Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 51/12

I, Barry Paul King, Coroner, having investigated the death of ***Kevin Maxwell Collins*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on* ***25 February 2014****, find that the identity of the deceased person was* ***Kevin Maxwell Collins*** *and that death occurred on* ***31 August 2010*** *at* ***Graylands Hospital*** *from* ***bronchitis (pandemic influenza A/H1N1 2009) in a man with chronic obstructive pulmonary disease*** *in the following circumstances:*

Counsel Appearing:

Ms M. Smith assisting the Coroner
Ms R Hartley (State Solicitors Office) appeared for Health Department WA, Graylands Hospital, Francis Kuranja, Patrick Devellerez, Dr Korede Ayeni and Dr Babu Mathew
Ms B Burke (ANF) appearing on behalf of John Holmes

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INTRODUCTION

1. Kevin Maxwell Collins (**the deceased**) died on 31 August 2010 at Graylands Hospital (**Graylands**) at the age of 50 from bronchitis as a feature of pandemic influenza A/H1N1 2009 (swine flu) in the context of chronic obstructive pulmonary disease.[1]

2. As the deceased was an involuntary patient under the *Mental Health Act 1996* at the time of his death, he was a 'person held in care' under section 3 of the *Coroners Act 1996*.

3. Section 22 (1)(a) of the *Coroners Act 1996* provides that a coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death a person held in care.

4. An inquest to inquire into the death of the deceased was therefore mandatory.

5. Under s.25 (3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

6. The death of the deceased was investigated together with the deaths of nine other persons who had been persons held in care as involuntary patients at Graylands under the *Mental Health Act 1996* immediately before they died.

7. A joint inquest commenced before Coroner D.H. Mulligan in the Perth Coroner's Court on 27 August 2012. Evidence was provided relating to the deaths of two of the other nine deceased persons. The inquest was then adjourned until it recommenced on 11 March 2013 when evidence relevant to another deceased person was adduced.

[1] Ex 1 Vol 1 Tab 5

8. On 18 and 19 March 2013 and 16 April 2013 evidence specific to the deceased was adduced.

9. On subsequent hearing days, evidence relevant to the other deceased persons and general evidence about Graylands was provided to the Court. The hearings were completed on 22 April 2013.

10. Coroner Mulligan became unable to make findings under s.25 of the *Coroners Act 1996* so I was directed by Acting State Coroner Evelyn Vicker to investigate the deaths.

11. To remove any doubt of my power to make findings under s.25, on 25 February 2014 I held another inquest into the death of the deceased and the other persons. The evidence adduced in that inquest was that which had been obtained by Coroner Mulligan, including exhibits, materials and transcripts of audio recordings of the inquests. Interested parties who were present at the inquests before Coroner Mulligan were invited to make fresh or further submissions. All of the parties indicated their agreement with the appropriateness of the procedure I had adopted.

12. I should note that there was a great deal of evidence adduced at the inquest that was related to general or systemic issues pertinent to Graylands. That evidence was adduced to investigate whether those issues had a bearing on any or some of the deaths and to allow the coroner to comment on the quality of supervision, treatment and care of the deceased patients. For example, evidence of the condition of the buildings at Graylands containing wards was provided in order to allow the Court to investigate whether the physical environment of the wards would have been more therapeutic had the buildings been refurbished.

13. That general evidence was useful in providing an overview of the context in which the deceased persons were treated for their mental illnesses; however, in my view many of the issues the subject of that evidence

were not sufficiently connected with all the respective deaths for me to comment on those issues under s.25 (2) or (3) of the *Coroners Act 1996* generally as if they did.

14. I have therefore not addressed those general issues separately from a consideration of each death. Rather, where I have come to the view that the issues were connected with the death or were potentially relevant to the quality of the supervision, treatment and care of the deceased, I have addressed them in the respective findings.

THE DECEASED

15. The deceased was born in Swan District Hospital on 3 September 1959 as the second of seven children. His father was in the rail industry and the family moved around a lot when he was young. The deceased remembered his childhood as a happy time.

16. The deceased left school when he was 14. As a young man the deceased had steady jobs, usually as a labourer, and he travelled frequently. He had worked in an abattoir and as a storeman and a cheese maker prior to being stricken with mental illness.

