MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

IN THE MATTER OF THE *CORONERS ACT* 1995

AND

IN THE MATTER OF AN INQUEST TOUCHING THE DEATH OF RICHARD MAURICE WEILY

FINDINGS, RECOMMENDATIONS AND COMMENTS of Coroner Rod Chandler following an inquest held in Hobart on 6 October 2015.

7 October 2016

PREAMBLE

On 15 July 2013 Richard Maurice Weily died at the Royal Hobart Hospital (RHH) in Hobart. For almost two months prior to his death Mr Weily had resided in care, initially at Huon Eldercare (Eldercare) at Franklin and then at the Roy Fagan Centre (RFC) at Lenah Valley. An inquest into his death focussed upon the care and management of Mr Weily whilst he was a resident of these facilities. These are the findings from that inquest.

BACKGROUND

Mr Weily was born on 12 February 1928 and was aged 85 years. He was a retired diesel mechanic and a widower. Up to April 2013 Mr Weily resided by himself in his home at Orford with the assistance of a carer provided by Community Based Support. His elder daughter Margaret (Meg) would visit him weekly and stay with him overnight. His medical history included congestive cardiac failure, Parkinson's disease and Lewy-body dementia.

A deterioration in Mr Weily's health was observed from about January 2013. He became more confused, was frequently incontinent and unsteady on his feet. On 30 April 2013 Dr Winston Johnson advised hospitalisation and Mr Weily was admitted to the Hobart Private Hospital (the Private). Investigations did not reveal any obvious infection or reversible causes for his condition. However, use of amiodarone, which had previously been prescribed to help manage Mr Weily's cardiac arrhythmias, was ceased because of thyroid dysfunction. At this time consultant physician, David Dunbabin, reported to Dr Johnson: *"He did well in an environment where he was being fed and watered regularly but his family felt that it really wasn't sustainable for him to return home to Orford. Permanent accommodation was found for him at Eldercare and he has moved there for ongoing care."* Mr Weily moved to Eldercare on 21 May 2013. His general practitioner became Dr John Riley.

CIRCUMSTANCES SURROUNDING DEATH

Mr Weily was first seen by Dr Riley on 22 May 2013. No changes were made to his medical management at that time. In her affidavit Ms Meg Weily describes her father's initial period at Eldercare in these terms: *"Our father was agreeable to the move (to Eldercare) and admitted that he 'needed more care than he could get at home.' He was in this care facility for a period of almost 3 weeks; he was staying active, was receiving physiotherapy and beginning to interact with other residents. We felt he was starting to settle in. Dad told visitors 'the staff are great, the food is great, but it's not home'."*

Mr Weily's situation took a turn for the worse on 10 June. He is recorded in Eldercare's Progress Notes to be *"agitated and confused."* Sometime during the day he telephoned his daughter Cheryl to say that he was concerned that his dog had been injured. In the afternoon he was found wandering outside the facility and was placed in Wellington, its secure unit. Dr Riley was contacted and he prescribed risperidone but Mr Weily refused to

take it. Mr Weily's daughter Cheryl was advised of the situation and she requested a meeting with Dr Riley and Eldercare staff. This was arranged for 12 June 2013.

Ms Meg Weily visited her father during the afternoon of 10 June. She described him as *"distressed but appeared to have calmed down."* However, Mr Weily's condition deteriorated further the following day. The progress notes record him to have *"increased confusion and is very teary, upset, angry and frustrated."* He complained of having been given an enema *"without his say so."* That afternoon the notes record him to be *"very depressed and paranoid,"* that he refused to take his risperidone and that he was expressing suicidal thoughts. In a similar vein, Ms Meg Weily, who along with her sister visited her father on 11 June, stated that his situation had *"considerably worsened,"* that he appeared *"agitated and aggressive, not like our Dad at all"* and that *"his agitation was directed at us and he ordered us out, saying he didn't want to see us."*

