IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 3232

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Darren J Bracken, Coroner
Deceased:	Valerie Lucy Jones
Date of birth:	30 May 1934
Date of death:	18 June 2020
Cause of death:	1(a) Plastic Bag Asphyxia
Place of death:	Alan David Lodge, 382 Torquay Road, Grovedale, Victoria 3216

INTRODUCTION

1. On 18 June 2020, Mrs Valerie Lucy Jones was 86 years old when she was found deceased with a plastic bag over her head in her room at Barwon Health's transitional care facility, Alan David Lodge, at 382 Torquay Road, Grovedale, Victoria.

2. Mrs Jones was a widow and had four children. At the time of her death, she was residing with one of her children, Penny, at 21 McNeil Avenue, East Geelong ("McNeil Avenue").

3. Mrs Jones had an extensive medical history that included ischaemic heart disease, atrial fibrillation, congestive cardiac failure, gastro-oesophageal reflux disease, hypertension, mechanical aortic valve replacement, permanent pacemaker (tachy-brady syndrome), diverticulosis, severe tricuspid regurgitation, hypercholesterolaemia, iron deficiency anaemia, peptic ulcer disease, anxiety, low moods and poor sleep.

4. In 2016, Mrs Jones formulated an Advanced Care Directive and Refusal of Treatment Certificate, setting-out that she was not for resuscitation "or life prolonging treatments". According to her daughter, Susan Gill, Mrs Jones was a strong believer in euthanasia.

5. On 12 April 2020, Ms Gill visited her mother at McNeil Avenue and found that Mrs Jones "seemed a little vague and confused...". About 10 minutes after leaving McNeil Avenue, Ms Gill received a phone call from her sister, Penny, telling her that their mother had suffocated her pet canary by putting it into a plastic bag and sealing it. Penny told Ms Gill that she could not get the plastic bag from their mother and that she was "totally unresponsive". Soon afterward, Mrs Jones was transported via ambulance to the University Hospital Geelong ("the hospital").

6. On admission to the hospital's Emergency Department, it was noted that Mrs Jones had been brought to the hospital because of her family's concerns about symptoms of increased confusion over the previous three weeks and unusual behaviour. Notes reveal that Mrs Jones reported feeling generally unwell (nausea, lethargy and poor appetite) and that her leg was swollen which was improving following her then recent commencement of frusemide prescribed by her general practitioner. Mrs Jones was assessed as suffering from delirium, deranged liver function and fluid overload. She was admitted the General Medical Unit for further assessment and management where she remained an inpatient until 13 May 2020.

7. Dr Piraveen Pirakalathanan, Director of Medical Services, Barwon Heath, advised that Mrs Jones' main issues during her admission were hypoactive delirium (fluctuating cognition and

visual hallucinations), depressive symptoms (low mood, low motivation and poor sleep), fluid overload secondary to congestive cardiac failure and deranged liver function (mild hyperbilirubinaemia).

8. No specific cause for the delirium was identified. Alternative diagnoses were considered, including depression and dementia. Mrs Jones received supportive care, which led to improvement, but not complete resolution of her delirium. Dr Pirakalathanan explained that in consultation with Mrs Jones' family, she was referred to the Transition Care Program (TCP)[1] for further resolution of the delirium and optimisation of functioning to allow for discharge home with community support.

9. With regard to Mrs Jones' depressive symptoms, Dr Pirakalathanan reported that Mrs Jones was to be prescribed Mirtazapine 15mg daily,[2] subsequently titrated up to 30mg daily during her admission. Mrs Jones was referred to the Mental Health Team for assessment of her morose ruminations and repeated requests to be euthanised. The Mental Health Team opined that the depressive symptoms were likely due to delirium, rather than an untreated depressive illness or major psychiatric disorder. Furthermore, they assessed Mrs Jones as not having active suicidal thoughts or self-harm behaviours. Their recommendation was for ongoing medical care and titration of the antidepressant. Ongoing mental health input was not recommended.

10. According to Ms Gill, on 1 May 2020, during a family meeting, Mrs Jones told "the doctors to end her life tonight as she was sick of being unwell and did not want to end up in an aged care home or be a burden to anyone." Ms Gill said that she believed that her mother was "*...totally lucid and determined in her thoughts*..." at the time, however the doctors believed she was experiencing delirium.

11. On 13 May 2020, Mrs Jones was transferred to Alan David Lodge. During her stay, Mrs Jones was reviewed on eight separate occasions by consultants and registrars between 13 May and 16 June 2020. By 8 June 2020, there were reduced fluctuations in her delirium albeit that her key medical issues continued to be delirium and depressive symptoms.

