Court Reference: 3026 / 07

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of Lorraine O'Leary

Delivered On:	1st December 2009
Delivered At:	Coroners Court Melbourne
Hearing Dates:	1st December 2009
Findings of:	Deputy State Coroner West
Place of death/Suspected death:	Alfred Hospital Prahran
*SCAU	S/C R. Antolini

Version 2 as at 25 November 2009

Court Reference: 3026 / 07

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

In the Coroners Court of Victoria at Melbourne

I, Deputy State Coroner West having investigated the death of:

Details of deceased:

Surname:	O'Leary
First name:	Lorraine
*Address:	Yarra West Aged Care, 44 Stephen Street, Yarraville

AND having held an inquest in relation to this death on 1st December, 2009

at Melbourne

find that the identity of the deceased was Lorraine O'Leary

and the death occurred 4th August, 2007

at Alfred Hospital, Prahran

from

1 (a) Ischaemic Heart Disease

2 Facial and airway burns

in the following circumstances:

1. Lorraine O'Leary, aged 57 years, had extensive health problems due to a stroke in 1994, which resulted in paralysis of her right upper and right lower limbs and an inability to speak. She suffered peripheral vascular disease which led to a right leg amputation in July 2007 and she further suffered from osteoporosis, elevated cholesterol, persisting hypotension and myocardial ischaemia.

2. On the 3rd of August 2007, Lorraine O'Leary singed her hair whilst smoking unsupervised, outside in the courtyard of her aged care centre. Staff instructed that she was no longer to smoke unsupervised and her cigarettes and lighter were removed, with instructions that they be provided as required. Later in the day, Lorraine O'Leary was found by a staff member in the courtyard with her upper clothing alight. After the burning fabric was extinguished and first aid administered, Lorraine O'Leary was ambulance transferred to

the Alfred Hospital, where she was admitted with facial and chest burns, together with respiratory problems.

3. At approximately 3.00am on the 4th August, Lorraine O'Leary suffered a myocardial infarction and went into cardiogenic shock. Following discussions between intensive care unit staff and a newly appointed guardian regarding the poor quality of life anticipated, the decision was made to palliate her and administer sedation for comfort. Treatment was slowly withdrawn and Lorraine O'Leary died at 3.10pm on the 4th August, 2007.

COMMENTS

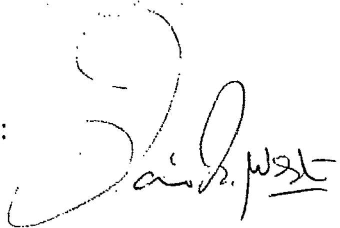
Pursuant to section 67(3) of the Coroners Act 2008, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

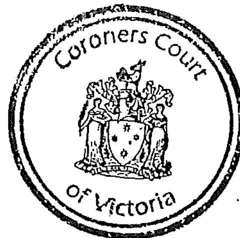
4. Investigation into the circumstances surrounding the death failed to determine how Lorraine O'Leary managed to access the courtyard or the cigarettes, as none of the staff opened the locked door for her. Staff did not have the authority to search her room and the possibility remains that a visitor to the aged care facility assisted her to gain access to the courtyard by operating the door code pad for her, as she was not physically capable of doing so. Regular visitors to the centre where given access to the code, after it was periodically changed.

RECOMMENDATION

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:

5. It is recommended that Yarra West Aged Care develop and implement a smoking policy, designed to protect patients who are mentally and/or physically impaired. The policy should aim to address issues of access to cigarettes and lighters, as well as ensuring appropriate supervision protocols are in place.

Signature: 



Date: 1st December, 2009

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- **MANAGER, YARRA WEST AGED CARE**