Dr Riley saw Mr Weily in the morning of 12 June. His notes made at that time include these comments: *"He is adamant about leaving, not being 'locked up'. He is angry, and I think depressed to a significant degree. He is a very proud and independent man and is unable to come to grips with his dementia and secondary dependency. He repeatedly states his intention to kill himself by refusing medication, food and fluids or some other unspecified means. He says he will create 'havoc' if he is put on (sic) Wellington. I must take his statements very seriously, and I think for his safety and that of staff, that he should go to Wellington unit immediately, receive IM Haldol 2 mg, and be started on mirtazapine ASAP. He will require close monitoring for suicidality until medications take effect and he has an opportunity to come to grips with his very unhappy situation."* Later that day Dr Riley met with Mr Weily's daughters as previously arranged. He told them that, in his view, Mr Weily was severely depressed. He told them too of his plan to treat him with haloperidol and mirtazapine. They were accepting of his proposed treatment.

Registered nurse, Ms Rae Kemp, is a behaviour consultant with Dementia Behaviour Management Advisory Service (DBMAS). On 12 June she was requested by registered nurse, Ms Jan Simmons, at Eldercare to carry out an assessment of Mr Weily. He was known to her as she had previously made an assessment of his Parkinson's disease and dementia whilst he was still resident at Orford. Ms Kemp attended at Eldercare at 3.30pm. She was informed that Mr Weily had been physically aggressive during the day and threatening self-harm. She was also informed that Mr Weily had been treated by Dr Riley and sedated. She found that she was unable to assess him because he was still in a semi-conscious state. Nevertheless, she took the view that he should be placed in a secure unit until his behaviour improved. She discussed the situation by phone with Dr Martin Morrisey, an old-age psychiatrist based at RFC. It was agreed that Mr Weily be monitored and that his situation be re-assessed the following day.

Ms Kemp interviewed Mr Weily in the early afternoon of 13 June. She noted that he was expressing suicidal ideas, that he was threatening physical aggression, that he was not eating or drinking and that he was non-compliant with his medications. Mr Weily made it clear that he did not want to be at Eldercare and in particular that he did not want to be placed in the Wellington unit. Ms Kemp considered him to be both delusional and paranoid. She again spoke again to Dr Morrisey. It was agreed that it was in Mr Weily's best interests for him to be admitted to RFC for urgent assessment and treatment.

Mr Weily was transported to RFC in the late afternoon of 13 June. The following day an Initial Order was made under the provisions of the *Mental Health Act 1996* enabling Mr Weily to be detained as an involuntary patient at RFC. Documents on Mr Weily's file at RFC show that on the same day a Continuing Care Order was made extending Mr Weily's detention as an involuntary patient for three months. That order was confirmed by the Mental Health Tribunal on 26 June 2013 but was subsequently discharged by an order made on 11 July 2013.

On arrival at RFC Mr Weily was considered at risk of suicide. Documentation in his record shows that he was also assessed as being paranoid and that he was *"…..at serious risk of harm by misadventure. In a nursing home setting he may also pose a significant risk to other frail elderly people."* Mr Weily's hallucinations were noted to cause him great fear and as a result he would often act aggressively to what he perceived as threats. The goals of care were set to treat his psychotic symptoms and agitation so that he would be able to return to Eldercare.

Two days after moving to RFC Mr Weily broke a window in his bedroom with a DVD player. He exhibited dementia symptoms especially during the night. He frequently refused medications and food but was noted to be mostly compliant and settled. His blood pressure and temperature were checked daily. Urinalysis showed no abnormalities.

Either both or one of Mr Weily's daughters visited their father each day he was in RFC. On 19 June they both attended a meeting with Dr Morrissey and Colin Brett, RFC's Clinical Nurse Manager. It was agreed to begin a trial of quetiapine. Two days later Dr Morrissey examined Mr Weily. He noted that he was tolerating the quetiapine. He further made this entry in the record: *"Please do not pass on to Mr Weily any MHA documents without letting daughters know, – they are concerned that Mr Weily misunderstands such documents and becomes distressed unless someone is able to explain and reassure him."* This entry was a consequence of concerns expressed by Mr Weily's daughters that their father had become distressed when served with documents generated under the *Mental Health Act 1996* without either of them being present to explain their meaning and purpose.

