QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Stephen John Mills**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2013/665
DELIVERED ON:	28 July 2015
DELIVERED AT:	Brisbane
HEARING DATE(s):	23 February 2015, 28 April 2015, 12 May 2015
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, fall in hospital, head injury, risk assessments and falls risk management, mental health medication management

REPRESENTATION:

Counsel Assisting:	Ms M Zerner I/B Office of State Coroner
Counsel for Mrs Mary Mills:	Mr M McMillan Lawyer
Counsel for Toowong Private Hospital and Staff:	Mr D Schneidewin I/B Minter Ellison
Counsel for Dr P Wong:	Mr A Luchich I/B Ashurst Lawyers

Introduction

1. Stephen John Mills was aged 57. He suffered from bipolar affective disorder for which he had been treated for the past 20 years.

2. In 2012 he commenced receiving treatment in Queensland under the care of Dr Patrick Wong, who consulted out of the Toowong Private Hospital (TPH).

3. He was admitted to the TPH on 1 February 2013 suffering a further major depressive episode.

4. During the evening of 17 February 2013 he had a fall on the ward. He was transferred to the Royal Brisbane and Women's Hospital (RBWH) for an assessment. It was discovered that he had suffered a bilateral frontal contusion with a large traumatic subarachnoid haemorrhage. Despite aggressive treatment he continued to deteriorate and after consultation with his family, treatment was discontinued on 20 February 2013 and he died. As a result his death was reported to the Office of the State Coroner.

5. Mr Mills' family made a complaint to the Health Quality and Complaints Commission (HQCC). The TPH identified a number of service improvements and process changes and conducted a Root Cause Analysis, which also identified a number of failings centred on falls risk management.

6. My office commissioned an independent expert report by Dr Storor, consultant psychiatrist. He noted that a formal falls risk assessment was not documented on his admission preceding the death and there were a number of problems regarding visual and physical observations, and other concerns regarding the appropriate management plan.

7. Mr Mills' family remain concerned regarding the events that led up to his death and subsequent treatment after he fell. The family applied for an inquest and a decision was made to hold an inquest.

8. At a pre-inquest hearing held on 23 February 2015 the following issues for the inquest were determined:–

    - findings as required by s. 45(2) of the Coroners Act 2003

    - whether the management by the TPH in relation to the care of the deceased from 1 February 2013 to 18 February 2013 was appropriate and adequate

    - whether the management and treatment by Dr Wong of the deceased from 1 February 2013 to 18 February 2013 was appropriate and adequate

- the adequacy of the policies and procedures of the TPH in relation to the care of the deceased.

Family concerns

9. Mrs Mary Mills provided a statement and gave evidence at the inquest. She described her husband as a man of great standing, a true gentleman with a great sense of humour. He was always thinking of others and would offer help when needed.

10. Mr Mills' family made a complaint to the HQCC. In general, this complaint was related to the care provided by Dr Wong and the TPH. Subsequently the HQCC referred the matter back to the coroner for a decision on further investigation.

11. The family have concerns the fall was due to inappropriate medication being administered. They also question conflicting advice regarding his lithium medication and being taken off this medication because it was at a toxic level. These issues are now addressed in the report of Dr Storor.

12. Mr Mills had returned from an enjoyable week's holiday with family in early January 2013 and struggled with bouts of tiredness, which saw him needing to sleep in the day. They believe this was as a result of the particular medication, Risperdal (risperidone) that he was prescribed.

13. On 5 January he had a scheduled appointment with Dr Wong and asked if the medication could be reduced. Dr Wong agreed and this appeared to have an immediate impact. His condition slowly deteriorated on a gradual slow decline. He made contact with Dr Wong who then prescribed him Lovan, an antidepressant. There was no improvement and after further advice Dr Wong increased this medication.

14. Mrs Mills noticed signs that Mr Mills was deteriorating, and reluctantly encouraged her husband to return to TPH. Mr Mills was then admitted on 1 February 2013 for what was thought to be a short stay.

15. On a previous visit to TPH on 13 August 2012, Mr Mills fell and was transported to Wesley Private Hospital. This resulted in a bleed to his brain, which the neurologists said was not serious. During his stay he had a defibrillator inserted. The family believe that one of the reasons he fell was that his bipolar condition was treated in isolation at TPH.

16. The family also said they had received conflicting reports about the fall that caused his death and as to whether it was witnessed or unwitnessed. The family had concerns as to why Mr Mills had to get out of bed to seek water. When he was at home and once he had taken his medications at night, Mr Mills did not get out of bed until the early hours to use the bathroom. He never got out of bed to get water. The family also have concerns as to the timing of the events the night he fell, whether first aid was provided immediately and in particular when Dr Wong was contacted and the ambulance called.

17. Of particular concern is that the first Mrs Mills knew of the fall was when she retrieved two missed call messages from the RBWH just before 6am. She immediately telephoned TPH and believes she spoke to a female nurse who informed her about the fall. She does not recall speaking to a male nurse (RN Laurie). She is also certain she did not take a telephone call from Dr Wong that morning.

18. Early on the hospital apologised to the family for staff not contacting Mrs Mills at the time of the incident, offering no excuse as to why there was no contact and explained that it was an error and should not have happened.

19. Mrs Mills also states that she was not informed by Dr Wong or hospital staff that her husband was experiencing tremors, was not eating and was not showering or looking after himself with respect to his appearance. She noticed his appearance at the RBWH and he looked terrible. Being unkempt was one of the recognisable signs for her of deterioration in her husband and if she had known of this she would have immediately attended at TPH.

20. In the TPH response to the HQCC it stated that it is unknown why Mr Mills got out of bed and walked to the water cooler that night. Nursing staff reported that Mr Mills had his own water bottle beside his bed at the time of the incident. The shift coordinator of the morning shift of 18 February 2013 assisted in packing up his belongings and recalls the water bottle being beside the bed.

21. The family believe that TPH has not provided a duty of care to that which was expected. They question whether Mr Mills' treatment was looked at from a holistic point of view or in isolation.

