Coroners Act, 1996
[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 2/15

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***Peta Susan DOIG****, with an Inquest held at Perth Coroners Court, CLC Building, 501 Hay Street, Perth, on 19 January 2015 find the identity of the deceased was* ***Peta Susan DOIG*** *and that death occurred on 4 January 2013 at Sir Charles Gairdner Hospital, as the result of pneumonia and cardiac failure complicated by hypoxic brain injury, in the following circumstances:*

Counsel Appearing :

Sergeant L Housiaux assisted the Deputy State Coroner

Ms J O'Meara (instructed by the State Solicitors Office) appeared on behalf of the North Metropolitan Health Service, Mental Health, and the Office of the Public Advocate

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INTRODUCTION

Late on 3 January 2013 Peta Susan Doig (the deceased), a long term resident of Graylands Hospital (Graylands) was transferred to Sir Charles Gairdner Hospital (SCGH) following a collapse at Graylands. On arrival at the hospital she went into cardiac arrest, was stabilised and transferred to the Intensive Care Unit (ICU). Her condition deteriorated and a decision was made for palliative care. Life support was removed and the deceased died at 12:21pm on 4 January 2013.

The deceased was 58 years of age.

The deceased had been an involuntary patient at Graylands for many years and although she was made a voluntary patient in July 2010 she was maintained at Graylands due to the inability to accommodate her in a more appropriate facility.

At the time of her death she was a voluntary patient, resident of Graylands and the Public Advocate was her guardian.

BACKGROUND[1]

The deceased was born on 15 September 1954 in Perth and is known only to have had a brother. Her mother had a

[1] Ex 1, tab 14 & 16

history of schizophrenia and had been institutionalised.[2] The deceased was identified as having developmental issues from four years of age but there was dispute over a diagnosis. She appeared to be responding to voices which caused clinicians to consider childhood onset schizophrenia with psychotic features. Following extensive assessments she was ultimately diagnosed as suffering childhood onset autism and severe mental retardation (with a full scale intelligence quotient of 50-60).[3]

The extent of the deceased's developmental and mental issues caused problems in caring for her in an appropriate facility.[4] She was placed in Nathaniel Harper Home, a home for children with intellectual disabilities, from 1963-1968. She was then hospitalised at Heathcote Hospital, and from September 1968 at Graylands.

The deceased had limited verbal expression and displayed stereotypical, repetitive movements and ritualistic compulsive behaviours. She presented as withdrawn, with a lack of responsiveness to others, and gross deficits in language development. She would often become agitated, distressed and aggressive and would self-harm by cutting herself, picking her skin and banging her head. Her management was complicated by her behaviour in being aggressively resistant to staff and she was vulnerable to sexual exploitation by other patients.

[2] Ex 1, tab 15
[3] t 19.01.15, p9
[4] t 19.01.15, p8

Her medical history included;

- Angioedema – March 2012
- Vasovagal episode secondary to constipation – seen at SCGH 2012
- Crush fracture of T7 and severe spinal canal narrowing causing inability to walk and incontinence - 2010
- Oesophageal and gastric erosions in 2001
- Thyroid nodules
- Fractured left arm

Her medications by the time of her death comprised;

- Quetiapine
- Risperidone
- Clomipramine
- Diazepam
- Movicol
- Docusate
- Lactulose
- Omeprazole
- Tramadol
- Gabapentin
- Risendronate
- Calcium and vitamin D tablets
- Promethazine
- Azithromycin

The deceased's medications were changed over time to respond to developments in knowledge about the effect and interaction of different medications, but her physical state always remained very difficult to assess. She could not verbalise symptoms other than appearing to be distressed and, on occasions, being able to identify the area of concern. She became very aggressive when any attempt was made to examine her physically. It was often difficult to determine if any distress the deceased exhibited was as a result of a physical illness or related to her developmental and intellectual conditions.

Many behavioural and other programmes were developed over the years in an attempt to improve the deceased's social skills without success. In later years the Autistic Association was sometimes involved in the plans; offering assessment and management advice only. She was never officially registered with the Autistic Association.

