CORONERS COURT OF
NEW SOUTH WALES 44-46 Parramatta Road GLEBE

Jurisdiction:	Coronial
Name of Deceased:	Paul Justyn BRAUER
File number:	1873/2007
Hearing dates:	9/2/2009 to 13/2/2009 at Griffith and 9/3/2009 to 13/3/2009 and 28-29/9/2009 at Parramatta
Date of Decision:	13 December 2010
Coroner:	M.MacPherson
Representation:	Kristina Stern counsel assisting; Graham Butler of counsel on behalf of Dr. Syed; Simon Davis of counsel for Greater Southern Area Health Services; Andrew Vandervord of counsel for Dr. Smith; Julia Lonergan for Dr. Gregory Weppner, Psychiatrist and Doctor Dr.Vikas Deshwal and Sophie Callan of counsel for the sister of Paul Brauer Margaret Brauer and Paul's family

Reasons for Decision

1 On the 13 October 2005 in the early hours of the morning Paul Brauer who was only 64 years of age and a person described by his family as 'the life of the party' died whilst a patient at Leeton District Hospital. By the 13 October 2005 his physical and mental state had deteriorated to the extent that he was unable to look after himself in the community without assistance.

2 In the last year of his life he had spent a considerable amount of time in both Leeton District Hospital and Wagga Wagga Base Hospital being treated for his various physical and mental problems and this Inquest looked at his care and treatment leading up to his death to determine if anything should and could have been done differently to prevent Paul Brauer's death.

3 Specifically counsel assisting set out the issues for examination and determination at the commencement of the Inquest as;

(a) What caused the Pulmonary Embolus from which Mr Brauer suffered in the early hours of 13 October 2005?

(b) Should warfarin or another anticoagulant have been prescribed prior to Mr Brauer's death?

(c) Should Mr Brauer have been discharged into the community on 12 September 2005?

(d) Should Mr Brauer have had additional services whilst in the community from 12 September to 27 September 2005?

(e) Was there any critical failure as regards psychiatric or bladder care that caused or contributed to Mr Brauer's death.

(f) The potential significance of such matters as regards the cause of Paul Brauer's death.

Role of Coroner

4 My role as Coroner is to establish, if possible, the identity, the date of death, the place of death and the manner and cause of death. The formal finding will be recorded at the Registry of Births, Deaths and Marriages

5 A Coronial Inquest is essentially an enquiry. It is not a criminal or civil trial in which two opposing parties engage in legal combat. It is not the role of the Coroner to attribute fault or make findings in relation to negligence or breach of duty of care

6 Another important function of an inquest is the making of recommendations, which are necessary or desirable in relation to any matter connected with a death. In this way the coronial proceedings can be forward looking, aiming to prevent future deaths, rather than allocating blame.

7 I say this not so much for the benefit of learned counsel, but more for the benefit of the family of Paul Brauer who may not always appreciate and understand the role of a Coroner or the Coronial Inquest.

Background

8 At 5.00 am on 13th October 2005 Paul Brauer was settled and sleeping with his indwelling catheter in situ and patent. At 6.05 am Dr Haasbroek recorded that Mr Brauer had no signs of life, no breathing, pupils fixed and dilated, no pulse, and declared that life was extinct.[1]

9 Marion Kirk recorded that Paul Brauer had walked to the shower at approximately 5.45 am (at the time the Nursing Care Plan was for Paul Brauer to be supervised in the shower).[2] When Nurse Queue heard distressed respirations she found him prostate on the floor of the bathroom with a small laceration above his left forehead.

10 It took Registered Nurse Kirk (RN) approximately 5-7 minutes to put her patient to bed and come to assist. Jugular heart rate was thready and rapid at 160 beats per minute. Pupils were pinpoint then rapidly began to dilate and fixate. His pulse faded. A bladder catheter was found, intact, lying on the floor.

11 Oxygen was administered initially via mask, then via rebreather. Paul Brauer had to be dragged out of the bathroom into the ward but due to the difficulty of this RN Kirk decided to use a mechanical lifter and this took approximately 3-4 minutes.

---

[1] 2/806.

12 At around 6.05 am cessation of respirations and absence of central cardiac pulse was noted.[3] No attempts were made at resuscitation at any time.[4] RN Kirk explained that Cardiac Pulmonary Resuscitation (CPR) would have been a good idea, but this was not done because electrical tracing couldn't be put on in the bathroom because of the water, and once they got Paul Brauer out of the bathroom Dr Haasbroek who arrived approximately 10-12 minutes after RN Kirk, said that it was too late.[5]

13 RN Kirk candidly accepted that she would have done CPR in the bathroom, but she was clearly running around trying to locate a doctor, and blankets for warmth, at the time.[6]

14 Paul Brauer's catheter was on the floor of the bathroom, pulled out with the balloon intact.[7]

15 A post mortem was performed by Dr Peter Den Houting who concluded that Paul Brauer died of a large pulmonary embolus secondary to bladder distension within the pelvis of 4-5 days duration. In his examination he had noted that there was marked bladder distension and it contained in excess of 600 mls of urine.

16 As explained by Dr. Burman, Consultant Psychiatrist, there were extraordinary difficulties for clinical staff in managing Paul given the overlap of his physical and psychological diseases.[8]

Factual Background

17 At the time of his death Paul Brauer was in Leeton District Hospital (LDH). He was admitted to LDH on 13 April 2005 with psychotic depression and suffering from severe neglect. This was detected when Dr Haasbroek attended his home for an aged care

---

[2] 2/711.
[3] 2/807-810
[4] Haasbroek 19/2 at 34.
[5] 12/2 at 9-10.
[6] 12/2 at 10.
[7] RN Kirk: 12/2 at 11.
[8] Addendum report of Dr. Burman dated 11 March 2009

assessment,[9] following a referral from the Aged Care Assessment Team who had visited Paul Brauer on 8 April 2005 following notification from Centrelink.[10]

18 Paul Brauer had seen Dr Haasbroek in January 2005 with depression. A referral from Dr Haasbroek to Access Line had not been effective. Dr Haasbroek's evidence was that he was sufficiently concerned about Paul Brauer's depression in January to give him his mobile telephone number[11] but Dr. Hassbroek had not attempted to make contact with Paul Brauer between January and April 2005.