Medical history and events leading up to death

22. Mr Mills' past medical history included a myocardial infarct (heart attack) in 2004 with a coronary artery bypass graft surgery x2, subarachnoid haemorrhage in July 2012, further coronary artery disease with a stent inserted in 2012, hypothyroidism and longstanding bipolar adjustive disorder. There was a prior history of suicide attempt and suicidal ideation.

23. Dr Margaret Harper had treated him in Sydney for his psychiatric condition for most of the time. In 2012, Mr Mills and his family decided to seek treatment in Queensland, it being closer to where they now lived in NSW.

24. Dr Wong first began treating him on 25 July 2012 after Mr Mills' general practitioner referred him to the TPH. At the time he was experiencing a major depressive episode and suffering from a manic episode.

25. An entry in the medical records during this admission noted Mr Mills had a blackout and a resulting fall. He was transferred to the Wesley Hospital and had a pacemaker fitted for an atrio-ventricular block. He was transferred back to the TPH and discharged on 31 August 2012.

26. Mr Mills was readmitted to the TPH on 25 October 2012 for the treatment of a hypomanic episode. He was discharged on 16 November 2012 having improved with treatment.

27. Mr Mills was readmitted as a voluntary patient on 1 February 2013 suffering a further major depressive episode. He was in a poor mental health state, lacking motivation, refusing to mobilise and resisting food and fluid.

28. On 15 February 2013, Dr Wong discussed the possibility of Electroconvulsive Therapy (ECT) as there had been a poor response to medical intervention. Mr Mills told Dr Wong he was not keen for this and Mrs Mills also said her husband would not agree to this. In any event it is apparent Dr Wong organised for a physician, Dr Ringrose, to examine him and also asked for a second opinion from a psychiatrist, Dr Josh Geffen. Before that second opinion could occur Mr Mills had the fall on the ward.

29. At around 11.50pm (there is some difference in the evidence as to the exact time) on 17 February 2013, it was reported he had a fall. Registered Nurses Anne Lipman, James Laurie, Robert Monaghan and Jackie Keyes stated they were all at the nurses' station. They heard a loud noise from the water cooler area located two metres from the nurses' station.

30. On investigating, the nurses all say they found Mr Mills lying on the floor having what appeared to be a Grand Mal seizure. It was reported that this lasted up to 5-6 minutes, but it could have been a matter of a few minutes. The nurses say they protected his head and put him in the recovery position. They checked his observations and noted he had vomited and was sweating profusely.

31. The nursing staff all agreed Dr Wong was contacted by telephone and he considered Mr Mills should be transferred to the RBWH. Queensland Ambulance Services (QAS) were contacted and transported him to RBWH.

32. All of the nursing staff agreed they had authority to make a decision as to transfer without speaking with the medical staff. RN Laurie made the call to Dr Wong and says he did so to check if there was any history of seizures that could be passed on to the QAS and RBWH. Based on Dr Wong's telephone records, it is apparent this call was made at 12.17am and lasted 52 seconds.

33. QAS records indicate it was called at 12.21am and that the ambulance arrived at the scene at 12.33am. The patient was loaded at 12.53am and arrived at RBWH at 1.03am.

34. Mr Mills was intubated in the Emergency Department. He was assessed as having a decreased level of consciousness secondary to an intracranial haemorrhage, or to analgesia. An urgent CT scan showed a bilateral

frontal contusion with a large traumatic subarachnoid haemorrhage. He was taken to the operating theatre for a right frontal external ventricular drain (EVD) insertion.

35. Post EVD insertion he was admitted to the intensive care unit at RBWH. Medical notes query whether he had a seizure and then fell or whether it was primarily an injury as a result of a mechanical fall.

36. He was kept sedated. A further CT scan revealed extensive progression of bi-frontal contusions and a new left frontal bleed. The EVD was not draining and a blood clot was noticed. An attempt at unblocking the EVD under sterile conditions was unsuccessful. It was considered he was not a candidate for evacuation of haematomas or craniectomy. The old EVD was removed and a new EVD inserted.

37. His condition continued to deteriorate despite maximal care. The family were expressing concerns about what had happened prior to the admission to RBWH.

38. Mr Mills had suffered a severe traumatic brain injury secondary to a fall but the mechanism was unclear. He had underlying ischaemic heart disease with a defibrillator in situ and was on aspirin. Multiple family meetings took place and they were advised that the clinical signs were consistent with brain death. Organ donation was consented to. He died on 20 February 2013.

Autopsy results

39. Mr Mill's family requested an external examination only and an external autopsy examination was ordered given the clinical picture. Toxicology testing of admission blood samples taken at RBWH and a review of the medical notes was also requested. Toxicology of blood samples taken at 1.35am on 18 February showed the presence of antipsychotic and antidepressant drugs at insignificant concentrations. Lithium was not found.

40. A post-mortem CT scan was consistent with the scan taken in hospital. This showed subarachnoid and subdural haemorrhage and bilateral frontal and temporal haemorrhagic contusions. There was a 3mm midline shift to the right. There was an undisplaced occipital skull fracture. Dr Olumbe stated in evidence that these injuries were consistent with a fall backwards causing fracture to the skull with a contrecoup effect reverberating through the brain causing damage in the opposite frontal lobe.

41. The cause of death was due to a head injury as a result of a fall with coronary atherosclerosis and complete heart block with a cardioverter-defibrillator in situ as significant contributing conditions.

42. In his conclusion, Dr Olumbe states:

The immediate cause of death was increased intracranial pressure consequent to head injury following a fall. It was not possible to verify whether the fall was consequent to a natural disease or accidental. However he had multiple cardiovascular conditions which could have predisposed him to a syncopal attack (transient loss of consciousness with an inability to maintain postural tone) leading to a fall.

The investigation and inquest evidence

Evidence of Dr Patrick Wong

43. Dr Wong understood Mr Mills had been suffering a Major Depressive Episode since November 2011 and had been receiving treatment for the condition at a clinic in Sydney with minimal improvement. He was not responsive to four courses of Electroconvulsive Therapy (ECT) at the Sydney clinic and he sought a second opinion.

