

IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: COR 2012 3462

**FINDING INTO DEATH WITH INQUEST**

*Form 37 Rule 60(1)*

*Section 67 of the Coroners Act 2008*

**Inquest into the Death of: ROBERT GEORGE REEVE**

Delivered On:	1 July 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne Victoria
Hearing Date:	24 June 2013
Findings of:	Coroner Paresa Antoniadis SPANOS
Police Coronial Support Unit Assisting the Coroner	Leading Senior Constable Tracey Ramsey

I, PARESA ANTONIADIS SPANOS, Coroner,  
having investigated the death of ROBERT GEORGE REEVE  
and having held an inquest in relation to this death on 24 June 2013  
in MELBOURNE  
find that the identity of the deceased was ROBERT GEORGE REEVE  
born on 5 July 1929, aged 82  
and that the death occurred on 23 August 2012  
at Biala Ward, Kingston Centre, Warrigal Road, Cheltenham 3192

**from:**

- 1 (a) COMPLICATIONS OF ATHEROSCLEROTIC HEART DISEASE WITH ATRIAL FIBRILLATION IN A MAN WITH THE CLINICAL DIAGNOSIS OF ALZHEIMER'S DEMENTIA

**in the following circumstances:**

#### BACKGROUND AND PERSONAL CIRCUMSTANCES

1. Mr Reeve was an 83 year old man who had lived independently in his home in Heidelberg until he was admitted to the Austin Hospital in June 2012 with a deteriorating mental state following a cataract operation in May 2012. He had a history of Alzheimer's dementia, coronary artery bypass surgery, atrial fibrillation, osteoarthritis, benign prostatic hyperplasia, ethanol dependence, alcohol hepatitis, glaucoma, diverticulitis and Gilbert Syndrome. Thereafter and until his death on 23 August 2012, he was assessed as unable to care for himself and live independently and remained, either an admitted hospital patient in acute care, a high level care resident or an involuntary psychiatric patient.

#### THE NEED FOR AN INQUEST

2. As at the date of his death, Mr Reeve was an involuntary psychiatric patient under the *Mental Health Act 1986*. He therefore fell within the definition of a "person placed in custody or care" for coronial purposes,<sup>1</sup> and an inquest into his death is mandated by the legislation.<sup>2</sup>

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<sup>1</sup> See section 3(i) of the *Coroners Act 2008* which defines a "person placed in custody or care" to include "a patient in an approved mental health service within the meaning of the *Mental Health Act 1986*."

<sup>2</sup> Section 52(2)(b) of the *Coroners Act 2008*.

The legislation thereby recognises the vulnerability of people placed in the custody or care of the State or its agencies and affords them the protection inherent in the independent and transparent scrutiny of the coronial process.

3. That said, prior to the inquest, Mr Reeve's family had not raised any concerns with the Court about the clinical management and care provided to him in the two months or so immediately preceding his death. Nor were any concerns raised when advised by my assistant Leading Senior Constable Tracey Ramsey that an inquest was mandated in the circumstances.

#### MR REEVE'S DECLINING HEALTH

4. On 27 July 2012, Mr Reeve was discharged from the Austin Hospital to a high care facility in Noble Park for residential care as it was assessed that he was no longer able to live independently and care for himself.
5. On 8 August 2012, Mr Reeve was taken to Dandenong Hospital Emergency Department for treatment of increasing aggressive, behavioural and psychological symptoms of dementia. He was assessed by medical and psychiatric staff with a plan to admit him to a psychogeriatric ward for further assessment and management. Due to a lack of beds at the Kingston Centre at the time, he was transferred to the Peter James Centre on 9 August 2012, where he continued to behave aggressively. He was psychiatrically examined as required under the *Mental Health Act* and made an involuntary patient on 9 August 2012, his involuntary status being confirmed by the authorised psychiatrist on 10 August 2012.
6. On 11 August 2012, when a bed became available, Mr Reeve was transferred to the Biala Ward at the Kingston Centre as an involuntary patient. Biala Ward is a 20-bed unit for aged, acute mental health patients requiring treatment for both their mental illness and complex medical conditions.
7. On 23 August 2012 at approximately 8.05 pm, Mr Reeve was being assisted to the toilet by nursing staff when he was observed to be pale, breathless and unresponsive. He was put to bed, given oxygen and a medical team called. He was found to have a weak pulse but no cardiac sounds or respirations. In line with his family's prior instructions, no resuscitation was attempted.