19 A mini mental state examination conducted by Dr Haasbroek at this time was 30/30.[12] Paul Brauer was transferred, apparently under a Schedule under the Mental Health Act, to Wagga Wagga Base Hospital (WWBH) on 14 April 2005.

20 From 21 April 2005 he was treated as a voluntary patient.[13] Throughout much of his time there he was noted to be uncommunicative and to have a flat affect. He spent a lot of time in his room. On 18 May 2005 Dr Smith carried out a TURP procedure.[14]

21 Whilst in WWBH he was accommodated variously on the medical ward or at Gissing House psychiatric ward. Dr Weppner's view is that he had a severe depressive episode.[15] His mental state resolved somewhat towards the end of June 2005, and he was observed to contribute to conversations, to be pleasant during interactions,[16] and to appear brighter.[17]

22 By 22 June when he was reviewed including by Dr Weppner he was noted significantly to have improved since admission, albeit that his own perception was that the medication had not helped his mood.[18]

---

[9] 1/192.
[10] 1/215.
[11] 9/2 at 23.
[12] 1/211 & 216.
[13] 1/250.
[14] 1/136 & 2/470.
[15] 9/3 at 19.
[16] 1/172.
[17] 1/173-4.
[18] 1/176.

23 The true extent of Paul Brauer's deterioration became apparent on 2 June 2005 when his brother and sister visited him and reported to Ms Appleyard, social worker at WWBH, that he had lost approximately 30 kgs in weight since they had last seen him and that he previously had been the life of the party.[19] However this information, which would have enabled a proper assessment of the extent of Mr Brauer's illness at any particular point in time,[20] was not communicated to the treating team at LDH when Paul Brauer was later transferred.

24 Paul remained at WWBH until 28 June 2005 when he was transferred back to LDH by way of a stepping-stone towards discharge into the community.[21] Upon transfer it was reported by Ms Appleyard to Sally Drummond, Mental Health Assessor, that there were no mental health issues on transfer.[22] It was reported by the nurse in charge at LDH to Ms Drummond that there were no concerns about Paul Brauer's mental state, but that he had been transferred due to the need for continued medical management of his catheter.[23]

25 Whilst it is difficult to be clear as to precisely how Paul Brauer functioned whilst at LDH from 28 June 2005, on 6 July 2005 he was noted to be blunted in affect and expressionless, and to experience poverty of thought with impaired judgment without any insight into his illness.[24]

26 Sally Drummond, Mental Health Assessor, describes him as having a significant depressive illness at this time.[25] On review by Dr Hickey, Psychiatrist, on 11 July 2005 he was noted to be flat, amotivated, pessimistic with slow speech and poverty of thought.[26]

27 On 11 August 2005 Dr Sangster described him as alert, rational and able to manage his affairs.[27] He was noted to be mildly nihilistic by Dr Graffan on 24 August 2005, and to

---

[19] 1/152.
[20] Ms Appleyard 9/2 at 50.
[21] 9/2 at 45.
[22] 2/445.
[23] 2/447.
[24] 2/449.
[25] 11/2 at 79.
[26] 2/450.
[27] 2/591. This is probably a letter to the guardianship board – 2/667.

be functionally too good for hostel care.[28] Bob Dow, Community Mental Health worker, assessed him on 24 August 2005 as presenting as well.[29] Following this, he was reviewed by Dr Sachdev, Psychiatrist, who noted that his mental state appeared subdued but appropriately reactive. He stated that once his catheter was out he could see no reason why Paul Brauer could not live independently.[30]

28 On 26 September 2005 Dr Sangster certified that Paul Brauer was fit and able to live in the community with services.[31]

29 Whilst in LDH he was repeatedly noted to be reluctant to mobilise from his bed or chair,[32] and reluctant to engage in conversation. However, there are also references to him interacting on the ward, and to him being orientated to TPP.[33] He had an episode of hypomanic behaviour on 24 July 2005.[34] From around mid August he was noted to remain in his room most of the time, but little by way of complaints or concerns were voiced by nursing staff. However, on 31 August 2005 he told staff that he had not been telling them the truth regarding his bowel motions.[35] On 1 September he was noted to be hypomanic at times.[36]

30 He was discharged from LDH into the community on 12 September 2005, following a series of home visits escorted by Cecilia O'Rourke. By 27 September 2005 he had to be readmitted on account of a clear breakdown in his care.

31 On 27 September the following were noted:

> blood stained urine with small clots, incontinent of faeces, catheter leaking all over clothes and not connected to the leg bag, urine in bag very concentrated, blood++++. Leuco ++++, urine culture reported infection, raised white cells and neutrophils.

---

[28] 2/616-7.
[29] 2/670.
[30] 2/456.
[31] 2/610. This may have been for the purposes of the Guardianship Tribunal.
[32] eg 2/644, 645, 647, 653.
[33] Eg 2/656-7, 2/658, 2/669.
[34] 2/659.
[35] 2/674.
[36] 2/674.

32 He remained in LDH until his death on 13 October 2005.

Issues Arising

The critical starting point – Dr Den Houting's report

33 Dr Den Houting concluded that the pulmonary embolus was secondary to bladder distension within the pelvis of 4-5 days duration.[37]

34 Giving evidence on 10 March 2009, there was this exchange between Dr Houting and counsel assisting;

> *Q. ..Your conclusion that the pulmonary embolus was secondary to bladder distension leading to pelvic thrombus, is one that is reached primarily is it not by reason of the coincidence between two findings that you made, namely the pulmonary embolus and the bladder distension?*
>
> *A. Yes it is*
>
> *Q. And is it not equally possible that the pulmonary embolus could have been caused by the deep vein thrombosis from the legs?*
>
> *A.* ***Certainly*** (My emphasis added)[38]

The evidence and extent of urine retention

35 Paul Brauer clearly had a history of urine retention. Upon admission on 13 April 2005 Dr Johannes Haasbroek noted that Paul Brauer clearly needed an Indwelling catheter (IDC) in view of obstructive uropathy.[39] He was noted to be resistant to the idea of an IDC.[40]

[37] B/30.
[38] Transcript 10/3/09 page 68 lines 35 to 40
[39] 1/65.
[40] 1/67.