44. Dr Wong began treating Mr Mills on 25 July 2012 when he was referred to the TPH by his GP.

45. On 13 August 2012, Mr Mills had a fall and it was arranged for him to be transferred to the Wesley Hospital where he had an implantable cardioverter-defibrillator inserted. He returned to the TPH for further treatment on 21 August 2012 and was well enough to be discharged on 31 August 2012.

46. Mr Mills was readmitted on 25 October 2012 suffering a manic episode. He was concerned about the imminent death of his father from cancer and reported having suicidal ideation but no intent or plan. His father passed away during this admission and his manic state improved with treatment and he was discharged on 16 November 2012.

47. Mr Mills was readmitted as a voluntary patient on 1 February 2013 suffering a further Major Depressive Episode. When admitted he was taking Seroquel XR, Efexor, aspirin, bisoprolol, Crestor, Isosorbide mononitrate, Perindopril, lithium and sodium valproate.

48. On admission it was noted that his mood was low and he was reported to stay in bed all day and was expressing suicidal ideation. His appetite was low and he had hyper-insomnia. Dr Wong increased Efexor on 3 February to 75mg twice daily and on 5 February the dose was increased to 450mg per day. Dr Wong stated in evidence that Mr Mills came in somewhat dishevelled and more depressed than during his admission in January. He had reasonable insight as Mr Mills agreed he was depressed.

49. On 6 February, Dr Wong stated Mr Mills appeared better and he prescribed dexamphetamine 5mg in the morning for augmentation of his antidepressant medication. This increased to 10mg on 7 February 2013. His BP was taken daily and he was encouraged to mobilise from bed.

50. In his evidence Dr Wong stated that the lack of mobility particularly concerned him as immobility in mental health patients was well known to exacerbate cognitive impairment due to depression as well as physical well-being. It was certainly not therapeutically beneficial to prevent him from getting out of bed. As far as he was aware Mr Mills was not mobilising on his own unless he was with staff. When he was observed by him to mobilise he was not 100% steady but was moving quite quickly.

51. On 8 February, Mr Mills was lacking in energy and motivation and Dr Wong removed the morning dose of Seroquel XR for the next day. On 9 February, he was informed that Mr Mills was having increased tremors and unsteady gait.

52. On 9 February, Dr Wong noted the long-term history of tremor, which had been reviewed by neurologists but no cause was found. Dr Wong prescribed diazepam 2mg in the morning for the tremor. Mr Mills was again encouraged to mobilise out of bed. Dr Wong discussed the possibility of ECT but Mr Mills said that this had not been successful in a past admission.

53. On 11 February, Dr Wong removed Seroquel XR and added Avanza 45mg at night. Dr Wong stated this was because Avanza has less effect on blood pressure levels. He requested a repeat lithium level test and Mr Mills was encouraged to drink fluid. Mr Mills was reviewed by Dr Wong on 12 February and then on 13 February and he was commenced on Sustagen. Dr Wong stated that by this stage Mr Mills was not eating very much at all and he was unable to recall if Mrs Mills had suggested this to him but stated he would usually start Sustagen after eight or nine days with low intake. Dexamphetamine was increased to 15mg in the morning and Dr Wong ceased Avanza and commenced him on Valdoxan 25mg at night.

54. On 14 February, Dr Wong ceased lithium as the level was 1.2 and Dr Wong was concerned Mr Mills was not hydrating, which could lead to lithium toxicity. Dr Wong stated that his lithium level at 1.2 was high but not in the toxic range but it was dangerous to continue with lithium and hence he stopped it. Dr Wong increased Valdoxan to 50mg at night and reduced the dosage of dexamphetamine to 10mg. Dr Wong again discussed the possibility of ECT. Dr Wong does not recall having been notified that Mr Mills had been seen to be very unsteady on his feet.

55. On 15 February, Dr Wong said he spoke to Mr Mills' wife about the possibility of ECT, despite the previous lack of success. Dr Wong arranged for Dr Ringrose, a physician, to review Stephen as he considered it necessary to consult with a physician prior to commencing such a procedure. As well there were issues with his low blood pressure. Dr Wong states that he would have reviewed the notes from the previous day, which noted an episode when he was very unsteady on his feet. Dr Wong was asked whether or not an earlier review by a GP or physician should have been organised and he stated there may have been an earlier

opportunity for such a review but he was not sure that it would have changed anything.

56. Dr Wong was asked why he had not referred Mr Mills to a physiotherapist given his concerns about his immobility and exacerbation of his depression. He stated he was not sure a physiotherapist would have been able to do much with him given his reluctance to mobilise.

57. He also requested a second opinion from Dr Geffen, a psychiatrist, who had a special interest in ECT.

58. Dr Wong was asked whether since this incident he would have considered any change in practice. He responded that he probably would have asked for Mr Mills to be transferred to a mental health unit at the RBWH.

59. Dr Wong again reviewed Mr Mills on 17 February.

60. During the night of 17/18 February, Dr Wong was contacted by nursing staff and he had agreed Mr Mills should be taken to the RBWH by ambulance.

61. Dr Wong's telephone records indicate he was contacted at 12.20am. There were apparently a number of other calls to the TPH and RBWH during the morning but he does not recall those calls. He recalls speaking to Mrs Mills and his records suggest this was made at 6.20am and lasted for just over four minutes. Dr Wong stated that it would not have been his practice to contact a family member in these circumstances as he had not seen the patient and without a clear picture he could possibly alarm the family. By 6.20am the situation was no doubt clearer.

62. Dr Wong is unable to state the cause of Mr Mills' fall or seizure that led to his death. He is not sure which came first, the fall or the seizure.

63. He noted that Mr Mills' blood pressure was fluctuating during this admission and was quite low at times. However, as Mr Mills had been laying down in bed for the majority of the admission and had not been eating, it was not unexpected for his BP to be low. He agreed the nursing notes indicated Mr Mills was unsteady on his feet and that he was a falls risk. Dr Wong stated that Mr Mills was 'always a falls risk' and this was evident to staff at all times. It is unclear from the records as to whether or not there were any specific discussions between Dr Wong and nursing staff or nursing administration regarding his falls risk and management.