Over the following days Mr Weily's behaviour oscillated between compliance and defiance. He frequently refused his medications and food and drink, and would occasionally kick out at staff, spit his drink out and, on one occasion, barricaded himself in his room. He remained suspicious about the reasons why he was at RFC. His daughter Meg reports that on 21 June he intentionally activated a fire alarm in an attempt to have the fire-fighters help him escape RFC. At around 6.00am on 30 June Mr Weily was found on the floor of his bathroom. It was assumed that he had slipped and fallen over. He did not appear to be injured but was lethargic for the rest of the day and was noted to be leaning to one side. By the evening his general condition had improved.

Although Mr Weily's behaviour continued to oscillate over the following days it was considered that he was becoming generally more stable and a meeting with family was set for 8 July to discuss his return to Eldercare. However, in the evening of 7 July Mr Weily pressed his nurse call-bell and when staff arrived in his room they found him kneeling on the floor and attempting to get back into his bed. He told staff that he had rolled out of bed whilst asleep. He complained of right-sided hip pain. Examination by a nurse indicated pain

on exertion but not on palpation. Standard observations were taken and were within normal limits. He was given paracetamol for his pain and later fell asleep. However, that morning Mr Weily was in significant pain and arrangements were made for him to be transported to the RHH by ambulance.

At the RHH an x-ray of Mr Weily's pelvis and right hip showed a comminuted fracture of his right acetabulum with *"associated protrusio acetabula"*. He was admitted to the orthopaedic unit. After he was reviewed at the orthopaedic, grand-round medical staff had a meeting with Mr Weily's daughters. They were informed that he was a high risk surgical candidate.

Mr Weily was assessed in the older persons unit on 9 July. His daughters expressed the view that their father did not have any quality of life. They did not want him transferred back to RFC. The plan was settled to provide Mr Weily with palliative care with the aim of maintaining comfort and dignity. Over the following days Mr Weily was troubled by wheezing but otherwise was kept comfortable with an analgesia regimen. He died in the morning of 15 July 2013.

POST-MORTEM EXAMINATION

This was carried out by forensic pathologist, Dr Donald Ritchey, and was confined to an external examination of Mr Weily's body along with the inspection of his records at the RHH. In Dr Ritchey's opinion the cause of Mr Weily's death was probable pneumonia following a hip fracture (a comminuted fracture of the right acetabulum) sustained in a fall in the RFC. Significant contributing factors were ischaemic heart disease, dementia and Parkinson's disease. I accept this opinion upon the cause of death.

ISSUES FOR CONSIDERATION

The investigation of this death was particularly assisted by the input of Mr Weily's daughters who articulated multiple issues of concern related to their father's residency in both Eldercare and RFC. These include communication shortcomings and cite as an example the fact that they were unaware of Mr Weily's transfer to RFC until after the event. Other concerns include the apparent lack of an activity/exercise programme at RFC and assertions of unprofessionalism on the part of some RFC staff. These are important issues as they have the capacity to adversely impact on a resident's care and management and the ability of that resident and his/her family to cope with the stresses associated with chronic and terminal neurological disease. However, in the particular circumstances of this case I am satisfied, with two qualifications, that the issues identified by Mr Weily's daughters are not sufficiently related to the cause(s) of death to permit investigation. The two qualifications are:

a) Mr Weily's medication regime.

b) Mr Weily's two falls at RFC and his falls risk assessment.

I will deal with each of these matters in turn.

MEDICATION REGIME

Dr Paul McIntyre is a consultant cardiologist. He first saw Mr Weily in November 2012 for the changing of his defibrillator generator. He next saw him on 29 January 2013 after Mr Weily had received three shocks from the defibrillator. Interrogation of the device showed that the shock therapy was appropriate for ventricular tachycardia. This led to Dr McIntyre prescribing amiodarone to try and suppress further arrhythmias. Dr McIntyre next saw Mr Weily when he was admitted to the Private in May 2013. At this time some thyroid dysfunction associated with the amiodarone therapy was detected and this led to the amiodarone being discontinued and replaced with Carbimazole.

It was the evidence of Ms Meg Weily that her father's use of amiodarone coincided with a deterioration in his health. Further, she said that in April 2013 she was informed by Dr Johnson that the drug had *"affected his thyroid, liver and kidneys"* and that it should be discontinued. Her evidence raises the question whether it was appropriate for Mr Weily to be prescribed amiodarone and whether it had played any role in his death.