An ultrasound scan on 14 April 2005 observed that Mr Brauer's bladder emptied from 740 mls minimally to over 700 mls.[41]

36 By 15 April 2005 he was noted to have an IDC in situ,[42] it having been inserted in the Emergency Department as Mr Brauer's bladder was palpable and he was in discomfort.[43] He was noted to have bladder obstruction.[44]

37 On 16 April 2005 700 mls of dark urine was drained once a catheter was inserted.[45]

38 On 17 April 2005 Paul Brauer was noted to have a palpable bladder, but only 300 mls of dark concentrated urine was drained.[46] On 21 April 2005 he was noted to be uncomfortable with a palpable bladder and 500 mls of blood stained urine was drained.[47] On 26 April 700-800 mls of urine were drained after an unsuccessful trial of voiding.[48] On 4 May 2005 1200 mls were drained.[49]

39 There were also occasions on which Paul Brauer's catheter fell out or was accidentally pulled out,[50] and occasions when it became blocked,[51] including by a clot.[52] Clots were also noted on 23 April,[53] and on 14 May the ongoing urinary retention was said to be likely secondary to clots.[54]

40 There are also references in the progress notes to Paul Brauer having a urinary tract infection in early May 2005.[55]

---

[41] 1/204.
[42] 1/69.
[43] 1/72.
[44] 1/70.
[45] 1/76.
[46] 1/82.
[47] 1/93.
[48] 1/101.
[49] 1/115.
[50] Eg 1/81, 131.
[51] Eg 1/107, 112, 115.
[52] 1/97.
[53] 1/98.
[54] 1/134.
[55] Eg 8 May 2005 1/118 *"unresolved medical issues – UTI"*, 9 may 1/124,

41 Dr. Alexander's evidence was the Paul Brauer had had an atonic bladder or detrusor failure from the first record that Dr. Alexander had seen, and that he would not have been aware if he had a full bladder[56].

42 It is likely that there was a degree of urine retention during the period when Paul Brauer was in the community before his admission on 27 September because when he was found he was soaked with urine but his catheter was connected to an ordinary drainage bag.[57]

43 During the admission 27 September to 13 October there is only one record of the amount of urine drained from the urine bag. No fluid balance charts were completed. Other than vague references in the notes to the catheter draining, it is not possible to know whether or not Mr Brauer's catheter was draining properly, or whether it may have been intermittently blocked, during this period. Nursing checks of catheter functioning may vary in their detail, and the likelihood is that at least on some occasions all that was done was a cursory check that there was some urine in the catheter bag. As Mr Brauer had an atonic bladder he would not have complained of discomfort when his bladder was full.

44 All that is known is that despite having been noted at 5 am to be draining, by around 6 am on 13 October there was 600 mls of urine in his bladder showing that the catheter was not draining properly.[58] As Dr. Alexander pointed out, if the catheter had been draining properly there should not have been more than 10 or 15 mls in his bladder which is a normal residual with a catheter.[59] As Paul Brauer had an atonic bladder, it was unlikely that urine retention would have registered as discomfort. Thus that potentially telling indicator of problems with the catheter was absent.

Finding

45 On balance, there is insufficient evidence in order to reach a firm conclusion as to the nature and extent of Paul Brauer's urine retention, other than that there was probably some urine retention on 27 September 2005, and that there was a significant amount of

[56] Transcript 29/9/09 at 6
[57] 2/708.
[58] Johnson report 20 April 2009 at 4.
[59] 29/9 at 8.

residual urine in Mr Brauer's bladder at the time of his death, and that this is indicative of a problem in the operation of his catheter at this time.

Urine retention and cause of death

46 The expert evidence is divided as to the extent to which urine retention could be relevant in causing Mr Brauer's death.

47 Dr. Johnson identified two potential mechanisms.[60]

48 One is that urine retention increases the pressure generally in the pelvic region causing sluggish circulation thereby increasing the risk of clotting in the legs.

49 The second is that there would be a direct pressure from the bladder onto the pelvic veins, causing thrombus.

50 Dr. Alexander and Dr. Katelaris, expert Urologists, are agreed that urinary retention and bladder distension would not cause pulmonary embolus. They rely upon their own extensive experience dealing with patients with a range of urinary problems, and upon their understanding of the physiology of the bladder, which is that; the bladder would not extend so as to obstruct the pelvic veins.

51 The evidence also establishes that pulmonary embolus is more frequently caused by a deep vein thrombosis than by thrombus in the pelvic veins, and that there were a number of features of Paul Brauer's circumstances which were risk factors for the development of a deep vein thrombus particularly his immobility in the period between 27 September and 13 October 2005.

52 Counsel for the family of Paul Brauer submit that notwithstanding the differences in opinion of the experts as to the origin of the thrombus I should be satisfied on the balance of probabilities that urinary retention, resulting in a distended bladder, caused the pulmonary embolus.

[60] Reports 9 February 2009 at p.11 and 20 April 2009 at p.6

Finding

53 I have carefully considered the submissions of all the parties but in particular the family of Paul Brauer but in the circumstances including the concession made by Dr. Den Houting to counsel assisting, it cannot be said on balance that urinary retention prior to Paul Brauer's death caused his pulmonary embolus.

Paul Brauer's history of stroke

54 On 19 April 2005 Dr Weppner at WWBH ordered a CT scan *"to exclude organic explanation for odd behaviour"*.[61] The CT scan was reported as showing two areas of hypodensity, one within the posterior aspect of the left cerebellar hemisphere and one superiorly within the left frontal lobe. The impression was of old cortical infarcts. An MRI scan was recommended.[62] This showed an old left inferior cerebellar hemispheric infarct but no other site of old or recent infarct.[63]

55 A further CT scan was carried out after Dr Yates expressed the view on 6 October 2005 that Paul Brauer was not currently significantly depressed but was significantly confused, and that this was likely to be the reason for his poor motivation.

56 His Mini Mental State Examination (MMSE) had deteriorated from 30 on 29 August to 22/30 on 6 October 2005.[64] Dr Yates' view was that it was likely that Paul Brauer had had a stroke making him susceptible to prolonged confusion after Urinary Tract Infection (UTI).[65] The CT scan showed discrete hypodensity in postero-lateral aspect of cerebellum on left. Impression of infarct in the postero-inferior cerebellar artery territory on the left.[66] This was interpreted by Dr Syed as "impression old CVA".

57 Dr. Johnson and Professor O'Rourke are agreed that Paul Brauer may well have suffered a stroke causing confusion in late September early October 2005, and that this would not necessarily have shown on CT scanning.[67]

[61] 1/87.
[62] 1/260.
[63] 1/264.
[64] 2/801.
[65] 2/801.
[66] 2/831.
[67].Johnson report 9 February 2009 at 7 and O'Rourke 9 March 2009 at 2.