Nurses Evidence

64. It is apparent from the substance of the evidence of RNs Lipman, Laurie, Keys and Monaghan that they were all largely on permanent night shift and had little to do with providing specific clinical care other than ensuring medications were taken and patients were getting the best sleep they could. RN Laurie was the nurse in charge.

65. A handover of all patients (up to 54 beds) is made at the commencement of the shift. The four nurses on night shift collectively looked after the patients and were not allotted specific patients. They did not therefore consider each patient's medical file other than as necessary. Mr Mills' room was close to the nurses' station. Mr Mills was on routine visual observations during the shift. He would have been observed along with other patients at around 10pm and 11pm.

66. None of the nurses recall any specific occasions of care for Mr Mills during this admission other than RN Laurie on one occasion. Sometime in the evening shift around 10 February 2013, RN Laurie recalls in his statement being approached by a patient who told him that Mr Mills had slipped in the bathroom. In evidence he says the patient did not refer to Mr Mills by name but RN Laurie went to the bathroom and Mr Mills was the only person there. He checked on Mr Mills who said he had not slipped and denied he had hurt himself. There were no physical injuries apparent and Mr Mills appeared to be walking steadily with no noticeable problems.

67. None of the nurses were aware of any nursing management problems other than Mr Mills would occasionally get up to go to the toilet or get a drink, but the rest of the time he would remain quietly in bed. None of them were aware of the previous fall incident during the earlier admission or of any falls risk assessments that had been made. The night shift staff were not involved in completing falls risk assessments.

68. With the exception of checking that he was asleep at various times whilst on duty, they largely had no other recollection of caring for him between 1 and 17 February 2013.

69. On 17 February 2013, it is apparent they were all at the nurses' station doing paperwork between 11.30pm and midnight. This was not unusual.

70. Sometime during this half hour period they recall hearing a loud noise/bang. RN Laurie looked around the nursing station counter, looked down the corridor and said someone had fallen. In oral evidence RN Laurie mentioned for the first time that he had just earlier seen Mr Mills walk past the nurses' station. They all rushed out of the nursing station and found Mr Mills lying on his back having a grand mal seizure. He was lying in front of the water cooler. They all said it was assumed he was at the water cooler to get a drink. RN Laurie stated an empty cup and water was on the carpet next to him and it appeared he had fallen whilst getting a drink. Once the seizure had stopped they moved him into the recovery position.

71. RN Lipman was asked to fetch a sphygmomanometre and RN Laurie undertook observations such as BP, temperature and oxygen saturation. No-one seems to have considered neurological observations, although RN Lipman says someone checked his head and they all considered he had a head injury. RN Laurie says he felt his head but could not see any physical injury. No-one completed a Glasgow Coma Score assessment.

They had some difficulty obtaining his BP but RN Keys was able to successfully from a lower limb. All of these observations were within the normal range, albeit they were not formally recorded anywhere. Mr Mills looked as if he was going to be sick and RN Lipman returned with a bowl and he vomited into the bowl.

72. RN Keys says she had a look in his medical records to see whether he had a recent history of suffering from seizures and noted there was no record of this. As he did not have a history of seizures she voiced her opinion that he should be transferred to another hospital to be reviewed medically.

73. It is now apparent that at 12.17am, RN Laurie rang the treating psychiatrist Dr Wong and at 12.20am the Queensland Ambulance Service (QAS). RN Keys photocopied various pages from the medical records so they could be sent to the hospital with the ambulance. RN Lipman stayed with Mr Mills giving him words of assurance and trying to cool him down. He was perspiring a lot and his clothes were wet with sweat. Mr Mills remained very confused and was sweating despite not having a temperature.

74. A short time later QAS arrived and a summary of what had occurred was provided. They were unable to put him in a collar as he was moving around and staff assisted with putting him on to the QAS trolley. RN Laurie recalls QAS staff asked various questions to try and assess whether he had suffered a cognitive impairment. He gave correct answers to some questions and a few minutes later gave incorrect answers to other questions. He left for the hospital at around 1am.

Issue of the time of the fall and subsequent actions taken

75. It was somewhat unclear from witness statements as to when the fall occurred and Mr Mills was first observed. This has been clarified with further investigation.

76. The progress notes indicate a set of physical observations was taken at 11.55am, although it is unclear as to where or if these observations are in fact recorded.

77. The notes also referred to the transfer to hospital occurring at 1am. The nurses recall different times of the collapse. RN Lipman states the collapse occurred at around 11.30pm. RN Laurie recalls the collapse at around 11.45 to 11.50pm. RN Monaghan recalls the event occurred at around 11.42 to 11.45pm.

78. Dr Wong simply states he was contacted by nursing staff. His telephone records shows this to be at 12.17am.

79. The incident report, completed by RN Laurie on 18 February 2013, indicates Dr Wong was notified at 12.25am and the incident occurred at 11.50pm.

80. The report states:–

When in nursing station staff heard Stephen fall backward onto the floor. All staff when out of the station upon hearing Stephen's fall and witness Stephen having a ground mal seizure. The seizure lasted about 5 minutes but remained confused, disoriented and bringing up sputum with possible blood.

81. Mrs Mills states that she was told by Dr Wong on the telephone on 18 February 2013 that he was telephoned by the hospital at 11pm and he told the staff to call an ambulance.

82. The QAS electronic ambulance report form (EARF) indicates a call was received at 12.21am and that the ambulance arrived at the scene at 12.33am. The patient was loaded at 12.53am and arrived at Hospital at 1.03am.

83. After hearing from each of the relevant witnesses it is my view that on balance the fall occurred before midnight and likely to be closer to 11.50pm than 11.30am.

Root cause analysis

84. A Root Cause Analysis (RCA) was conducted and a report published on 2 May 2013. The RCA found a number of causal events and made a number of recommendations.