12. On 9 June 2020, while visiting her mother, Ms Gill noted that Mrs Jones was talking "…in muddled ways and desperately wanted to her life to end." The following day, Mrs Jones had an MRI performed. It did not reveal a cause for her delirium.

[1] The Transition Care Program (TCP) is a form of short-term, sub-acute inpatient care. It is provided at the Alan David Lodge, Barwon Health.
[2] Mirtazapine is a medication that is indicated for the treatment of depression.

13. It was noted that Mrs Jones had occasional episodes of low mood whilst at the Alan David Lodge. Her prescription of Mirtazapine continued during this time.

14. On 16 June 2020, Mrs Jones expressed to nursing staff that "she was going to die soon". During the review on that day, she was unable to elaborate further other than to say that she "*...listens to the environment and she just knew*." Mrs Jones expressed no active suicide thoughts and her Geriatric Depression Scale score was recorded as 1 out of 15.[3] The plan was to continue monitoring Mrs Jones' mood and maintain her current antidepressant dose. Further discussions were conducted with Mrs Jones' family regarding transferring her to long-term care.

15. Ms Gill said that when she visited her mother on 16 June 2020, her mother was "*...rambling and had confused thoughts.*" and she noticed "about 20 plastic bags from the back of Mrs Jones' bathroom door tied up individually in knots, on [her mother's] over bed tray." When she questioned why her mother had so many bags, Mrs Jones responded that she was cleaning up the environment.".

16. On 17 June 2020, Mrs Jones' son Murray visited her. After Mr Jones left, Mrs Jones told her roommate, Lucy Farrugia: "Tomorrow the lights will go out. There will be no electricity." Mrs Jones had not raised any concerns with staff on that day.

THE CORONIAL INVESTIGATION

17. Mrs Jones' death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

18. 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.

19. 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.

[3] A low score indicates a low probability of depression.

20. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mrs Jones' death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist and investigating officers – and submitted a coronial brief of evidence (coronial brief).

21. This finding draws on the totality of the coronial investigation into the death of Mrs Jones, including evidence contained in the coronial brief. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[4]

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

Circumstances in which the death occurred

22. On 17 June 2020 at about 9.45pm, Mrs Jones went to bed, being tucked into bed at 10.00pm by nursing staff. During the night Mrs Jones had two brief conversations with Ms Farrugia. The following morning at about 5.30am, Mrs Jones was reviewed by staff. There were no issues identified. At about 7.45am, Ms Farrugia awoke and on attempting to wake Mrs Jones, noticed that she had a plastic bag, similar to those hanging at the back of the bathroom door, over her head. Ms Farrugia immediately alerted staff. A short time later, Mrs Jones was formally declared deceased.

Identity of the deceased

23. On 18 June 2020, Murray Jones identified the deceased as his mother Valerie Lucy Jones, born 30 May 1934.

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

Medical cause of death

25. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (VIFM), examined the deceased on 19 June 2020 and provided a written report of her findings on 23 June 2020.

[4] 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.

26. Dr Glengarry reported that examination of a post-mortem CT scan showed no skull fracture or intracranial haemorrhage. Imaging of the neck was unremarkable. A pacemaker was in situ. There was widespread arterial calcification.

27. The external examination showed features as per the clinical history. There were no head injuries except for a small abrasion of the nostril. There were no injuries to the neck. There were no petechial haemorrhage. There were no injuries elsewhere.

28. Toxicological analysis of post-mortem samples identified mirtazapine at a level of ~0.3mg/L in Mrs Jones' blood.

29. Dr Glengarry provided an opinion that the medical cause of death was '1(a) plastic bag asphyxia'.

30. I accept Dr Glengarry's opinion.

FURTHER INVESTIGATION

31. In light of the circumstances surrounding Mrs Jones' death, Dr Pirakalathanan advised in his statement dated 6 November 2020, that the hospital notified Safer Care Victoria of Mrs Jones' death on 24 June 2020,[5] and that her death was noted as a sentinel event (Sentinel Event Number: SE 1672).[6]

32. Dr Pirakalathanan also reported that Mrs Jones' case was reviewed by the hospital using a Root Cause Analysis process[7] and that in the course of that review, it was identified that the nursing staff member who attended to Mrs Jones at about 5.30am on the morning of 16 June 2020, to administer medications, noticed that Mrs Jones had several plastic bags on her table. The nursing staff member removed the bags, leaving only one bag for Mrs Jones' rubbish collection. It is unknown whether the remaining bag was the same bag as found around Mrs Jones' head on 18 June 2020.