58 Dr. Johnson’s view is that the presence of a previous stroke is associated with an increased risk of stroke of a factor 2.5.[68]

Atrial Fibrillation and Anticoagulants

59 It is clear that Mr Brauer had Chronic Atrial Fibrillation. [69] This gives rise to a risk of blood clotting and strokes. Because of this warfarin, or some other anticoagulant, is sometimes administered. It is more likely to be administered where there are other factors increasing the risk of stroke. The presence of a stroke in the past is one such factor.

60 However, warfarin is an unpredictable drug and is associated with risks in patients who take an excessive dose, whose INR levels become unacceptably high for example by reason of fluctuations in their diet, illness, alcohol use or other medications, or in whom there are significant risks of bleeding.[70] There may be a need to alter the required dose following blood tests, so it is not suitable for administration via a Webster Pack, which was the means by which Mr Brauer’s medications were administered whilst he was in the community.[71]

61 The anticoagulation guidelines at Greater Southern Area Heath Service (GSAHS) current in 2005 provided that low molecular weight heparin or unfractionated heparin should be used for other cardiac indications, including AF, but that heparin should be discontinued if a significant bleeding event occurs. However, in each case, as was clear from the expert evidence, the decision whether or not to prescribe anticoagulants would be one of clinical judgment balancing risks and benefits.

62 Warfarin or heparin may also be prescribed for prevention of venous thromboembolus. Risk factors for venous thromboembolus include age, immobility, surgery and acute on chronic infection.

---

[68] Report 20 April 2009 at 4.
[69] 1/63, 1/81, 2/471, 2/411
[70] This information is reflected in the Greater Southern Area Health Service Pharmacy Dept Patient Information Leaflet for Warfarin.
[71] Dr Syed, 10/2 at 45.

63 It is also clear that Mr Brauer was significantly immobile at times during his admissions. He is repeatedly noted not to want to mobilise, although he was clearly more mobile between mid August and 12 September 2005. After his readmission on 27 September he was repeatedly noted to be lying on his bed and Dr Syed described him as "actually immobile".[72] Paul Brauer's degree of immobility is agreed to, have given rise to a risk of venous thrombosis.[73]

64 From 27 September 2005 Paul Brauer also clearly had an acute on chronic urinary tract infection. According to Dr Syed (the treating doctor at LDH during this period), this had not wholly resolved as at 11 October.

65 The prevention of venous thrombosis guidelines current at GSAHS in October 2005 included in the category of medical patients at high risk of venous thrombosis those that are aged greater than 60 years, and those with acute on chronic inflammatory disease. Paul Brauer was thus at high risk on two counts, and was also largely immobile. He should have been given anticoagulation on this account also, according to these guidelines.

66 The anticoagulation guidelines at GSAHS current in 2005 recommended that unfractionated heparin should be used for medium risk patients, which included general surgery in patients over 40 with immobility. In the 2008 rewrite, heparin was recommended for high risk medical cases including where age is greater than 69 years with acute on chronic inflammatory disease, although risk was clearly identified as relating to extent to which patients are ambulant.

67 As regards Paul Brauer certainly from 27 September 2005 until 13 October 2005, upon a mechanistic application of these guidelines Warfarin or some other form of anticoagulation should have been given. However, again the evidence establishes that much depends upon clinical judgment in the circumstances of the particular patient.

---

[72] 10/2 at 46.

[73] Professsor O'Rourke says that people who are recumbent and move little as Paul Brauer did in hospital often have terminal thrombosis in deep veins and die from pulmonary embolus) report 9 March 2009 at 2, also report 26 February 2009 at 4.)

68 It was on a number of occasions identified that Paul Brauer was not on medication for his AF. [74] He had had a stroke in the past. It was probably an ischaemic stroke, caused by a clot. This was a factor increasing his risk of strokes in the future, as, according to Dr Graffen, it is probably one of the highest risk factors for another stroke. That risk was in the region of 12% or so per year.[75] Warfarin is suggested for patients at a risk of stroke of about 3-5% per year,[76] so Paul Brauer was well over that threshold.

69 It was also clear that from 27 September 2005 he was significantly immobile, was suffering from an acute on chronic UTI, and that his age put him at risk of embolus. However, during this period, Paul Brauer was suffering from a urinary tract infection which had not resolved, and his mental state had deteriorated. These are factors, which have been relied upon by Professor O'Rourke as incompatible with the safe administration of Warfarin. Professor O'Rourke's evidence was that the aim seemed to be to get Paul Brauer on his feet again and back to the community and that in those circumstances the clinical staff would be justified in attempting to get Paul to be more active rather than prescribing anti-coagulation. [77]

70 Dr. Johnson's view, by contrast, was that at all times the risk to Paul of not taking anti-coagulation outweighed the risks of Warfarin (or another form of anticoagulation), and that in the circumstances it should have been prescribed.

71 Professor O'Rourke and Dr. Johnson both agree that the administration of Warfarin would probably have prevented Paul Brauer's pulmonary embolus.[78]

72 There had been suggestions from those responsible for his care that Warfarin should have been administered on account of Paul Brauer's Atrial Fibrillation.

73 On 8 May 2005 Dr Stoita, medical registrar, noted that Paul Brauer had "Chronic AF not on medication".[79]

---

[74] 1/66.
[75] 11/2 at 9-10.
[76] Dr Graffen: 11/2 at 11.
[77] 298/9 at 60-61
[78] Report of Dr. Johnson 9 February 2009 p.7 and report of Pro0fessor O'Rourke 9 March 2009 page 2
[79] 1/121.

74 On 7 June 2005 Dr Hardy, Medical Registrar, noted that Paul Brauer had had chronic AF since 1992, was not taking medication, but saw a cardiologist in Mona Vale.[80] He recommended that Paul Brauer should be on warfarin for his AF and requested a chest x-ray.[81]

75 On 9 June 2005 Dr Hardy reviewed Paul Brauer together with Dr McCready, Consultant. Dr McCready, having noted the current problems with Mr Brauer's postural hypotension, set out a plan that;

> *"will need to start warfarin 2° to AF when he settles and his haematuria resolves" and noted "needs warfarin for AF but fall risk" and "warfarin when steady on feet and catheter out".*[82]

76 Despite the apparent resolution of the problems of haematuria and falls, there is nothing in the progress notes to indicate that any further consideration was given to administering warfarin to Paul Brauer, and there were no further medical, as opposed to psychiatric, attendances.

