IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 004473

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	CLX[1]
Date of birth:	1936
Date of death:	24 August 2021
Cause of death:	1(a) Incised wounds to the wrist 2 Myelodysplasia
Place of death:	Cohuna District Nursing Home, 144 King George Street, Cohuna, Victoria, 3568
Keywords:	Myelodysplasia, euthanasia, Cohuna District Hospital, Bendigo Hospital, Cohuna District Nursing Home, Echuca Regional Health.

[1] This Finding has been de-identified by order of Coroner Simon McGregor to replace the names of the deceased and their family members with psuedonyms of randomly generated three letter sequences to protect their identity and to redact identifying information.

INTCLXUCTION

1. On 24 August 2021, CLX was 85 years old when he died in circumstances suggestive of suicide. At the time of his death, CLX lived in Leitchville.

2. CLX and his wife, FXJ, grew up in the Echuca area and, in 1963, they purchased a farm in Leitchville where they raised and milked cows until CLX turned 70 years of age. He then turned to rearing and selling beef cattle which he continued to enjoy, despite a total hip replacement in 2017.[2]

3. In April 2021, CLX had a clearing sale where he sold most of his farm machinery. He told FXJ that he was doing it so their children wouldn't have to worry about it when he was gone.[3] FXJ stated that CLX never voiced any thoughts of self-harm or suicidality to her.[4]

4. In around June 2021, CLX's son took him to see his general practitioner (**GP**) in Cohuna due to him being in severe pain in his hip. CLX told his GP that he was dying and "not to do anything to save him".[5] He told the GP that he "was not depressed but was not happy with his life".[6] CLX was eventually diagnosed with myelodysplasia resulting in anaemia and decreased functional reserve.[7]

5. On 1 July 2021, CLX was taken to Echuca Regional Health by ambulance after being unable to move his legs.[8] He was discharged on 5 July after declining further investigations and management. The following morning CLX developed severe pain and a fever and was taken to Cohuna District Hospital (**CDH**) where he was diagnosed with an ischiorectal abscess. This was drained but continued to cause him significant amounts of pain.[9]

[2] Coronial brief, statement of FXJ dated 2 January 2022, page 17.
[3] Coronial brief, statement of FXJ dated 2 January 2022, page 18.
[4] Coronial brief, statement of FXJ dated 2 January 2022, page 20.
[5] Coronial brief, statement of FXJ dated 2 January 2022, page 18.
[6] Coronial brief, statement of Dr Peter Barker dated 24 November 2021, page 72.
[7] Coronial brief, statement of ZVZ dated 13 October 2021, page 25.
[8] Coronial brief, statement of FXJ dated 2 January 2022, pages 18-19.
[9] Coronial brief, statement of FXJ dated 2 January 2022, pages 18-19; statement of Dr Peter Barker dated 24 November 2021, page 72; statement of Dr Nayomi Kadugodage dated 24 November 2021, page 75.

6. CLX was commenced on antibiotics and transferred to Bendigo Hospital for surgical debridement.[10] On 15 July 2021, CLX was transferred back to CDH where he was given a blood transfusion for his anaemia.[11] During this time, the COVID-19 restrictions resulted in CLX's family being unable to visit him on his birthday.[12]

7. On 27 July 2021, CLX's treating practitioner, Dr Nayomi Kadugodage, reviewed him and noted that CLX did not want further active management to of his conditions and wanted to be discharged home to commence palliative care. This was discussed with his family who decided that they would not be able to provide sufficient care so, on 4 August 2021, CLX was transferred to Cohuna District Nursing Home (**CDNH**) to commence palliative care.[13]

8. CLX later told FXJ that he disliked it at CDNH as he did not have anyone to talk to, and the increasing COVID-19 restrictions continued to prevent his family from visiting him.[14] CLX continued to experience severe pain in his hip during his time at CDNH despite being prescribed various analgesics.[15] During the course of his illness, CLX told his son, ZVZ, several times that he had a long life and wanted to die.[16]

THE CORONIAL INVESTIGATION

9. CLX's 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.

10. 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.

[10] Coronial brief, statement of FXJ dated 2 January 2022, pages 18-19.
[11] Coronial brief, statement of Dr Nayomi Kadugodage dated 24 November 2021, page 75.
[12] Coronial brief, statement of FXJ dated 2 January 2022, page 19.
[13] Coronial brief, statement of Dr Nayomi Kadugodage dated 24 November 2021, page 75.
[14] Coronial brief, statement of FXJ dated 2 January 2022, page 19.
[15] Coronial brief, statement of Janette Thompson dated 26 August 2021, page 42.
[16] Coronial brief, statement of ZVZ dated 13 October 2021, page 28.

11. 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.

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

13. This finding draws on the totality of the coronial investigation into the death of CLX 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.[17]

14. In considering the issues associated with this finding, I have been mindful of CLX's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006* (Vic), 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

15. When CLX was initially admitted to CDNH he maintained a bright and bubbly attitude towards the staff and other residents, however in the week prior to his death his pain increased, and he began to spend most of his time lying in bed. CLX was reviewed by the palliative care nurse and his medication was increased as a result.[18]

16. On 21 August 2021, CLX was collected by ZVZ who took him back to the farm in Leitchville for the day. ZVZ noted that CLX was happy to be at the farm for the day, however he appeared to be very unwell and was in significant amounts of pain from his hip. CLX returned to CDNH later that afternoon.[19]

[17] 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.
[18] Coronial brief, statement of Debbie Dingwall dated 13 January 2022, page 32.
[19] Coronial brief, statement of ZVZ dated 13 October 2021, page 28.