17. He was a gentle person who was very social and had long-term friends, though he apparently told admitting doctors at Graylands that he lost all his friends when he became an evangelist Christian in 1987.[2]

18. When he was 27 or 28 the deceased started studying nursing at Curtin University. He lived in a caravan close to the university and began to use drugs, mainly cannabis. He would spend his income on drugs instead of food.

19. His elder sister went to visit him and saw that he was obviously ill so she and her husband took him to their

[2] Ex 1, Vol 3, Tab 1 p137

home to live with them. While there, the deceased suffered a schizophrenic episode so his sister took him to Fremantle Hospital where he was admitted. He was then transferred to Graylands where, on 3 November 1986, he was admitted for the first time.[3]

20. It appears that it was at this time that the deceased had the first schizophrenic episode of which his family was aware, though it appears that he suffered an earlier psychiatric episode in 1985 when he was admitted to Royal Perth Hospital.[4]

1986 TO 2009

21. During the deceased's first admission to Graylands in 1986, he was diagnosed with schizophrenia. In the following years he was admitted another 16 times and spent almost all of 2008 and 2009 in Graylands. His last admission began on 24 March 2010.[5] By then the deceased had been diagnosed with paranoid schizophrenia by at least two psychiatrists.[6]

22. On the occasions when the deceased was admitted to Graylands he generally presented with psychotic and affective (manic) symptoms. The psychotic symptoms included delusions, hallucinations and thought disorder. The manic symptoms included irritability, lability of mood, disinhibition and grandiosity.

23. Over the years the deceased had been treated with a variety of medications, both for his psychiatric symptoms and for his mood symptoms. In the early years of his treatment, his symptoms responded well to the medications, but as time went by, the medications had less effect, so that he was left with residual symptoms even after long admissions.[7]

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[3] Ex1, Vol 1, Tab 8 and Tab 11
[4] Ex1, Vol 1, Tab 11
[5] Ex 1, Vol 3, Tab 2 p1
[6] Ex 1, Vol 1, Tab 11 p2
[7] ts 96

24. In 1988 the deceased overdosed on medications when he was at home. He was found in the back yard of his home and was taken to Royal Perth Hospital where he was admitted to the intensive care ward to be treated for aspiration pneumonia.

25. In April 2004 the deceased intentionally overdosed on medication and was found in a railway station toilet and taken to Sir Charles Gairdner Hospital emergency department.[8] There is no other record of a suicide attempt by the deceased apart from this occasion and the previous one in 1988.

26. When not in Graylands, the deceased lived in various hostels as well as in caravan parks and sometimes on the street as a homeless person.[9] It seems that over time the deceased had become institutionalised, in the sense that he was unable to cope outside of the environment with which he was familiar at Graylands.[10] For example, there was evidence to suggest that, when he was discharged to a hostel, the deceased would refuse to go to the hostel and would present himself at Graylands instead. This may have been partly because living at a hostel would have been expensive for the deceased, and there would not be much money left over from his pension for cigarettes.[11]

27. The deceased suffered from several serious medical problems. In about 2002 he was diagnosed with chronic obstructive pulmonary disease and obstructive sleep apnoea. These conditions were exacerbated by his heavy smoking and his morbid obesity. During 2003 and during his long admissions in 2008-2009, the deceased was sent more than once from Graylands to Sir Charles Gairdner Hospital for urgent treatment for respiratory failure. In 2009 he was also admitted to the intensive care unit there for a collapsed lung.[12]

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[8] Ex 1, Vol 1, Tab 11 p2
[9] Ex 1 Vol 1 Tab 11; ts 18/3/13 p16
[10] ts 19/3/13 p98
[11] Exhibit 1, Vol 3, Tab 3 p59; ts 19/3/13 p98
[12] Ex 1, Vol 1, Tab 14; ts 99

28. At times the deceased would be uncooperative with medical treatment and doctors would have to change his status from voluntary to involuntary in order to provide him with emergency treatment.[13] The last change of status in 2009 occurred on 2 December 2009 when his involuntary status was changed back to voluntary.[14]

29. The deceased was repeatedly advised to reduce his smoking and to address his obesity through diet and exercise, but he refused to comply with the advice. He was offered testing for eligibility for a BiPAP machine to use at home to address the sleep apnoea, but he declined. As late as 9 August 2010 he told doctors at Graylands that he was not willing to accept a machine for the sleep apnoea.[15]

30. During the deceased's last admission to Graylands, staff tried to monitor his respiratory functions with oxygen saturation tests, but he was regularly uncooperative. In the last two months of his life, his oxygen saturation varied from 94% to 88%.[16]