77 The inference was that no further consideration was given. That is consistent with the evidence of Dr Weppner that he would not have considered starting warfarin but may in theory have asked Dr Deshwal to contact Dr McCreadie to see what his view was, but would not have done so if the catheter was still in.[83]

78 The discharge summary completed by Dr Deshwal on 1 July 2005 makes no reference to warfarin in the recommended care plan, and incorrectly describes Paul as suffering from paroxysmal AF rather than chronic AF.[84] Accordingly staff at LDH were not aware of the recommendation for warfarin.

79 There is doubt whether or not Dr Graffen's letter was given to the hospital staff (as opposed to the Aged Care Assessment Team (ACAT)) at LDH. In any event, the progress notes completed by Dr Graffen included his recommendation to *"consider Warfarin"*.

---

[80] 1/163.
[81] 1165.
[82] 1/ 69.
[83] 9/3 at 6-7.
[84] 1/196.

80 The absence of any notes reflecting that consideration give rise to an inference that in fact this recommendation was missed by the treating team, and that no-one at LDH in fact considered whether or not Paul Brauer should receive warfarin. Also, that the potential contraindications for Warfarin were not discussed with Dr Graffan at the time.

81 Dr Syed, responsible for Paul Brauer's medical care from 27 September, did not consider whether or not this immobility would pose a risk for pulmonary embolus.[85] Nor, after Dr Syed reviewed the CT scan in October 2005, which showed that Mr Brauer had at some time had a stroke, did Dr Syed consider whether or not this suggested that an anticoagulant should be administered.[86]

Reasons advanced by doctors caring for Mr Brauer not to administer anticoagulants

82 A number of different reasons have been advanced why anticoagulants were not in fact administered.

83 Other than risks associated with an unsupervised discharge, Dr Graffen who actually saw Paul Brauer and considered this did not see any contraindications to the use of warfarin.[87]

84 Dr Haasbroek simply said that the AF did not appear to be his most pressing problem, although he accepted that it was possible that he was unaware of the AF.[88]

85 Dr Weppner stated that the risk of a catheter being pulled out would have contraindicated warfarin.[89]

86 Dr Syed, responsible for Paul Brauer's care only between 27 September and 13 October, was not considering warfarin on 27 September. He was concerned with the UTI.[90] However, he stated that given Paul Brauer's apparent inability to manage his medication in the community (and his presenting problem of a UTI with haematuria) he would not

[85] 10/2 at 47.
[86] 10/2 at 56.
[87] 11/2 at 11.
[88] 9/2 at 28 & 31.
[89] 9/3 at 15.
[90] 10/2 at 43.

have regarded it appropriate to prescribe Warfarin to him in the community.[91] He also explained that in Leeton it would be too costly to arrange for daily district nurse supervision of the administration of warfarin.[92] He also suggested that the fact that Paul Brauer had blood in his urine might have prevented the administration of anticoagulants.[93]

87 Dr. Smith, who performed the TURP in May 2005, gave evidence that Paul Brauer's mental state made him unsuitable for Warfarin.[94]

Contraindications to warfarin in this case

Self-neglect or confusion

88 It is clear that Paul Brauer had a history of self-neglect in early 2005. He was noted to be severely depressed in January 2004. By 13 April 2004 Dr Haasbroek found him in a state of severe neglect.[95] He was noted to have psychotic features. His insight and judgment were noted to be poor.[96]

89 However, his condition improved in hospital. By 26 June he was noted to be compliant with medications, but to require encouragement as regards fluid intake.[97]

90 It is clear that there was a continuing risk of self-neglect, but it is equally clear that there were no references to confusion on the part of Paul Brauer in the period leading up to his discharge on 12 September. Further, he was discharged on a range of medications, with a clear expectation that these medications would be self-administered subject to the weekly supervision of District Nurses and daily calls with Access Line.

91 Dr. Burman's view was that Paul Brauer was capable of complying with medication until some time prior to 26 September 2005.[98]However, the evidence was that safe administration of Warfarin requires a combination of the reliable taking of medication

[91] 10/2 at 45.
[92] 10/2 at 45.
[93] 10/2 at 57.
[94] 29/9 at 25
[95] 9/2 at 23 & 1/58.
[96] 1/68.
[97] 1/180.
[98] Burman addendum report dated 11 March 2009

and compliance with regular monitoring, and the safety of the dosage can be affected by supervening infection and by changes in diet. All of these factors may have caused clinicians to decline to prescribe warfarin despite his apparent alibility to comply with a range of other medications.

92 There was evidence that one of the services, which can be provided by Home Care, was medication supervision.[99] Home care services were, of course, not made available to Paul Brauer.[100] Had a medication supervision service been requested, it is possible that Paul Brauer could have had the benefit of that service as and when Home Care had availability.

93 The District Nurses did not have capacity to provide a daily medication supervision service, but could negotiate with others if that was needed.[101] All of these possibilities may have been of assistance in ensuring safe administration of Warfarin.

Falls

94 On 15 May 2005 a significant postural drop was noted when Mr Brauer got up to have a shower. He became light headed and unsteady.[102] A postural drop was also observed on 26 May 2005.[103] On the same day it was noted that he had passed out on wards for no apparent reason.[104] He fell again on 3 June,[105] and was noted to overbalance when getting up quickly on 14 June.[106] Metoprolol, noted to have an effect on his falling, was stopped on 7 June.[107]

95 There are no references to falls in the progress notes after 14 June, save for one episode when Paul Brauer slipped in the bathroom in LDH.

96 It would thus appear that from early June 2005 this was no longer a contra-indication to the administration of warfarin.

---

[99] RN Bunyan: 11/2 at 41; cf evidence of RN MacMahon: 12/2 at 55.
[100] 2/618
[101] RN Bunyan: 11/2 at 42.
[102] 1/195.
[103] 1/144.
[104] 1/145.
[105] 1/153.
[106] 1/173.
[107] 1/305.