17. At approximately 11.30pm, CLX spoke with one of the nursing staff after being given analgesia and spoke to her about euthanasia. The nurse recorded these statements in the electronic nursing notes system however she stated that CLX seemed to be simply giving voice to the thoughts in his head. She later provided further analgesia which seemed to settle CLX and allowed him to sleep.[20]

18. On 24 August 2021 at approximately 7.35am, a nurse attended CLX's room and discovered that he had lacerated his wrist during the nursing handover period with a razor.[21] A medical emergency call was activated, and nurses attempted to render first aid to CLX however he told them several times to "let [him] go" and resisted efforts to help him, making it "abundantly clear that he did not want to be resuscitated and not for [staff] to interfere". The on-call doctor and CLX's family were notified.[22]

19. Nursing staff were eventually able to dress CLX's wound and attempted to do further assessments however CLX continued to refuse until he eventually succumbed to his injuries. CLX was later declared deceased at 8.20am by the on-call doctor.[23]

20. The subsequent investigation into CLX's death did not reveal any suspicious circumstances.

Identity of the deceased

21. On 24 August 2021, CLX, born in 1936, was visually identified by his son, ZVZ.

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

Medical cause of death

23. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 25 August 2021 and provided a written report of her findings dated 25 August 2021.

24. The post-mortem examination revealed findings consistent with the history given.

[20] Coronial brief, statement of Debbie Dingwall dated 13 January 2022, page 33.
[21] Coronial brief, statement of FXJ dated 2 January 2022, page 20; statement of Janette Thompson dated 26 August 2021, page 44.
[22] Coronial brief, statement of Debra Munzel dated 19 December 2021, pages 36-38.
[23] Coronial brief, statement of Debra Munzel dated 19 December 2021, page 38; statement of Detective Sergeant Jason Frost dated 7 October 2021, page 89.

25. The post-mortem computed tomography scan showed coronary artery and generalised calcifications, bilateral plueral effusions, enhanced markings of the left lower lobe, and metal in the left hip.

26. Toxicological analysis was not indicated and was not performed.

27. Dr Fronczek provided an opinion that the cause of death was from 1 (a) incised wounds to the wrist.

28. I accept Dr Fronczek's opinion.

FAMILY CONCERNS

29. On 12 October 2021, CLX's son, UTK, wrote to the court expressing concerns regarding his father's care, including whether CLX's abscess should have been identified earlier and the adequacy of the pain management he received during his time at CDNH.

30. In consideration of UTK's concerns, I note the statement of Dr Kadugodage in which she recalls that CLX declined further investigation and management of his pain during his initial presentation to Echuca Regional Health in July 2021, however he represented on 6 July 2021 at which point his abscess was appropriately diagnosed and treatment initiated.

31. With regards to CLX's pain management, I note that he was appropriately prescribed several pain management medications, including oxycodone, paracetamol, and a fentanyl patch. According to CDNH staff, CLX was frequently reviewed by both the palliative care team and day to day nursing staff who appropriately attempted to manage his pain.

32. Whilst I understand UTK's concern that CLX remained in pain during his time at CDNH, pain management is delicate and inexact science in which a patient's pain must be balanced against their functional reserve to avoid adverse outcomes, especially important in a compromised individual such as CLX, whose frailty and immunocompromised state left him vulnerable to adverse outcomes such as medication overdoses.

33. After careful consideration of the available evidence, I am satisfied that the care that CLX received, including from Echuca Regional Health, CDH, and CDNH, was reasonable and appropriate given CLX's circumstances.

34. I note that it remains open to CLX's family to contact CDHN directly to discuss his concerns or lodge a complaint with the Health Care Complaints Commissioner, however.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was CLX, born in 1936;

    b) the death occurred on 24 August 2021 at Cohuna District Nursing Home, 144 King George Street, Cohuna, from *incised wounds to the wrist*; and

    c) the death occurred in the circumstances described above.

36. Having considered all of the circumstances, I am satisfied that CLX intentionally took his own life, as evidenced by the lethality of means. I note his statements over the past few months to caregivers and his family regarding his desire to die, including a discussion on 21 August 2021 regarding euthanasia.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations to Cohuna District Hospital:

1. Cohuna District Hospital provides psychosocial supports for residents in the aged care and palliative care programs;

2. Strengthen staff training in the assessment of suicide risk for aged care and palliative patients;

3. Develop a flowchart outlining access to mental health services for residents in the aged care and palliative programs; and

4. Update the suicide risk procedure for aged care and palliative programs.

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

Pursuant to section 73(1A) 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:

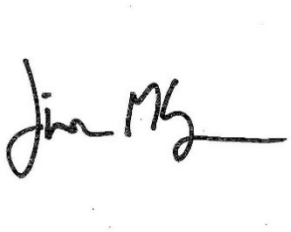
FXJ, Senior Next of Kin

Safer Care Victoria

Bernadette Loughnane, Cohuna District Hospital

Sergeant Josh Coombs, Victoria Police, Coroner's Investigator

Signature:



CORONER SIMON McGREGOR

CORONER

Date: 1 August 2022

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.