Causal statement 1

Due to an objective and systematic falls risk assessment tool not being completed, the client's acuity level for risk of falling was not identified in a timely manner. This may have been a contributing factor in the unexpected death of an inpatient as comprehensive falls prevention strategies were not considered in a timely manner.

Recommendation 1

Undertake a training needs analysis to identify strategies to increase conformance with the Falls Management Policy.

Review the Falls Management Policy and associated risk assessment tool to align with NSQHS standard 10 'Preventing Falls and Harm from Falls' and identify and instigate the implementation of falls prevention strategies on admission, during admission or when clinically indicated.

Causal statement 2

Due to the omission of communicating a syncope episode and fall that occurred during a previous admission the client's acuity level for risk of falling was not considered in a timely manner

Recommendation 2

Review the risk alert process to ensure that when a client is identified as a falls risk, this is clearly communicated between admissions to prompt consideration of acuity level on admission.

Causal statement 3

Due to no clearly defined processes for observing and responding to deterioration in physical health, results of fluid balance and physical observation charts were not clearly and consistently communicated between the multidisciplinary teams. This may have been a contributing factor in the unexpected death of an inpatient as the patient's physical health combined with his cardiac history may have increased the risk of the patient falling.

Recommendation 3

Review best practice guidelines for the completion of the body weight, diet and fluid, blood pressure pulse and temperature clinical observation charts. Develop an internal process/guideline and tools that clearly define the expectations of communication between the multidisciplinary team to share and effectively communicate clinical deterioration of inpatients and associated managed actions, in consultation with the multidisciplinary team.

Causal statement 4

Due to no clearly defined processes for observing and responding to deterioration in physical health as a result of medication intake, potential medication side-effects and interactions were not clearly and consistently communicated between the multidisciplinary teams.

Recommendation 4

Assess staff knowledge of how to access the online MIMS resource. Consider the development of an internal process/guideline for the management of clients taking medication such as lithium carbonate and dexamphetamine. Define the assessment, review communication of clinical deterioration of inpatients and associated managed actions for each medication. Develop an internal process/guideline and tools that clearly define the expectations of communication between the multidisciplinary team to share and effectively communicate clinical deterioration of inpatients and associated managed actions, in consultation with the multidisciplinary team.

Causal statement 5

Due to an individualised care plan not being documented, strategies to mitigate identified risks were not communicated in a clear and concise manner between the clinical team.

Recommendation 5

Undertake a training needs analysis to identify strategies to increase conformance with the Care Plan-Individual Management Policy. Review the care plan and associated risk assessment tools to align with NSQHS standard 6 ‘Clinical Handover’.

85. TPH was requested to report on the implementation of the recommendations.

Recommendation 1

The Falls Management Procedure and Falls Risk Assessment tool were reviewed by senior members of nursing staff. Whilst the policy and tool were found to align with NSQHS standard 10 the tool was revised with a change of format and further instructions added to assist less frequent users to complete the form correctly.

The form was shifted from within the patient's medical record to a newly created folder for each patient that contain documents frequently used by nursing staff including the patient's care plan and observation and response chart.

The revised tool was implemented on 11 September 2013. Individual training was provided to the main initiators of the tool and formal education regarding falls management policy and risk assessment tool was provided to the wider group of nursing staff.

Recommendation 2

The risk alert process was reviewed by senior members of nursing staff. The patient alerts form was reviewed and altered both in format and content to prompt nursing staff to update the form on admission and if clinically required. Individual training was provided to the main initiators of the form.

Recommendation 3

New vital signs equipment was ordered. On 29 August 2013 and following the provision of equipment training a new policy *Recognising and Responding to Physical Deterioration Procedure* and *Observation and Response Chart* were implemented.

Expert review and evidence of Dr Storor

86. Dr Storor is a consultant psychiatrist. He is also a Visiting Medical Officer at Brisbane Private Hospital. He was asked specific questions and provided his opinion.

Your opinion as to the appropriateness of the suicide and/or risk assessments conducted by Toowong Private Hospital

87. Dr Storor was of the opinion that appropriate risk assessments, functional assessments, substance assessment, and symptom assessments were carried out in all three admissions. On each admission he was identified as a low risk of suicide and low risk of harm to others.

88. Dr Storor stated that in formulating falls risk management plans the duties should be divided between nursing and medical staff. Nurses can take steps to address identified risks, relay these to the medical staff and in consultation work out a management plan. Falls risk management is part of the National Framework and is now routine.

89. In relation to falls risk assessments he noted that given Mr Mills had a serious fall in his first admission, it was appropriate that his falls risk be assessed on his readmission to hospital thereafter.

90. However, Dr Storor stated there is no record in the file of a falls risk assessment being undertaken during the third admission. This was particularly significant given that during this admission he was noted to be unsteady on his feet and suffered from low blood pressure.

91. Dr Storor stated it was his opinion that it was inappropriate that Mr Mills did not have a formal risk assessment documented on his third admission to Toowong Private Hospital.

Your opinion as to whether the level of observations of the deceased during his admission at Toowong Private* Hospital *were appropriate in light of his presentation and history

92. Dr Storor stated that as to visual observations of Mr Mill's physical state, his opinion was these were not appropriate during the third admission to hospital. He was identified to be unsteady on his feet on 14 February 2013. The frequency of physical observations was increased. However, there was no increase in visual observation. Patients suspected to be at a risk of falls can be observed more frequently to better determine their risk of falling. If assessed to be at a risk of falling they can be nursed in bed and mobilised with nursing assistance and observation. In his opinion increased observation and monitoring of falls risk should have occurred.

93. Dr Storor noted physical observations were undertaken in all three admissions. In the case of the third admission, daily blood pressure readings were taken. However, a lying and standing blood pressure reading was taken on only one occasion on 10 February 2013. No postural drop was detected. Notwithstanding this lack of postural drop on that one occasion, in his opinion, given the reports that Mr Mills was hypotensive and unsteady on his feet, lying and standing or lying and sitting BP readings should have been taken regularly to monitor for postural blood pressure drop. He noted it was appropriate that blood pressure and other physical observations were increased to twice daily on 14 February 2013 after he was noted to be unsteady.