Dr A J Bell is the medical adviser to the coroner. It was his evidence that:

- In his opinion the use of amiodarone to manage Mr Weily's arrhythmia was a sound choice. A review on 19 February 2013 indicated that it had been successful in controlling the arrhythmias.
- The amiodarone was unrelated to Mr Weily's death as a thyroid function test on 4 June 2013 was normal indicating that the biochemical thyroid dysfunction attributable to the amiodarone had resolved. (This was of course almost seven weeks before Mr Weily's death.)

I accept Dr Bell's evidence and am satisfied that Mr Weily's use of amiodarone was appropriate and that it played no part in his death.

I have noted earlier that on 12 June 2013 Dr Riley prescribed haloperidol for Mr Weily. The dosage was 2 mg. In his evidence Dr Riley described haloperidol as *"an old anti-psychotic"* which provided immediate effect in sedating a patient exhibiting dangerous behaviour. In Mr Weily's case he said that *"it seemed to work and to calm him down"* pending the involvement of Ms Kemp from DBMAS.

Ms Kemp gave evidence that whilst the use of haloperidol may have been justified to deal with a dangerous situation, it was not a drug suited for use by patients in RFC. In Mr Weily's case its use was of particular concern because of its potential interaction with his Parkinson's disease.

It was the evidence of Dr Bell that 30% to 50% of individuals suffering from Lewy-body dementia have a severe sensitivity to a neuroleptic or antipsychotic medication such as haloperidol. Acute reactions can include severe, sometimes irreversible Parkinsonism and impaired consciousness, sometimes with other features suggestive of neuroleptic malignant syndrome. He said that this can occur in individuals without baseline Parkinsonism and is not dose related. Such medications may also precipitate or worsen confusion or autonomic

dysfunction and their use has been associated with a 2 to 3-fold increase in mortality. He said that the drug is also relatively contra-indicated for patients with cardiac disease due to the precipitation of cardiac arrhythmias. Because of these prospective effects it was Dr Bell's opinion that Dr Riley should not have prescribed the haloperidol for Mr Weily.

On balance, the evidence satisfies me that it was unwise for Dr Riley to prescribe haloperidol for Mr Weily. However, his use of the drug was only brief, it occurred a month prior to Mr Weily's death and there is not any evidence to suggest that it caused a worsening of his condition. These matters lead me to conclude that Mr Weily's use of haloperidol did not contribute to his death.

Quetiapine is an atypical antipsychotic drug. Mr Weily began taking it on the advice of Dr Morrissey to assist in the management of his Parkinson's disease. A known side-effect is dizziness with an increased rate of falls. For patients with Lewy-body dementia Dr Bell advises that recurrent falls may occur in up to one third of patients. The question arises whether Mr Weily's falls, occurring on 30 June and 7 July, could be attributed to his use of the quetiapine and hence played a role in his death.

The evidence shows that Mr Weily was prone to falls prior to his admission to RFC. In her affidavit his daughter Meg recites: *"Between January and April 2013, I accompanied Dad on a number of visits to his GP……..as his health appeared to be deteriorating. For instance, he went from occasionally falling and/or wetting himself to that happening several times a day."* The general practitioner, Dr Johnson, has reported that Mr Weily had an increased susceptibility to falls noted in April 2013 and Dr Dunbabin, in a report to Dr Johnson dated 30 May 2013, states: *"There had been evidence of some postural hypertension precipitating some of his falls."* Finally, as I have already noted, Dr Morrissey observed two days after Mr Weily commenced the quetiapine that he was tolerating the drug well. All this evidence together satisfies me that Mr Weily, well prior to his admission to RFC, was experiencing regular falls which were attributable to his underlying illnesses. In my view his falls occurring at RFC were not a consequence of his use of quetiapine and his use of this drug whilst at RFC was appropriate.

To summarise, I conclude that I am satisfied, and so find, that Mr Weily's use of the three drugs which I have addressed in this portion of my findings did not cause or contribute to his death.