There was little dispute Graylands was not a suitable place for the deceased to reside, especially at a young age, however alternative accommodation was difficult to achieve and invariably failed as a consequence of her behaviour.[5]

Applications to the Disability Services Commission (DSC) for funding to assist with alternate accommodation was

[5] t 19.01.15, p10

rejected until very late in the deceased's life.[6] By then she was so institutionalised and adapted to the Graylands environment it became impossible to move her.

The deceased was managed in the open area of Murchison Ward at Graylands for many years as an involuntary patient. She did not go on outings but wandered the grounds independently. As she became older she increasingly confined herself to the wards and would only go to the hospital kiosk with staff with whom she was familiar. She did not engage with occupational therapy but in earlier years was reported to go through bins, tidy magazines and eat other patients' food.

Initially, the deceased's family of origin were supportive but from the mid 1990's, when her parents were quite elderly, this declined. After her father died her mother was placed in a hostel, then a nursing home. The last contact with the deceased's mother was in 2007 when she asked after the deceased's health. Her brother has remained un-contactable.[7]

In 1999 the deceased was placed at the Glide Street Psychiatric Hospital for a period of three months. The deceased returned to Graylands as a result of her behaviour making it impossible to accommodate her with other

[6] t 19.01.15, p11
[7] t 19.01.15, p10

residents. Further attempts to find suitable accommodation for the deceased were unsuccessful.

In 2002 the deceased was referred to the Community Options Project, which was intended to provide high support psychiatric accommodation for people such as the deceased in the community. The deceased's registration with DSC made this possible however, there was no funding attached to the registration and the Community Options Project could not be utilised.

It was reconsidered later in 2008, when DSC was prepared to provide some funding but the deceased had physically deteriorated, and her referral was declined. She needed a secure environment with a very high level of support which could not be sustained as part of the Community Options Project.

While the deceased had initially been managed in the open part of Murchison Ward, she began to require longer periods in the locked ward, and eventually became so severely institutionalised she had no meaningful relationships with anyone outside the hospital.

In 2008, following a period of physical unwellness, the SCGH Emergency Department would not accept the deceased for assessment without being satisfied there was a need for medical intervention. Graylands staff attempted to

obtain blood for investigations, but the deceased became so agitated she suffered a cardiac arrest before she could be sedated. She was resuscitated and transferred to SCGH via ambulance.[8]

The deceased was then assessed under sedation and examination revealed considerable faecal loading, with a right upper lobe chest infection, hiatus hernia and an enlarged heart.

Following that incident Graylands was advised by SCGH the deceased should only be medically examined when there was an acute medical need. It was suggested the deceased be surreptitiously provided with oral sedation before that occurred to prevent a repeat of her cardiac compromise.

The Public Trustee was the deceased's administrator, but on 15 October 2008 the State Administrative Tribunal (SAT) appointed the Public Advocate as plenary guardian for the deceased.[9] The application had been brought by one of the social workers on the Murchison Ward in an attempt to support the deceased's application for the Community Options Programme.[10]

While the Public Advocate was not able to assist further with the applications for the Community Options

[8] t 19.01.15, p12
[9] t 19.01.15, p19
[10] t 19.01.15, p18

Programme due to the deceased's deteriorating health, the Public Advocate remained involved as the deceased's guardian. The deceased had four delegated guardians overtime to assist with decision making surrounding her treatment and care.

The role of the officer of the Public Advocate was to provide advocacy to improve the deceased's living conditions within Graylands and to seek more suitable community living options for her. They were significantly involved with submissions to the DSC in an attempt to provide funding to improve her accommodation.

In 2009 further representations were made to DSC including concern from the Mental Health Review Board (MHRB) that the deceased was inappropriately placed in the mental health system. In October 2009 DSC advised the deceased's delegated guardian that an application had been successful and the deceased was recommended to receive accommodation support funding from DSC to relocate her from Graylands Murchison Ward to a supported option in the community.

However, by that time the deceased's physical condition had deteriorated further. She had to be managed on a low rise bed during the day time, with use of a wheel chair for transfers and toileting because she could not walk independently. She had to be taken to the toilet every two

hours and wore incontinence pads between times. Her management was extremely difficult due to her lack of cooperation and again suitable community accommodation could not be provided.