33. The hospital review found that the organisation's relevant suicide risk procedure was not implemented during Mrs Jones' admission to TCP. The circumstances in which the procedure should be implemented is potentially ambiguous; while it relates to all staff working in Aged

[5] Safer Care Victoria is the peak state authority for quality and safety improvement in healthcare. It oversees and supports health services to provide safe, high-quality care to patients.
[6] A sentinel event is defined as any unanticipated event in a healthcare setting that results in death or serious physical or psychological injury to a patient, not related to the natural course of the patient's illness.
[7] Root Cause Analysis (RCA) is a method of problem solving used for identifying the root causes of faults or problems. It is widely used in many industries such as accident analysis, medicine, IT operations and the healthcare industry.

Care (inclusive of TCP), it only mentions residents at Blakiston Lodge Oak (a Barwon Health sub-acute facility), which notably does not provide TCP.

34. Dr Pirakalathanan advised that the review's main findings were:

    (a) It was not known if Mrs Jones' death could have been prevented with further suicide assessment.

    (b) The combination of delirium and depression made assessment of suicide risk difficult for the Transition Care Program's clinical team.

    (c) At Alan David Lodge, staff knowledge in assessment of suicide risk may have been limited.

    (d) There was a lack of psychosocial supports for residents in the Transition Care Program, which may have contributed to suicide risk not being effectively recognised and managed.

    (e) There was limited communication with nursing staff providing direct care to Mrs Jones in the Transition Care Program about Mrs Jones' risk factors for suicide, which may have limited their assessment of her suicide risk.

35. Dr Pirakalathanan reported that the key recommendations from the review were:

    (a) Develop a new procedure for care planning for Transition Care Program residents.

    (b) Improve communication processes among healthcare staff within Alan David Lodge (includes the Transition Care Program).

    (c) Provide psychosocial supports for residents in the Transition Care Program.

    (d) Strengthen staff training in assessment of suicide risk for Aged Care (includes Transition Care Program).

    (e) Document a flowchart outlining access to mental health services for residents in Aged Care (includes Transition Care Program).

    (f) Update the suicide risk procedure for Aged Care (includes Transition Care Program).

36. Dr Pirakalathanan advised that the recommendations take into account the findings from the review of Mrs Jones' death, and also broader opportunities for system improvements that are

not directly related to Mrs Jones' case. Dr Pirakalathanan also advised that the recommendations were currently being actioned at the time of his statement and were due to be finalised no later than March 2021.

FINDINGS AND CONCLUSION

36. Pursuant to section 67(1) of the *Coroners Act 2008* I find:

    (a) the identity of the deceased was Valerie Lucy Jones, born 30 May 1934;

    (b) the death occurred on 18 June 2020 at the Alan David Lodge, 382 Torquay Road, Grovedale, Victoria, from plastic bag asphyxia; and

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

37. Having considered all of the circumstances, I am satisfied that Mrs Jones died from plastic bag asphyxia while an inpatient at Alan David Lodge. However, I am unable to identify with any certainty Mrs Jones' state of mind at the time she made her fateful decision. Further, given that no protocol was in place to check on Mrs Jones' welfare and the narrow time band during which she took her own life I am unable to say whether any particular protocol may have prevented her death.

38. I acknowledge and commend Barwon Health for their prompt review of Mrs Jones' case and welcome the implementation of their recommendations.

39. As at the time of drawing this Finding, I note that the Court has not been notified that the review recommendations have been implemented.

COMMENT

40. Pursuant to section 67(3) of the *Coroners Act 2008,* I make the following comment:

    (a) Irrespective of Mrs Jones' delirium and depressive symptoms, given her references to suicide and otherwise to her own death, a process should have been put in place by which Mrs Jones was regularly checked for her own welfare.

RECOMMENDATIONS

41. Pursuant to section 72(2) of the *Coroners Act 2008,* I recommend that the recommendations made by Barwon Health's review of Mrs Jones' death including that the organisation:

(a) Develop a new procedure for care planning for Transition Care Program residents.

(b) Improve communication processes among healthcare staff within Alan David Lodge (includes the Transition Care Program).

(c) Provide psychosocial supports for residents in the Transition Care Program.

(d) Strengthen staff training in assessment of suicide risk for Aged Care (includes Transition Care Program).

(e) Document a flowchart outlining access to mental health services for residents in Aged Care (includes Transition Care Program).

(f) Update the suicide risk procedure for Aged Care (includes Transition Care Program) be implemented.

42. Pursuant to section 73(1B) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

I convey my sincere condolences to Mrs Jones' family for their loss.

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

Ms Susan Gill, Senior Next of Kin

Mrs Lorraine Judd, University Hospital Geelong, Barwon Health

Leading Senior Constable Sean Rafferty, Coroner's Investigator

Signature:

DARREN J BRACKEN

CORONER

Date: 12 August 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