94. Dr Storor stated that although there were things undertaken there was no documentation as to why that was and there was no formal plan other than the isolated chart entry on 14 February and nothing after.

Any comment regarding the appropriateness of the medication (or the combination of medications) given to the deceased

95. Dr Storor stated there were a number of medication changes made in the third admission. Overall, he thought the medication changes were reasonable. He stated it should be noted that one of the benefits of inpatient treatment, is that it enables a clinician to make appropriate

medication changes much quicker than could be done in an outpatient setting, as it is possible to observe and monitor the patient regularly, watch for side-effects and their response to treatment. In his opinion the medication treatment undertaken by Dr Wong, was compatible with reasonable care as exercised by his psychiatric peers. That is not to say that all psychiatrists would have treated Mills in the same way. There is always difference of opinion and also Dr Wong had the benefit of seeing and treating Mr Mills on three previous hospital stays and had the benefit of his knowledge of past response to pharmacotherapy.

96. Dr Storor agreed Dr Wong made appropriate adjustment to his medication due to the low blood pressure. Dr Storor stated Mr Mills deteriorated quickly during this admission and when you step back and look at it in hindsight his management should have been medical as well as for mental health.

Your opinion as to whether the care and treatment of the deceased during his admission at the Toowong Private Hospital was appropriate

97. Dr Storor stated that the death of an inpatient at a psychiatric facility is an uncommon event and inevitably raises questions about the care and treatment of the patient. It is customary to conduct some form of clinical audit and this was done through the Root Cause Analysis.

98. The RCA made five major causal statements. In summary, these were:
    - A systemic falls risk assessment tool was not completed.
    - Mr Mills' acuity level for risk of falling was not considered in a timely manner.
    - Results of fluid balance and physical observation charts were not clearly and consistently communicated between the multidisciplinary team.
    - Potential medication side-effects and interactions were not clearly and consistently communicated between the multidisciplinary team.
    - An individualised care plan was not documented and thus strategies to mitigate identified risks were not communicated in a clear and concise manner between the clinical team.

99. In the opinion of Dr Storor, the RCA clearly documents the problems that occurred during the third admission. First and foremost, his falls risk was not clearly identified and communicated. No falls risk assessment was undertaken and the past history of a serious fall was not incorporated into the management plan. Secondly, when it became apparent that Mr Mills was a falls risk, there is no record in file notes that appropriate steps were taken to mitigate his risk. Typically, if a patient is considered to be a falls risk, they are placed on a bed close to the nurses' station so they can be observed more closely. File notes indicate his bed was near the nurses' station, however, there is no documentation to indicate this was part of a falls risk management plan. If it is considered that a patient was an

ongoing falls risk, then it is appropriate to nurse the patient in bed and mobilise under the direct supervision of nursing staff. In the event the patient does not comply with these directions, then they may require constant observation. There is no documentation that these latter steps were considered or put in place in the third admission. This is in contrast to his second admission where he was identified as being at risk of falls and was moved closer to the nursing station and reviewed by a physiotherapist who implemented falls risk management strategies.

100. There were a number of other factors that may have contributed to his falls risk, including his fluid intake, the effects of his medication regime on his blood pressure and the possibility of significant postural drop in blood pressure on standing. The medical file documents that these factors were noted and observations recorded, but there is no documentation that comprehensive individual plans were adopted in light of these observations.

101. In Dr Storor's opinion, the standard of care provided to Mr Mills during this third admission was not what would be expected of an inpatient psychiatric facility. The major problems were that firstly, visual and physical observations were insufficient, and secondly, that when concerns were noted, there did not appear to be any coordinated response to those concerns or appropriate changes made to the management plan.

102. He found that Mr Mills did not have a formal risk assessment documented on his admission preceding his death. He considered this was not compatible with an appropriate standard of care for someone who had previously suffered a serious fall whilst an inpatient and was noted to be a falls risk on a number of previous admissions.

103. Dr Storor noted there were a number of medication changes to his medication regime during the admission preceding his death. Overall these changes were reasonable. In his opinion the medication treatment of Mr Mills undertaken by Dr Wong was compatible with reasonable care as exercised by his psychiatric peers.

104. Dr Storor stated his opinion that the RCA report documents clearly the problems that occurred during Mr Mills' admission to the hospital. In summary, the major problems were firstly, visual and physical observations were insufficient, and secondly, that when concerns were noted, there did not appear to be any coordinated response to those concerns or appropriate changes to the management plan.

Response by TPH to RCA Implementation

105. Christine Alexia Gee is the Chief Executive Officer of Toowong Private Hospital. She is also a current board member of the Australian Commission for Safety & Quality in Health Care. She provided a statement and a number of exhibits setting out the key steps taken and changes that have occurred since Mr Mills' death.

106. The hospital has become accredited to the Australian Quality Management Systems Standard and other standards in line with the Australian Health Services Safety and Quality Accreditation Scheme.

107. The hospital initiated two separate reviews, the first being the Root Cause Analysis and the second review by the hospital's Patient Care Review Committee. She states that the hospital has implemented actions in accordance with the recommendations which arose from the RCA and the PCRC. In particular, the falls management procedure was reviewed by senior clinical staff members and found to align with the National Standard but the format was changed and further instructions added to assist less frequent users to complete the form correctly.

108. Prompts to ensure compliance by nursing staff to complete the Falls Risk Assessment Tool have also been initiated. The tool document has also now been shifted to a blue folder which contains documents for each patient that are frequently used by nursing staff including the patient's care plan and observation and response chart. In addition, if a patient is assessed as a falls risk, it is recorded on the nurse's station electronic white board in the comments section alongside the patient's name. At the commencement of each shift, this comment is then automatically generated on to the patient's allocated nurse's handover sheet.

109. Individual training has been provided to the main initiators of the tool namely the admissions nurse and shift coordinators.