MR WEILY'S FALLS AND HIS FALL RISK ASSESSMENT

As I have already noted, Mr Weily had his first fall at RFC on 30 June 2013 when he was found on the floor of his bathroom by Registered Nurse, Nevin Steward. An incident report was completed by Mr Steward. It includes this description: *"At 0600 hr staff heard noice (sic) from Richard's room; room door was open at the time as staff previously in there five minutes ago. The light was off and Richard was on the floor next to the bathroom. Assumed he had fallen, got him up and placed in chair in dining area where he remains. Richard had had PRN Oxazepam earlier on as he was quite unsettled. Very restive, still sleepy but insisting he gets out of bed."* The Review/Resolution portion of the form has been completed by Registered Nurse Colin Brett. Under the heading Incident Outcome Mr Brett has written

"No Harm (incident reached individual)". As to Actual Contributing Factors he has written *"confused/disoriented"* and *"current diagnosis/condition"*. The section headed Summary of Actions Taken has been completed with this entry: *"discussed with staff"*. The evidence shows that Mr Weily did not suffer a significant injury from this fall which caused any long-term effects.

Mr Steward was unable to recall the falling incident on 30 June when he gave his evidence to the inquest. He said that RFC has two devices by which nursing staff are made aware of particular risks concerning each patient. The first is each patient's Individual Service Plan (ISP) which has a section entitled Significant Risks. It was Mr Steward's evidence that if Mr Weily had been assessed to have a high risk of falling then this should have been recorded in this portion of his ISP. It was not. It is noted that the ISP also has a section entitled Mobility where Mr Weily's fall risk is stated to be *"High."* That same section has been completed to indicate that Mr Weily *"should use walking stick or wheelie walker"*. I interpolate at this point to observe that it was the evidence of Ms Meg Weily that she had not observed her father utilising either of these devices whilst at RFC. It was the further evidence of Mr Steward that RFC has the practice of keeping an Alert Sheet at the top of each patient's file which is utilised to make staff aware of specific risks attaching to that patient. Again Mr Steward said that if Mr Weily had been assessed to have been at high risk of falling then he would have expected this information to have been recorded on his Alert Sheet. There are two Alert Sheets on Mr Weily's file. Neither of them makes any reference to his falls risk.

Mr Weily's second fall was late in the night of 7 July. Registered Nurse Maria Price received the alarm on her pager and attended him. In her affidavit she gives this account: *"I attended his room immediately and found him kneeling in front of his bed, trying to pull himself back into it. I went to Mr Weily and asked him what had happened. He told me that he had rolled out of bed whilst he was asleep. He required minimal assistance to get back into bed, he was a mobile man and very independent. I requested that another staff member attend from another unit to assist me, William Wildy, RN. Mr Weily pointed out his right hip and told me that it was sore. I asked him if it was painful and he said it was not, just sore. I asked him if he was able to raise his leg 30° off the bed, which he was able to do without the movement causing pain. Upon examination, there was some swelling to the right hip area, which was not painful when touched. I asked Mr Weily to raise his leg 30° above the level of the bed after his fall as patients with an injury to the hip area are generally unable to move the affected area at all, or cannot do so without any movement causing significant pain. If the patient is unable to complete the movement or the movement causes pain, our procedure is to call for an ambulance immediately. As Mr Weily appeared comfortable and able to raise the affected leg without pain, staff did not believe that admission to hospital was required at that time."* Later she states: *"We provided Mr Weily with hip protection and placed a floor mat next to his bed."* Ms Price further stated that she gave Mr Weily paracetamol to assist with his soreness and he quickly went to sleep. Thereafter she made hourly checks and found that he was asleep each time.

Ms Price was unable to remember whether Mr Weily, before his fall, was wearing hip protectors, had a floor mat in place or had his bed lowered.

The following morning Registered Nurse Junerose Read attended Mr Weily. She noted that he was *"in significant pain"* and an ambulance was then called. Ms Read was able to explain that the practice at RFC was to prepare the ISP one to two weeks after a patient's admission when there had been sufficient time to observe the patient and to settle on an appropriate plan. It was her further evidence that it was standard practice for a falls assessment to be done on the day of admission. The failure for this to occur in Mr Weily's case was an *"oversight".* However, she said that a notice board was kept in an office which listed the patient's names and included falls risk information. She said that staff would have been aware from this notice that Mr Weily was a falls risk.