Haematuria

97 Repeatedly during his stay in WWBH it was noted that Paul Brauer had blood in his urine.

98 Up until around 9 June there were reports of blood stained urine although around this time there were also reports of a UTI,[108] problems with the catheter,[109] and there was a period where bleeding may have been expected following the Trans Urethral Resection procedure (TURP) on 18 May 2005.

99 Dr McCready identified this as a contraindication to Warfarin on 9 June 2005. However, after 9 June 2005 there are no references to haematuria in the progress notes at WWBH. There is no indication that this was brought to the attention of Dr McCready, or that staff at WWBH revisited the decision to defer warfarin. The plan to use warfarin at some point was not identified in the discharge summary to LDH. LDH were thus not aware of this plan.

100 In the period when Paul Brauer was in LDH between 28 June and 12 September

(a) Rose coloured urine was noted on 13 July 2005 when the catheter was blocked.[110]

(b) There was a reference to blood stained urine on 19 July 2005 around the time that the catheter was blocked,[111]

101 But otherwise no episodes of blood stained urine are recorded. Nor did Dr Graffan raise this as a possible contraindication to warfarin administration.

102 Upon readmission on 27 September Paul Brauer was clearly suffering from a UTI and he was noted to have blood stained urine with small clots.[112] The Pathology report on 27

---

[108] 1/118, 124,
[109] eg
[110] 2/652.
[111] 2/655.

September 2005 noted, *"blood ++++"*. Dr Syed explained that these were due to the UTI.[113] By 30 September it was noted that his urine was clearer.[114] The only other report of blood stained urine was on 11 October.[115]

103 Dr Graffen's view was that this would be something to cause you to hold back for a little while until the bleeding settled, but that "*if the bleeding problem is due to an infection it should clear up fairly smartly*."[116]

104 Dr. Alexander's view was that a minor amount of blood in the urine would not be a contraindication for Warfarin but a significant amount of blood in the urine (such as indicated by *"blood +++"*) would require consultations with a cardiologist to balance the risks of bleeding against the risk of not taking Warfarin.[117]

Catheter

105 Dr. Alexander did not regard the presence of a catheter as a contraindication to Warfarin.[118]

Conclusion as to anticoagulation

106 The likelihood in this case is that none of the Doctors, Dr Weppner, Dr Sangster or Dr Syed, ever gave serious consideration to the administration of warfarin. This was so despite recommendations that this be considered.

107 Whilst it is possible that anticoagulation would have been prescribed if the recommendation to consider Warfarin from Dr. Graffen had been given that serious consideration at Leeton District Hospital, the evidence on this issue is not clear.

108 Dr. Graffen in oral evidence accepted that it was a decision that required a balance of factors.[119] Professor O'Rourke was clear that even the degree of immobility which Paul

---

[112] Eg at 2/797.
[113] 10/2 at 47.
[114] 2/797.
[115] 2/805.
[116] 11/2 at 19-20.
[117] 29/9 at 3-4
[118] 29/9 at 3.
[119] Transcript 11/2 at 11 lines 5 to 15

showed after 27 September was not such as to justify the administration of Warfarin. He was asked by counsel assisting if the degree of immobility noted in the records between 27 September and 13 October was a reason to prescribe some form of anti-coagulation and he replied;

> *"Not really, I think there was a reason to try and make him more active because that was part of the reason for getting him back into the community and out of the hospital."*[120]

109 He explained that there were a number of things that would make the administration of anti-coagulant inappropriate, he said;

> *"I think the worry of his ability to take the drugs or to remember to take the drugs. I suppose in hospital they're being given to him but I think they seemed to be trying to get him back onto his feet again so that he had more confidence and would be able to go back into the community again and so they would see little benefit in treating him with Warfarin with anti-coagulants in that period of time when the same objective could be gained by having him move about walk around, look at things and get out of bed and stop watching television. I think he was tried to be made active, that's the usual thing that we try and do in hospital. We don't put all such patients on anti-coagulants."*[121]

110 Dr. Johnson had the opposite view that Warfarin should have been administered when a long question was put to him by counsel assisting setting out the area of disagreement with the opinion of Professor O'Rourke that there were sufficient contra indications to the administration of Warfarin when he said;

> "*I don't agree with that view. And I should add it is not just Warfarin it is anticoagulation, so whatever form of anticoagulation. Warfarin or not was indicated.*"[122]

111 Further, Professor O'Rourke was of the view that it would have been unsafe to discharge Paul Brauer on Warfarin with follow up 2 to 3 times per week.[123]

---

[120] Transcript 28/9/09 page 60 lines 30 and 35
[121] Ibid pages 60 lines 45 and 50 and 61 line 3
[122] Ibid page 9 lines 5 and 10
[123] Ibid page 66 lines 17 and 20

112 Given the evidence of the clinicians involved in the care of Paul Brauer there was clearly a difficulty in deciding whether or not to prescribe Warfarin because of the contraindications.

113 If active consideration had been given to prescribing anticoagulation on account of Paul Brauer's atrial fibrillation on or prior to 12 September 2005 it is possible that either Paul would not have been discharged on 12 September 2005 and would have been anticoagulated in Leeton District Hospital, or that he would have been discharged on anticoagulants, possibly with provision for more frequent General Practioner or hospital attendances.

114 This still means that the clinicians treating Paul would have needed to weigh up the benefits as against the dangers associated with the administration of anticoagulants in either setting.

Finding

115 Because of the conflict in the evidence in relation to whether Warfarin should have been prescribed it makes it difficult in the circumstances to reach a firm conclusion that Warfarin should have been prescribed to Paul Brauer either prior to 12 September or after his re-admission to LDH on 27 September 2005, even on balance of probabilities.

Discharge

116 At the time when Paul Brauer was admitted to LDH in April 2005 he was asked what he would do if no agency provided support to him. His response was that he would stay home even though aware that lack of foodstuffs would lead to a deterioration in his physical health and that he might die.[124] This response was perhaps unsurprising given the state of self-neglect in which he was found and his psychotic depression.

117 It is clear that from an early stage options for Paul Brauer's discharge were being considered. On 24 May 2005 accommodation on discharge was discussed with Paul Brauer.[125]

---

[124] 1/236.
[125] 1/142.

118 In June 2005 it was noted that ACAT was required to assess hostel level care in the Sydney area,[126] and that applications had been put in with the Department of Housing.[127] Ms McFarlane, Occupational Therapist, said on 24 June 2006 that Paul Brauer would require community follow up to review coping skills and engage him in community activities.[128] It appears that this information was not in fact given to LDH when Paul Brauer was transferred, although it is doubtful that it would have made any difference to his discharge planning.