110. The effectiveness of strategies to prove the completion rate of the falls risk assessment tool has been assessed monthly through an audit. The completion rate currently approaches 90%.

111. The risk alert process has also been reviewed with a number of strategies to ensure compliance. Audits indicate completion on admission at an average of 86%.

112. The hospital has also now implemented a Recognising and Responding to Physical Deterioration Procedure. New mobile equipment was introduced and formal training in relation to the procedure and use of the equipment has taken place. Audits have indicated a high level of compliance with the new procedure.

113. A revised Fluid and Sustenance Chart has also been developed. The changes made to the form enable the intake and output of fluids to be totalled every 24 hours to assist with monitoring.

114. With regards to neurological assessments, the head injuries observation form has been updated to make it more user friendly. A new GCS neurological chart has also been introduced.

115. The hospital has also made a decision to develop a procedure aligned with the RANZCP's Guidelines for the use of dexamphetamine and methylphenidate in adults. This requires a psychiatrist to obtain a second medical opinion before commencing an inpatient on dexamphetamine or methylphenidate or as soon as possible following the patient's admission for ongoing prescriptions. These procedures have been implemented since 29 January 2015.

116. A review of the nursing care plan has also been undertaken which has been shifted from the patient's medical record to the blue folder for each patient referred to previously. Training and formal education with regards to the nursing care plans have been held on a number of occasions. Two specific days per week have been allocated for nursing staff to review and/or complete nursing care plans. Compliance has been audited with a marked increase in compliance of completion for the nursing care plan approaching 95%.

117. Since February 2003, a one hour overlap between shifts has been introduced to enable clinical handovers to take place. A revised Clinical Communication and Handover Procedure has also been developed and the new process has been rolled out.

118. As well the inter-hospital transfer process was reviewed and a new form developed to facilitate clinical handover between hospitals. This form includes a checklist to prompt staff to comply with the procedure including contacting the next of kin.

119. All staff receive annual compulsory in-service training on a range of health and safety topics including risk management, incident and accident reporting and CPR. Clinical staff also attend an annual compulsory clinical skills day on a variety of subjects and topics. Staff surveys indicated that a high majority of staff agree they possess knowledge across the variety of policy areas at a high level.

120. In Ms Zerner's submissions she stated there were two possible further improvements, which the hospital may consider. They include:

    a. Reviewing the section 'Post Falls Management' in the 'Falls Management Procedure' in relation to assessing and managing a patient with a potential head injury in a witnessed or unwitnessed fall. This includes, if the fall is unwitnessed, having staff undertake a neurological assessment using the Glasgow Coma Scale.

    b. Reviewing the process of patient allocation on night duty. Currently the nursing staff are required to care for all patients who are in hospital for that shift. At capacity, that is 54 patients which makes it difficult for staff to review the relevant medical records and to get to know the patients they are allocated.

121. The hospital completed that review and their submissions note the following:

    (i) The hospital has recently undertaken renovations which has increased capacity from 54 to 58 a beds.
    (ii) The 58 bed facility was due to commence on 29 June 2015.
    (iii) With this increase in bed numbers additional nursing staff will be rostered on the night shift.
    (iv) From 29 June 2015, the hospital will implement a three month trial of allocating specific patients to specific nursing staff on the night shift, rather than by the current arrangement of allocating all patients in the hospital to all nursing staff on the night shift.

122. Ms McGee stated it was always hospital policy that family should be notified in the event of a transfer to another hospital and this should have been conducted by nursing staff whether or not the medical staff intended to also contact family. In this instance this fell to RN Laurie. Ms McGee also apologised for a subsequent call made by another staff member regarding the transfer of Mr Mill's belongings at a time that was clearly upsetting for the family. That staff member would not have been aware of the seriousness of the event.

Conclusions

123. In reaching my conclusions it should be kept in mind that a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.[1] The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths.

124. If, from information obtained at an inquest or during the investigation, a coroner reasonably believes that the information may cause a disciplinary body for a person's profession or trade to inquire into or take steps in relation to the person's conduct, then the coroner may give that information to that body.

125. Although there were some minor discrepancies in some of the evidence ultimately this does not create any significant concern for my ultimate findings. As I have found, the fall happened after 11.30pm and closer to 11.50pm. I find there was no delay in staff attending to Mr Mills. The contact with Dr Wong and the transfer by ambulance to RBWH was relatively timely although in hindsight this could have occurred sooner. There did appear to be some degree of complacency in the tone of the telephone call by RN Laurie to QAS as regards to the level of emergency. However, if there was any consequent delay this did not contribute to the outcome given the severity of the injury to Mr Mills' head.

[1] s 45(5) *Coroners Act 2003*

126. It is evident that Mrs Mills should have been contacted by the hospital staff when Mr Mills was transferred to RBWH and this did not happen. The hospital has apologised. There is no doubt this has added to the perception by the family that Mr Mills' management and care by TPH was lacking in some way.

127. In most health care related adverse events there are usually multifactorial issues and a combination of system and human errors. Poor communication, poor documentation and a lack of safeguards can result in poor decisions being made.

128. In-hospital trauma from a fall is certainly an event that should in most cases be preventable or at the very least minimised. It is for this reason that significant attention has been given to falls prevention in the hospital system over the last decade or so. It has been identified that falls prevention requires a multidisciplinary approach with engagement by staff at a number of levels and requires the setting up of appropriate operational practices and engagement by the organisation.

129. TPH did have a falls risk policy and assessment tool in place. The hospital falls management procedure also outlined the steps, which should be taken following a fall. This included recording neurological observations using the Glasgow Coma Scale. In this case it also noted that although the staff suspected Mr Mills had hit his head they did not undertake a neurological observation or utilise the Glasgow Coma Scale and this should have occurred. Again, this failure did not alter the outcome for Mr Mills but maybe an example of a degree of disconnect by staff from operational policy.

130. The submissions by TPH concede that during the admission to hospital an objective and systemic falls risk assessment tool (FRAT) had not been completed and so the risk of falling had not been formally identified using a standardised tool. The hospital acknowledges that in not completing the tool, Mr Mills was not afforded the opportunity to have a coordinated plan put in place to address any risk of falling with which he presented, or to have that plan amended as his condition, cooperation and compliance warranted.

