However, I am unable to find with certainty that Kathleen Mary Savage's death was preventable had earlier intervention taken place.

4. AND FURTHER, I find that Alexandra District Health have implemented appropriate restorative and preventative measures in response to Kathleen Mary Savage's death, and I am

satisfied that there are no further prevention opportunities to be pursued. In this regard, I have not made any recommendations.

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

PUBLICATION OF FINDING

To enable compliance with section 73(1) of the *Coroners Act 2008 (Vic)*, I direct that the Findings will be published on the internet.

DISTRIBUTION OF FINDING

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

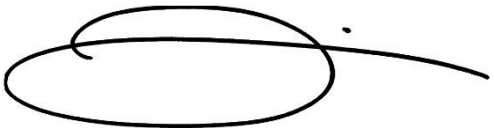
Sydney Savage

Alexandra District Health

Disability Services Commissioner

Leading Senior Constable Ian Hamill

Signature:



AUDREY JAMIESON
CORONER

Date: 15 March 2024

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 inquest. 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.