119 The involvement of ACAT in this case was somewhat informal, given that, at age 64, Paul Brauer did not qualify for the Commonwealth funded care with which ACAT was involved. Paul's age thus restricted the availability of placements, other than as a last resort if a community placement were trialled and broke down.[129]

120 The plan noted on 15 July 2005 was to wait until Paul Brauer had been seen by Dr Graffen, geriatrician, and that Paul Brauer needed more time to get over his depressive episode.[130]

121 Dr Hickey, psychiatrist, reviewed Mr Brauer on 11 July 2005 and stated that his psychiatric illness should not keep him in hospital and he could be managed as an outpatient.[131]

122 This was also the view of Ms Brassington, ACAT, although she candidly stated in her evidence that nobody was sure whether he actually would or would not manage in the community with services.[132]

123 On 13 August it was noted that Paul Brauer was for discharge to a Department of Housing house with services.[133]

---

[126] 1/177.
[127] 1/178.
[128] 1/180.
[129] Brassington 10/2 at 3.
[130] 2/443.
[131] 2/451.
[132] 10/2 at 5.
[133] 2/453.

124 Dr Graffan's view following his assessment of Paul Brauer on 24 August 2005 was that he was not a candidate for an aged care hostel and would be better off returning to the community with home help. He also felt he needed psychiatric review and case management from a community mental health worker who could supervise his resumption of life back in the normal community. Depression was listed as one of his current problems, and it was noted that his biggest problem was his perceived "*difficulty in coping*" back in the community.[134]

125 Dr Graffen agreed that because of his depression he would have difficulty in coping in the community,[135] but felt that it could actually be more depressing for Paul Brauer to be in an aged care facility.[136]

126 It is clear that throughout his admissions Paul Brauer experienced difficulties with his catheter becoming blocked.[137]

127 Margaret Brauer, Paul's sister, has at all times maintained that Paul Brauer required hostel care. She also requested on 27 July 2005 that Paul be transferred to Sydney or Melbourne to be closer to family, but was told by RN McMahon that the hospital could not arrange this.[138]

128 The Greater Murray Area Health Service Mental Health Policy and Procedure in place in September 2005 required that a patient have an appropriate discharge plan formally documented and put in place, involving consultation with Community Mental Health, prior to discharge, and that discharge and follow up arrangements should be in collaboration with patients, carers, families and relevant health professionals, involving community teams in the discharge decision if possible. Consultation is required to ensure discharge occurs only when support services are in place and optimal. The Greater Murray Area Health Service Mental Health Policy and Procedure in force in September 2005 also required that a discharge plan be formulated in close consultation with the community mental health worker.

---

[134] 2/616-7.
[135] 11/2 at 6.
[136] 11/2 at 9.
[137] Eg at 2/657.
[138] 2/661.

129 These policies were not adhered to in this case as there was minimal direct communication with community teams prior to discharge. In particular, the system broke down as regards the involvement of Mr Dow, the community mental health worker, and the relevant GP (it is not clear which GP was in fact the relevant GP as a number had at different times been involved in Paul Brauer's care).

130 The care plan as set out upon discharge, as written up in the progress notes,[139] comprised the following:

(a) District nurses notified re catheter care.

(b) Scripts and Webster packs organised.

(c) Access Line calls every night for one week to check he is taking his medication and is OK;

(d) A worker to call in twice a week for 6 weeks, then weekly;

(e) Pastoral care worker to call in once a week;

(f) A doctor's appointment had been made every Monday at 10.30 for three weeks;

(g) Mental Health Worker notified of Mr Brauer's discharge.

(h) Home care had refused services.

131 Paul Brauer was discharged on Lacatulose 20 mg x 2 daily, Lanoxin .25 daily, Hiprex 1 g x 2 daily, efexor 25 x 2 morning and risperidone 1 mg at night.

132 Dr Graffen's view, having seen Paul Brauer on 24 August, was that second daily nursing checks would have been appropriate *"at least initially until they were sure that things were running on track"*.[140]

133 The situation which in fact transpired upon discharge:

---

[139] 2/676-7.
[140] 11/2 at 19.

(a) It appears that no GP appointments were in fact made, and Paul Brauer did not see a GP;

(b) Paul Brauer was seen by Cecilia O'Rourke on 13, 15 (TV still in a box and some garbage in the kitchen), 26 and 27 September. On 26 September Ms O'Rourke identified that Paul had deteriorated, was sat in the dark, unshaven, and with garbage in the kitchen. His TV was still in a box and his fridge was still off.[141] Ms O'Rourke was clearly not aware of the care plan for Mr Brauer or of the other services he was to be receiving.[142]

(c) The referral to the district nurses asked for weekly checking of the catheter and general observation but provided almost no clinical information.[143] This was the sum total of information provided to the district nurses on referral as regards Paul Brauer, although further information was obtained orally later.[144] A Bunyan, RN, visited Paul Brauer at home on 15 September and noted IDC draining well from her visual check of the catheter bag having noted that urine was in it and having checked the colour,[145] and on 22 September when it was noted that he was managing his catheter and she felt his mood was stable.[146]

(d) On 17 September Paul Brauer attended A&E at LDH for his catheter to be changed by Dr Sangster. Dark yellow urine was noted.[147]

(e) Yvonne Brassington made an informal home visit to Paul Brauer on 17 September with her husband. The fridge was not turned on but she turned it on before she left. The kitchen was cluttered but the living area was tidy. The TV was still unpacked but Paul Brauer wanted to wait for a table to put it on.[148]

(f) A referral to Bob Dow, CMH worker, was made by Access Line (not by LDH) but as no category had been given for the referral, indicating the frequency of follow up required, he was awaiting further contact and did not contact Mr Brauer.[149] Mr Dow's evidence was that he was not aware of Mr Brauer's history of self-neglect, and that no member of staff from LDH got in touch with him as regards the discharge of Mr Brauer.[150]

(g) Thus, in practice no case management (the responsibility of mental health in this case) was in place.

---

[141] 2/460-1.
[142] 10/2 at 78.
[143] 2/697.
[144] RN Bunyan: 11/2 at 47.
[145] RN Bunyan: 11/2 at 54.
[146] 2/463.
[147] 2/708.
[148] 2/693.
[149] 2/448.
[150] 10/2 at 71-2.