The deceased suffered with ongoing abdominal pain in November 2009 and in early 2010 the deceased was very distressed with poor mobility. She pointed to her lower back and was diagnosed with an exacerbation of an old spinal fracture. She had to be restrained with general anaesthetic to enable proper investigation. On this occasion the deceased was admitted to SCGH for five days and found to have significant spinal cord compression with consequent paralysis with pain, weakness of her left leg and neurogenic bladder.[11]

Surgery was considered and discussed with the deceased's guardian, but not pursued as there was concern she would not cooperate with rehabilitation following surgery. As a result she was managed conservatively while attempting to accommodate her needs.

The deceased was moved to Casson Ward which had a more nursing home type environment and was better suited to deal with the deceased. Staff found moving the deceased from her room into the day area tended to improve her responsiveness because she could see what was happening.

[11] Ex 1, tab 15

It was as a result of being placed on the Casson Ward the deceased was, on 7 July 2010, made a voluntary patient under the *Mental Health Act* with her guardian consenting to her management.

EVENTS LEADING TO DEATH

Attempts continued to be made to move the deceased to community nursing home accommodation. Applications were made to Nelson Haven and Bright Water Nursing home, supported by her guardian, but both referrals were declined. Her guardian had regular meetings with staff from Graylands to discuss her management in view of her physical deterioration and physical health issues.

The deceased remained relatively settled on Casson Ward until Christmas 2012 when she became anxious and agitated and required extra doses of medication to keep her calm. The following day she was screaming and crying and extra medication was having little effect. The deceased returned to tearing the bed linen and clothes and repeatedly banging her head. Due to her lack of mobility these behaviours did not interfere with the management of the facility as much as they had previously.

By midnight the deceased was noted to have a swelling on the right side of her face but refused examination. Her lips were not swollen and she did not have breathing difficulties

and did not appear to be in distress. There was concern she might be suffering from a dental abscess or cellulitis and she was started on an antibiotic with an antihistamine in case of allergic reaction. Her breathing was monitored.

On the morning of 27 December 2012 the bruising was noted to be a purple swelling under her right eye and, without examination, it was agreed it seemed likely she was suffering from a dental abscess or cellulitis.

The deceased's behaviour remained unsettled and on 31 December 2012 there is a nursing note the deceased had not slept, but had been lying on her bed cradling her head in her hands. The deceased continued to be restless and need further medication.

On 3 January 2013 the deceased was reported to be *"chesty"* and the nurses managed to obtain some observations which indicated a low oxygen saturation of 93%, with a BP of 143/94, pulse of 89 and temperature of 35.7°C. She was reviewed by the doctor at approximately 3pm who suspected a chest infection and changed her antibiotics from a penicillin based antibiotic to Azithramycin.

Later that night the deceased was still very chesty and breathless and agitated. She would not allow the nurses to

record her temperature and screamed whenever they approached.

Shortly before 10pm the deceased appeared to stop breathing and a code blue was called with CPR commenced immediately. The deceased's oxygen saturations had dropped to 26% and her heart rate was approximately 10bpm. A defibrillating machine reported no shockable rhythm and CPR was continued. Initially an intravenous IV access was unsuccessful.

The deceased was given adrenaline and emergency services called. Paramedics arrived at 10:07pm and the deceased was noted to have fixed dilated pupils. Thereafter an IV access was achieved and IV sodium chloride commenced. The deceased was administered more adrenaline and at 10:14pm was intubated, with further adrenaline administered at 10:17pm. At 10:23pm the deceased was taken by ambulance to SCGH.

On arrival at SCGH the deceased arrested and CPR was resumed and ceased at 10:35pm with a return of her circulation. Her oxygen saturation was then recorded as 100% by bag and mask, and her pulse rate was 65 and blood pressure 135/41. She was assessed as had having a cardiac arrest from unknown cause and was transferred to the ICU.[12]

[12] Ex 1, tab 13

At 3:35am on 4 January 2013 the deceased again deteriorated and became minimally responsive. A head CT scan showed signs of raised intracranial pressure, loss of grey/white matter differentiation and early signs of brain stem herniation. She was diagnosed with hypoxic injury secondary to her cardiac arrest.