31. Throughout much of his time while admitted at Graylands, the deceased was in an open ward where he could smoke. When a no-smoking policy was introduced in 2009 it did not affect him much because it was easy for patients on open wards to find a place outside to smoke. He was not always compliant with the policy and was counselled accordingly.[17]

2010

32. At the beginning of 2010 the deceased was accommodated at Graylands in Hutchison Ward, a

[13] ts 99
[14] Ex 1, Vol 3, Tab 1, p15
[15] ts 105
[16] ts 104
[17] Ex 1, Vol 3, Tab 1, p52-52 eg

mixed and open ward for acute patients. He had been with the same treating team for over two years.

33. In February 2010 the organisation of services provided at Graylands was changed to create two distinct streams: acute and rehabilitation. The deceased's treating doctors considered that he could benefit from a transfer to a rehabilitation team, so on 15 February 2010 he was moved from Hutchison ward to Plaistowe Ward with the plan to place him in the rehabilitation stream on 1 March 2010.[18] His legal status was still as a voluntary patient.[19]

34. On 1 March 2010 the deceased went out to the local shops and did not return. He was declared Absent Without Leave and reported missing to the police, but because he was a voluntary patient he had the right to discharge himself.[20] Graylands staff were concerned for him because he left without medications and was therefore at risk of physical and mental harm from an abrupt cessation of medications.[21]

35. On the next day the deceased rang Graylands to demand a referral to a men's hostel. A referral was arranged and a prescription for the deceased to obtain a month's supply of medications was sent to the hostel. He was also put on leave for two weeks with a plan to discharge him from Graylands if all went well.[22]

36. On 4 March 2010 Graylands staff learned that the deceased had not gone to the hostel. For the next three weeks his whereabouts were unknown.

37. On 24 March 2010, the deceased's treating team in the rehabilitation stream headed by psychiatrist Dr B Mathew determined to discharge the deceased and to alert the tertiary hospitals of the discharge so that, if the deceased presented at any of them, they should

[18] Ex 1, Vol 3, Tab 1, p50-51
[19] Ex 1, Vol 3, Tab 1, p15
[20] Ex 1, Vol 1, Tab 28
[21] ts 107
[22] Ex 1, Vol 3, Tab 1, p59-60

consider whether he needed to be referred to Graylands.[23]

38. That same day, the deceased was transferred back to Graylands from Sir Charles Gairdner Hospital after having been taken there by police. He was admitted into Montgomery Ward, a locked long term rehabilitation ward, as an involuntary patient. His case manager was Dr L Priestley and his psychiatrist remained Dr Mathew.[24]

39. By the beginning of May 2010 the deceased had improved enough to be moved into an open ward, but his mental state deteriorated and after 10 days he was moved back into the locked Montgomery Ward where he would remain.[25]

40. The next few months were characterised by little change in the deceased's mental state, with significant ongoing delusions of primarily a religious and grandiose nature, though he did have occasional episodes of lucidity. He continued to smoke excessively despite his serious respiratory condition and despite the no-smoking policy.[26]

41. The deceased had been administered a range of antipsychotic and mood stabilising medications over the years with some benefit, but the medications no longer dealt with the deceased's symptoms effectively, even at higher doses. At the end of June 2010 consideration was given to administering the deceased clozapine, an antipsychotic drug that had the reputation of being effective when other drugs were not.[27]
42. Clozapine has a range of serious possible side-effects so patients receiving it require careful monitoring. The possible side effects include fever and flu-like symptoms as an indication of agranulocytosis, whereby the body's ability to defend itself from bacterial infection is

[23] Ex 1, Vol 3, Tab 1, p63-64
[24] Ex 1, Vol 3, Tab 2, p2; ts 109
[25] Ex 1, Vol 3, Tab 2, p39 and p47
[26] ts 110-111
[27] ts 113

significantly reduced. This was considered a rare side-effect affecting 1% of patients administered clozapine.[28]

43. The deceased's chronic obstructive pulmonary disease, sleep apnoea, obesity, tachycardia and smoking placed him at greater risk from side-effects than a patient in better physical health would have been.