(h) Access Line telephone calls did take place as planned, although it is clear that Mr Brauer dissembled during these calls.

(i) Meals on wheels were delivered but for a period prior to 27 September were not even opened.

134 Paul Brauer clearly did not see a General Practitioner whilst discharged.[151]

135 No discharge summary was prepared by LDH. No written care plan was given to all relevant agencies. Had such documents been prepared and circulated this would have provided valuable additional information to focus and mange interventions. This was a failure to comply with the applicable policies requiring written communication and involvement of community agencies to ensure properly coordinated and appropriately informed service provision on discharge. Further, there was a clear lack of coordination between the different service providers, so that possible inconsistencies in the information being provided by Paul Brauer were not identified.

136 Despite the fact that Paul Brauer's trousers were wet and there was a clear deterioration by 26 September when she saw him late in the afternoon, Ms O'Rourke did not refer Paul Brauer to hospital. Her explanation for this was that "*I think he was low but he didn't appear sick, I asked him if he was sick and he didn't respond.*"[152] She did however call the district nurses early the next morning.

137 His deterioration by 27 September was marked. He was wet with blood stained urine. His bed was urinated. The house smelt bad. Meals in wheels bags were still in the sink. His mental state had clearly deteriorated and he was taken by ambulance to hospital.[153]

138 Clearly Paul Brauer would not have deteriorated as he did if he had not been discharged on 12 September. However, in the light of the recommendations of all doctors who saw him, there is no basis to criticise the decision to discharge Paul Brauer in the light of the then current treatment plan. The indications were that his depression was improving and his medical condition was not such as to keep him in hospital.

---

[151] Haasbroek 9/2 at 21.
[152] 10/2 at 83.
[153] 2/461 & 2/464.

139 Further, whilst with hindsight it would clearly have been preferable for Paul Brauer to have been accommodated in supported accommodation, on the information available at the time, it can readily be understood why an attempt was made to discharge Paul Brauer to DOH accommodation with services in place, provided that those services were functioning as planned. Indeed up until at least 17 September it appeared that Paul Brauer was coping, including with his catheter care, in the community.

140 It is likely that Paul Brauer's deterioration would have been prevented if he had had active case management by a properly informed Mr Dow, been seen twice weekly by Ms O'Rourke, and more frequently by district nurses for catheter care, in particular between 19 and 26 September 2005, or would have been of a lesser extent if Ms O'Rourke had promptly admitted him to hospital on 26 September. Further, if Paul Brauer had had GP's appointments arranged as stated in RN MacMahon's discharge plan and/or his attendance monitored and promptly acted upon then it is likely that the extent of his deterioration would have been identified at a GP appointment on the Monday 26 September.

141 Indeed, it would appear likely that if Paul Brauer had been seen between 22 and 26 September the fact that his fridge remained off, he was not eating his meals on wheels, and his general deterioration would have been identified, and most probably acted upon. Further, if Paul Brauer had been subject to a face to face interaction with an experienced mental health worker in this period there is a significant possibility that a deterioration in his mental state may have been identified.

Potential relevance of discharge to cause of death

142 The question of the causal link, if any, between the extent of Paul Brauer's deterioration between 12 and 27 September and his death thus arises. On the evidence there appears to be two potential mechanisms of contribution. The first is that Paul Brauer's acute UTI and the consequent immobility from which he suffered clearly increased his risk of Pulmonary Embolus. The second is that during the period of hospitalisation between 27 September and 13 October Mr Brauer was clearly substantially immobile. Both of these factors are recognised as risk factors for the development of pulmonary embolus.

143 However, much depends upon the extent to which these conditions would have been prevented had Paul Brauer either not been discharged, or been monitored more closely during discharge. On the evidence, although it is a indictment on the system, no finding on the balance of probabilities as to a causal link between the relatively scant monitoring of Paul Brauer during the period after 17 September, the lack of any trained face to face mental health assessment, or the lack of any GP attendance, can be made.

Cause of death

144 Mr Brauer clearly suffered from Pulmonary Embolus, causing his death.

145 In the light of the uncertainty identified above, it is not possible to reach any conclusion on the balance of probabilities as to the cause of Mr Brauer's Pulmonary Embolus, which caused his death.

146 There are three possibilities. First, a DVT primarily caused by immobility. Second, a DVT caused in part by immobility and in part by sluggish circulation secondary to urine retention. Third, pelvic thrombus.

147 The deep vein thrombosis, if that was the causative mechanism, could have been present for some time and it is not possible, even though counsel for the family suggest that I can find that the clot probably formed four to ten days before Paul died, to reach a conclusion on that issue.

148 Although a number of failures and deficiencies in the system and in the care and treatment of Paul Brauer have been identified during this Inquest I am unable to conclude that those failures and deficiencies contributed to Paul Brauer's demise.

Formal Finding

I FIND THAT PAUL JUSTYN BRAUER DIED ON THE 13 OCTOBER 2005 AT LEETON DISTRICT HOSPITAL FROM A LARGE PULMONARY EMBOLUS THE ORIGIN OF WHICH THE EVIDENCE ADDUCED DOES NOT ENABLE ME TO SAY.

Recommendations

149 Paul Brauer required the attention of a number of health professionals covering urology, cardiology and mental health. There was no one person who was charged with being responsible for his overall health whilst in either Wagga Wagga Base Hospital or Leeton District Hospital had there been one it may have assisted in disseminating vital information between those health professionals and assisted in formulating a care plan both inside and outside hospital.

(1) I therefore recommend the appointment of an overall person to be responsible for the holistic management of patients, such as Paul Brauer, during their admission to Wagga Wagga Base Hospital and Leeton District Hospital.

(2) I recommend the appointment of an overall person to be responsible for the implementation of the Leeton District Hospital's plans/policies in relation to patient discharge (such as Paul Brauer's discharge).

150 I thank my counsel assisting Kristina Stern and Pamela Lazzarini of the Crown Solicitors office and I also acknowledge the work done by the Officer in Charge Detective Senior Constable Christopher Nocente in preparing the comprehensive brief of evidence in this matter, which was not an easy task, and I will convey my views to his superiors.

151 Finally I extend mine and the courts sympathies to Paul's sister Margaret Brauer and his family for their sad loss.

M.MacPherson
Deputy State Coroner
13 December 2010