131. The hospital also acknowledged that during the subject admission there were incidents and circumstances antecedent to Mr Mills' collapse, which indicated that he was a falls risk. Despite the numerous references to Mr Mills spending most of his time in bed, there is evidence Mr Mills was mobilising. On 16 February 2013, Mr Mills was observed to be out of his room on four occasions to get water. RN Lipman recalls Mr Mills would occasionally get up to go to the toilet or to get a drink during the night. None of the night staff were advised either in a handover or elsewhere that Mr Mills was a falls risk. There was some information on the patient record, which if collated together and considered could have resulted in that conclusion. But this is why it is important for falls risk assessments to be made on admission and be reconsidered as circumstances for the

patient changed and considered by staff at various levels so an understanding and plan can be implemented.

132. The hospital states, and it is accepted, that although no FRAT was completed, the incidents and circumstances referred to above were not totally ignored and that a number of practical strategies were implemented by moving him to a room closer to the nurse's station, monitoring his fluid intake, increasing his daily physical observations to twice daily and encouraging mobilisation and noting his mobility issues in the progress notes.

133. The hospital's submissions queried whether any other strategies might have been implemented which would have prevented the outcome. It is stated that in the event the fall was caused due to a transient loss of consciousness, it is difficult to conceive how this could have been avoided short of a confinement to bed. It submitted that even if a number of other strategies had been implemented as suggested by Dr Storor, it still could not be reasonably concluded that the fall and head injury would have been avoided.

134. Such strategies included potential participation in physiotherapy, an earlier review by a physician or transfer to another hospital for further assessment. If a coordinated plan for managing Mr Mills had been documented and implemented it would most likely have been highlighted to nursing staff that Mr Mills was a falls risk and during the occasions when he was observed to be mobilising, monitoring of his movement and other interaction would have taken place. It is accepted that none of this may have made a difference but it could have and that is the very point in having these procedures, tools and plans in place.

135. From the outset of Mr Mills' admission Dr Wong was concerned about Mr Mills' low blood pressure and mobility. He said he knew all along that Mr Mills was a falls risk and that he spoke frequently to nursing staff about the risk. He expected Mr Mills would be supervised by nursing staff when mobilising.

136. As at 11 February 2013, Dr Wong was aware Mr Mills was suffering postural hypotension. Despite this, he did not request the monitoring of Mr Mills' lying and standing blood pressure or increase the daily observations to twice daily (this was nurse initiated on 14 February 2013). Further, despite the obvious deterioration in Mr Mills' physical condition and his concern that they were 'racing against time' to treat Mr Mills' depression, he did not seek the input of a physician until 15 February 2013.

137. Dr Wong was of the view Mr Mills had long standing low blood pressure and that even if he had sought advice or review, it would not have changed the outcome. Dr Ringrose, physician had seen Mr Mills on a previous occasion and was aware of his low blood pressure but did not alter Mr Mills' treatment. Dr Wong was cognisant of Mr Mills' low blood pressure in prescribing the various medications he did for Mr Mills. Dr Storor was not

critical of the medications prescribed or the frequency of the changes to the medication regime by Dr Wong. There was no evidence the medications ordered by Dr Wong were affecting Mr Mills' mobility. Dr Storor stated he is of the view it is only with hindsight that Dr Wong should have sought earlier physical review of Mr Mills.

138. Dr Wong conceded Mr Mills was not afforded the opportunity of considering whether he would participate in physiotherapy; or being reviewed earlier by Dr Ringrose; or of being transferred to the Wesley Hospital for assessment. Such interventions would not guarantee he did not fall and may not have changed Mr Mills' outcome, but they may have.

139. Dr Wong advised as a result of the death of Mr Mills, he would now transfer a patient suffering similar symptoms to Mr Mills to another hospital for assessment at an earlier time.

140. The TPH has undertaken a review of its policies and procedures following Mr Mills' death. Whilst this was in response to the RCA and the outcome of the Patient Care Committee review, a number of the changes were also in response to the Australian Health Service Safety and Quality Accreditation Scheme and the NSQHS (National Safety & Quality Health Service) Standards, which were introduced in January 2013. Evidence was heard that staff have been trained, new equipment purchased and an auditing system implemented to ensure compliance. At one level it appears the hospital has endeavoured to improve its services, including its management of patients who present as a falls risk. I did get a slightly apprehensive feeling on hearing some of the limited evidence from the night staff that they were not altogether aware of some of the changes. That is frequently the type of evidence I hear in other health care related cases, so TPH is not alone in its struggles to communicate changes to policy and procedure to all staff. No doubt Ms McGee heard some of that evidence and I certainly encourage the hospital to remain vigilant regarding staff engagement in policy changes and training.

Findings required by s. 45

Identity of the deceased – Stephen John Mills

How he died – Mr Mills died from a head injury suffered from a fall whilst he was a patient at the Toowong Private Hospital. No falls risk assessment was completed on his admission to hospital despite a history of a fall at a previous admission. During the admission there was an abundance of objective evidence that Mr Mills was a falls risk. Although there were steps taken to treat individual aspects of his condition, some of which included those placing him at risk of a fall, none of this was considered holistically as part of a falls risk management plan. As such there

was an opportunity lost where the outcome could have been changed.

Place of death – Royal Brisbane and Women's Hospital Butterfield Street Herston Qld

Date of death– 20 February 2013

Cause of death –

1(a) Head injury (treated)
1(b) Fall
2 Coronary atherosclerosis (previous bypass surgery), Complete heart block (cardioverter-defibrillator in situ)

Comments and recommendations

The RCA and subsequent actions by the Toowong Private Hospital to implement a number of improvements to policy and procedure appear to meet most of the identified concerns and as such no further comment or recommendations will be made.

No referral of any person for disciplinary action will be made.

I close the inquest.

John Lock
Deputy State Coroner
Brisbane
28 July 2015