44. After obtaining a second opinion from another psychiatrist on 23 July 2010, and after detailed discussions with the deceased and his sister on 17 August 2010, Dr Mathew referred the deceased's case to a specialist clozapine cardiologist and arranged for an echocardiogram. The specialist advised on 23 August 2010 that she could find no contraindication to clozapine use[29] and the echocardiogram indicated that the deceased's heart was essentially normal.[30]

45. The deceased was started on clozapine on 26 August 2010 with no apparent physical problems. His vital signs were within limits and he was compliant with his medication.[31]

EVENTS LEADING UP TO DEATH

46. On the afternoon 30 August 2010 the deceased saw Dr Mathew and complained of sedation from the clozapine,[32] a reasonably common side-effect.[33] Dr Mathew decided to stop two other medications the deceased was being administered and to increase the clozapine at a slower rate.
47. That evening at about 8.45pm the medical officer on duty, Dr K Ayeni, was asked to see the deceased. Dr Ayeni was an experienced psychiatrist although at the time he was working at Graylands as a medical officer only. He said in evidence that he was afraid of

[28] Ex 1, Vol 3, Tab 3, p162
[29] Ex 1, Vol 3, Tab 3, p158
[30] Ex 1, Vol 3, Tab 3, p68
[31] Ex 1, Vol 3, Tab 3, p70
[32] Ex 1, Vol 3, Tab 3, p71
[33] Ex 1, Vol 3, Tab 3, p162

clozapine and would not have prescribed it to the deceased if he had been asked to do so.[34]

48. When Dr Ayeni saw the deceased he was informed that the deceased had had a temperature of 38.2°, but that the deceased's temperature had dropped to 37.2 when he was given paracetamol. The deceased allowed Dr Ayeni to examine him and to carry out an ECG.[35]

49. Dr Ayeni's first reaction when he saw the deceased was to transfer him to Sir Charles Gairdner Hospital because of the possible side effects of clozapine. However, the deceased refused to go, and his vital signs were all normal, so Dr Ayeni ordered that the deceased's morning dose of clozapine be stopped until the deceased was reviewed by the unit's doctor. He also ordered blood tests and another ECG, as well as the continuation of paracetamol as required and the monitoring of the deceased's vital signs every four hours. The next check of the deceased's vital signs was 1.00am on 31 August 2010.

50. There was a team of four nurses on duty in Montgomery Ward from 11.21pm on 30 August 2010 until 7.30am on the morning of 31 August 2010. The shift coordinator was Patrick Devellerez, an experienced mental health nurse clinician.

51. Nurse Devellerez was aware that the deceased had recently started on clozapine so needed to be closely monitored. In his experience the first adverse reaction to clozapine was a raised temperature. He was made aware at handover of the shift of the deceased's raised temperature earlier that evening.

52. As a part of the nurses' duties, each patient had to be checked every hour to ensure that they were present and alive by way of a visual observation. On that night, nurses were also supposed to check the deceased's vital signs at 1.00am as noted.

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[34] ts 81
[35] Ex 1, Vol 3, Tab 3, p71

53. At the start of the shift the deceased was already in his bed sleeping soundly on his back and snoring loudly as was typical for him. The nurses conducted visual checks on him every hour and recorded that he was in bed. His snoring could be heard from the nurses' station in the ward.

54. Registered Mental Health Nurse John Holmes carried out hourly checks and at 1.00am attempted to carry out the check of the deceased's vital signs as ordered by Dr Ayeni. The deceased abused him for waking him up and refused to cooperate.[36]

55. Nurse Holmes carried out further hourly visual observations on the deceased until 4.00am and noted each time that he was in bed.

56. At about 4.30am one of the patients sharing the deceased's room approached the nurses' station to report that the deceased was making a funny noise.[37]

57. Nurse Holmes and Registered Nurse Francis Kuranja quickly went to the deceased's room where they realised that the deceased was having difficulty breathing and that he required assistance.

58. Nurse Kuranja obtained baseline observations indicating that the deceased had a raised temperature at 37.9°, low blood pressure at 80/60, pulse at 88bpm, normal (for the deceased) oxygen saturation at 92% and shallow fast breathing at 66 breaths per minute.[38]

59. At 4.40am the deceased stopped breathing.[39]

60. The other nurses attended and helped move the deceased onto the floor to enable CPR and oxygen to be administered. They called for the emergency team which

[36] Ex 1, Vol 1, Tab 31
[37] Ex 1, Vol 1, Tab 31
[38] Ex 1, Vol 3, Tab 3, p74
[39] Ex 1, Vol 3, Tab 3, p74

arrived in two or three minutes as did the duty medical officer, Dr Farzad. Nurse Kuranja administered adrenaline and atropine to the deceased.[40] A staff member called for an ambulance.