Registered Nurse Peter Fraser carried out Mr Weily's falls assessment on 21 June 2013, that is nine days after his admission. He described this delay as *"staggering."* Mr Fraser had a 15-20 minute interview with Mr Weily and completed a Falls Risk Assessment Tool. That document provides for a scoring system to be applied to a range of risk factors and Mr Weily was rated 22, with the maximum being 36. This score placed Mr Weily in the High category as a falls risk. In Mr Fraser's opinion the strategies to address this rating included a high/low bed, a floor mattress and hip protection and he was surprised that these were not listed on Mr Weily's ISP.

Mr Weily's fall on 7 July caused him to suffer a comminuted fracture of the right acetabulum. This raises the question whether the nursing staff at RFC responded appropriately to the injury on the night of its occurrence. On this subject Dr Bell advises that Mr Weily's fracture differed from the more common hip fracture in that it often caused minimal pain except when weight bearing and permitted the patient to raise his leg against gravity when lying in bed. For these reasons there is often a delay in diagnosis. It was his opinion that the nursing staff's decision to return Mr Weily to bed and to provide paracetamol for pain relief was understandable. I accept Dr Bell's opinion and thus make no criticism of RFC's nursing staff for not seeking medical attention for Mr Weily's injury at an earlier time.

I now turn to consider issues surrounding the assessment of Mr Weily for falls risk. In my view the evidence highlights a number of shortcomings. They are:

- The failure to promptly conduct a falls risk assessment of Mr Weily. Clearly an unexplained delay of nine days before his assessment took place was unsatisfactory.

- Although the assessment undertaken by Mr Fraser placed Mr Weily in the high category as a falls risk this finding was not recorded on his Alert Sheet and hence this tool was unable to serve as a notice to staff of a significant risk that needed to be managed in providing Mr Weily with proper care.

- The failure to show Mr Weily's high falls risk rating as a significant risk in his ISP thereby diluting the value of this document as a tool to alert staff to this risk.

- The apparent failure to devise and record a plan to manage Mr Weily's falls risk. The evidence indicates that a plan could have included the use of a low bed, a floor mat and hip protectors.

- Although Ms Read testified that Mr Weily would have been shown to be a high falls risk on an office notice board there is not any evidence that satisfies me that on the

night of 7 July nursing staff had implemented any strategy to address this risk. Notably he was not, prior to his fall, provided with hip protectors or a floor mat.

- Although Mr Weily's ISP indicates that he required a walking stick or a wheelie walker to assist with his mobility, I am satisfied, accepting the evidence of Ms Meg Weily, that neither of these items was provided to Mr Weily whilst he was at RFC.

All of the foregoing leads me to **recommend** that RFC undertake a review of its processes surrounding falls risk with a view to ensuring that assessments are promptly carried out, that risks identified on assessment are properly recorded on patients' ISPs and, if appropriate, on Alert Sheets, and that suitable strategies to address falls risk are planned, recorded and implemented.

FINDINGS REQUIRED BY S28(1) of the CORONERS ACT 1995

The evidence enables me to make these findings:

a) The identity of the deceased is Richard Maurice Weily.

b) Death occurred in the circumstances set out in these findings.

c) The cause of death was probable pneumonia following a hip fracture (a comminuted fracture of the right acetabulum) sustained in a fall in the RFC. Significant contributing factors were ischaemic heart disease, dementia and Parkinson's disease.

d) Death occurred at the RHH in Hobart on 15 July 2013.

e) Mr Weily was predeceased by his wife Alison Joan Weily. They had two children, namely Margaret Irene Weily and Cheryl Ann Weily.

CONCLUDING COMMENTS

Counsel assisting at this inquest was Sgt. Mick Allen. I wish to acknowledge and thank him for his excellent work in his preparation and presentation of the evidence.

I accept that the gradual decline in Mr Weily's mental health and the circumstances leading up to his death caused considerable stress to his daughters. I extend my condolences to them and to Mr Weily's other family members and loved ones. I trust that this inquest may have, to some modest degree, assisted them in coping with their loss.

Dated: 7th day of October 2016 at Hobart in the State of Tasmania.

Rod Chandler
Coroner