Dr Stuart Baker from the ICU contacted the deceased's guardian to advise she had suffered a massive cardiac arrest the previous evening and was now unresponsive and being ventilated. He advised the guardian the deceased showed no brain activity and recommended life supports be withdrawn.

End of life determinations with respect to somebody with guardianship delegated to the public advocate can only be dealt with by the public advocate herself.[13]

Ms Bagdonavicius, the Public Advocate, accepted Dr Baker's recommendation and provided consent for the treating team to withdraw life supports from the deceased and she died at 12:21pm on 4 January 2013.

Review of the deceased's medication in the 24 hours before her death indicated she had been appropriately medicated with both her regular medications and antibiotics during

[13] t 19.01.2015, p18

her time at Graylands. Her management, while restricted by her behaviour, had been appropriate as overseen by the Public Advocate.

POST MORTEM REPORT[14]

The deceased's post mortem examination was undertaken by Dr Gerard Cadden, Forensic Pathologist of PathWest Medicine Laboratory on 16 January 2013. Initially the cause of the deceased's death was undetermined but after further investigations Dr Cadden was of the opinion the deceased's death was as a result of pneumonia and cardiac failure, complicated by hypoxic brain injury. Dr Cadden was of the view the deceased had effectively suffered two cardiac arrests while suffering a chest infection and the resulting hypoxia had compromised her ability to survive independently.

While toxicology revealed a relatively high level of clomipramine, the dose the deceased had been receiving whilst at Graylands was well below the maximum dose allowable. It is possible the deceased's blood level was increased by her other medications and failure of her liver.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 58 year old woman who had been diagnosed with autism and severe mental

[14] Ex 1, tab 6

retardation which had caused her to be institutionalised since approximately 8 years of age. She was placed in Graylands at the age of 13 or 14 because there was no where appropriate to place her with the extent of her difficulties and the interrelationship of her diagnoses.

The deceased was always hard to manage having difficulty in verbalising and communicating effectively. This resulted in her becoming very agitated and difficult to deal with both on a person to person level, and as part of a community.

Attempts were made to obtain funding for more appropriate accommodation but disputes as to her correct diagnosis and placement continued until she was so institutionalised she could not be placed elsewhere.

Due to a wish to have the deceased placed in community accommodation which would require funding, a social worker from Graylands approached the Public Advocate to advocate on behalf of the deceased for her applications for funding. The deceased was appointed a public advocate as guardian in October 2008 and thereafter her application for additional funding was successful, but could not be utilised because her physical state had deteriorated. She remained at Graylands but was transferred to Casson Ward.

The deceased was made a voluntary patient in July 2010. She continued to display ritualistic, and sometimes

aggressive, behaviour and was non-compliant with medical examinations which made evaluation of any physical difficulties extremely difficult. Her physical condition deteriorated to the extent she was bed bound and required full nursing care.

On 26 December 2012 the deceased developed signs of a chest infection. She was commenced on antibiotics but on 3 January 2013 these were changed to one most appropriate for a chest infection. Later that day she suffered a sudden cardiac arrest.

In spite of resuscitation efforts she suffered significant hypoxia and following transfer to SCGH intensive care unit died on 4 January 2013 following discussions with the public advocate for a palliative management plan.

The deceased's disabilities made her care an extreme challenge for everybody involved in attempting to manage her. While the mental health facilities were an inappropriate placement for a child, Graylands was the only facility who did care for her and eventually she could not be accommodated elsewhere.

Despite her placement in Graylands not being appropriate those caring for her appear to have managed her well. The deceased survived, despite her difficulties, to middle age. This, in the context of Carers being unable to examine her

for physical ailments and having to rely on extreme measures on the occasions she did become acutely unwell.[15]

The inability to properly monitor the deceased's health due to her agitated reactions prevented informed interventions which may have prolonged her life further, but would not have promoted the little quality she had.

I find death arose by way of Natural Causes.

E F Vicker
Deputy State Coroner
26 February 2015

[15] t 19.01.15, p12