61. The emergency team continued resuscitation with the help of the ward's nurses. When the ambulance paramedics attended at about 5.00am, the CPR was still in progress but the deceased's pupils were dilated, he was asystole, meaning he had no electrical or mechanical activity in his heart, and was cyanosed. The officers indicated to Dr Farzad their intention to cease the CPR given that the deceased had been asystole for 20 minutes, but Dr Farzad insisted that the resuscitation continue on the way to Sir Charles Gairdner Hospital.

62. The ambulance paramedics conveyed the deceased to the emergency department of Sir Charles Gairdner Hospital and continued to administer CPR and adrenaline with the assistance of Nurse Kuranja, but the deceased remained asystole.[41] At the hospital the deceased was intubated and ventilated but he could not be resuscitated. He was declared deceased at 5.55am.

CAUSE OF DEATH

63. Forensic pathologist Dr J McCreath conducted a post mortem examination of the deceased and found an enlarged heart, narrowing of blood vessels supplying blood to the heart and excess fluid in the lungs.[42]

64. Microscopic examination of the deceased's tissue showed bronchitis in the lungs and fatty change to the liver. Microbiological testing of lung tissue showed the presence of Influenza A virus RNA H1N1, also known as swine flu virus.[43]

[40] Ex 1, Vol 1, Tab 24
[41] Ex 1, Vol 1, Tab 25
[42] Ex 1, Vol 1, Tab 5
[43] Ex 1, Vol 1, Tab 5 p1

65. Dr McCreath concluded that the cause of death was bronchitis (pandemic influenza A/H1N1 2009) in a man with chronic obstructive pulmonary disease, and I so find.

HOW DEATH OCCURRED

66. On the basis of the circumstances described above, I find that the manner of death was natural causes.

QUALITY OF THE SUPERVISION, TREATMENT AND CARE OF THE DECEASED

67. The deceased was a long term patient at Graylands due to the intractability of his mental illness, but also it seems to have been due to his desire to be there. For example, there is evidence that the deceased sabotaged his placements at hostels in order to return to Graylands and that he regularly presented himself at Graylands after unauthorised absences.[44]

68. The deceased's integrated progress notes from Graylands show that the deceased was often a difficult patient due to an aggressive attitude and his unwillingness to comply with policies such as the no-smoking policy.

69. The deceased's major physical medical problems were chronic obstructive pulmonary disease and morbid obesity, but he refused to take any steps to address those problems; in fact he exacerbated the former by maintaining a heavy smoking habit despite repeated counselling by doctors at Graylands to reduce the number of cigarettes he smoked.
70. Notwithstanding the challenges in managing the deceased, he received a considerable amount of high level treatment and care for several years, including

[44] ts 108

dental care, occupational therapy and medical treatment at Graylands and Sir Charles Gairdner Hospital, as well as the nursing and psychiatric care at Graylands.

71. On the night and early morning leading up to his death, the deceased had a slightly raised temperature which was lowered to a normal range with paracetamol.

72. When Dr Ayeni checked the deceased at 8.45pm on 30 August 2010, his vital signs were normal, but Dr Ayeni took the cautious step of requiring four-hourly checks of the deceased's vital signs because he was concerned about the fact that the deceased had been given clozapine. Dr Ayeni could have had no reason to suspect that the deceased was suffering from swine flu.

73. When Nurse Holmes attempted to conduct the check of the deceased's vital signs at 1.00am on 31 August 2010, the deceased refused to cooperate and did so in his usual way, leading Nurse Holmes to believe that the deceased's condition had not changed. Hourly visual observations of the deceased and the easily recognised sound of the deceased's snoring led the nurses to believe that the deceased was sleeping soundly.

74. When the deceased's room-mate noted that the deceased was not breathing normally, the deceased had the benefit of the almost immediate attention of highly trained and experienced nurses, and then a medical officer and an emergency response team within a short time. A defibrillator was attached to the deceased but the deceased did not display a shockable rhythm, so the defibrillator was not used to provide a shock.

75. I am satisfied on the basis of the evidence available to me that the quality of all facets of the care and treatment of the deceased was reasonable and appropriate.

Barry King
Coroner
11 April 2014