## MEDICAL CAUSE OF DEATH

8. No autopsy was performed at the direction of the coroner. This was in accordance with advice from Dr Jacqueline Lee, a Forensic Pathologist with Victorian Institute of Forensic Medicine (VIFM) who undertook a preliminary examination in the mortuary on 27 August 2012, and provided a written report of her findings. Dr Lee noted that Mr Reeve appeared his age and, other than a number of post-operation scars, the examination was unremarkable. The results of whole body post mortem computed tomography (PMCT) showed sternal wires (consistent with an earlier procedure), coronary artery calcification, right pleural effusion, no acute changes within the head and no evidence of other significant injury. Dr Lee noted that the medical deposition provided by treating clinicians expressed the opinion that death was due to "VF arrest" (ventricular fibrillation arrest) and that there were no issues (in their opinion) to be addressed at autopsy by a forensic pathologist.
9. On the basis of the available medical history and other information, and in the absence of a full post mortem examination, Dr Lee advised that it would be reasonable to attribute Mr Reeve's death to *complications of atherosclerotic heart disease with atrial fibrillation in a man with the clinical diagnosis of Alzheimer's dementia.*

## CLINICAL MANAGEMENT AND CARE

10. In response to my request, an overview of the clinical management and care provided to Mr Reeve in the two months preceding his death, was provided by Mr Grant Wishnowsky, Registered Psychiatric Nurse and Deputy Director of Nursing in Aged Persons' Mental Health at Southern Health which encompasses Biala Ward and the Kingston Centre. Upon admission to the ward, Mr Reeve was assessed as being at high risk of absconding, cognitive impairment, non-compliance with treatment, falls and a high risk to staff and at medium risk of harm to others in the ward. His whereabouts were accordingly checked every 15 minutes and he remained on this observation regime throughout his admission. Although he continued to display a range of difficult behaviours, Mr Reeve was managed with reassurance, re-direction and distraction as far as possible, without the need for seclusion. He was reviewed regularly and his medication regime as appropriate.

11. Following discussions on admission between the medical registrar and Mr Reeve's daughter, he was deemed "not for resuscitation" in the event of a collapse. After a series of consultations between healthcare professionals and discussions with family members, a family meeting was held on 21 August 2012 where the family agreed to the care plan proposed for Mr Reeve. The plan included the use of oral and intramuscular psychiatric medications that carried some risk of increased sedation and likelihood of falls, and a recognition that Mr Reeve would require ongoing care in a specialist psycho-geriatric nursing home.

## FINDING

I find that Mr Reeve was a person who was "placed in custody or care" immediately before his death from natural causes, namely from the *complications of atherosclerotic heart disease with atrial fibrillation in a man with the clinical diagnosis of Alzheimer's dementia*. I find that his death was not related to his status as a person placed in custody or care, and further that the evidence does not disclose any want of clinical management or care on the part of the staff of Southern Health which may have caused or contributed to his death.

I direct that a copy of this finding be provided to the following:

Mr Reeve's family

The Authorised Psychiatrist, Kingston Centre, Warrigal Road Cheltenham

CEO, Southern Health, Locked Bag 29, Clayton South 3169

The Chief Psychiatrist

O.I.C./P.C.S.U. – Attention LSC Tracey Ramsey

Signature:



CORONER PARESA ANTONIADIS SPANOS

Date: 1 July 2013

