Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 25/12

I, Barry Paul King, Coroner, having investigated the death of ***Ritchie Gordon*** *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* ***Ritchie Gordon*** *and that death occurred on* ***12 July 2005*** *at* ***Graylands Hospital*** *in the following circumstances:*

Counsel Appearing:

Ms M. Smith assisting the Coroner
Mr N. Snare (Aboriginal Legal Service) appeared for the family of the deceased
Ms C. Lakewood (State Solicitors Office) appeared for the North Metropolitan Area Health Service (NMAHS)

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INTRODUCTION

1. The deceased was a 49 year old Aboriginal man from a small community near Halls Creek. He had been a long term involuntary patient at Graylands Hospital (Graylands) since 6 August 2002 because of his psychiatric condition.[1]

2. The deceased was managed at Graylands at an open ward and spent much of his time wandering around the grounds of the hospital responding to hallucinatory stimuli.

3. In June 2005 the deceased was trialled on the antipsychotic medication clozapine after other medications had little effect.[2]

4. On 12 July 2005 the deceased was found dead on a veranda of his ward after not being seen for some hours. The cause of his death could not be ascertained.

5. 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*.

6. 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.

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

8. 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.

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[1] Exhibit 1 Volume 1 Tab 14
[2] Exhibit 1 Volume 1 Tab 13

9. 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.

10. A joint inquest was held before Coroner D.H. Mulligan in the Perth Coroner's Court on 27 to 29 August 2012 and was then adjourned and recommenced on 11 March 2013. The hearings were completed on 22 April 2013. Evidence specific to the deceased was taken on 27 August 2012.

11. 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.

12. 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.

13. 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.

14. 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.

15. 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 potentially connected to the death or were relevant to the quality of the supervision, treatment and care of the deceased, I have addressed them in the respective findings. In accordance with that process, in this finding I have canvassed evidence raised with respect to the available facilities and staffing levels available in the deceased's ward at the time of his death.

THE DECEASED

16. The deceased was born on 1 April 1956. He originated from the Lajamanu community, Ringer Soak, Halls Creek, where he was raised as a traditional Aboriginal person. By the time of his death, both his parents were deceased, and he had no contact with his only sibling, a sister who was also reported to have a mental illness.

17. When he was 16 years old, the deceased suffered a head injury after which he was observed to experience symptoms of mental illness. He had a history of alcohol abuse and he engaged in glue and petrol sniffing when younger. He was also a heavy smoker.

18. The deceased was first admitted to Graylands in 1991 and was re-admitted on 10 occasions. He was diagnosed with chronic schizophrenia, organic brain syndrome from the injury, and alcohol and drug abuse. His symptoms were unintelligible speech, inappropriate

giggling and deteriorated episodes with aggressive behaviour. He had no history of self-harm.

19. The deceased spent about three years in long term rehabilitation at Graylands from 1996 to 1998 and was then discharged to Sherwood Hostel where he spent a further three or so years.

20. Attempts were made to return him to his community, but he would act inappropriately socially and he became frustrated and abusive when not comprehended.

21. In January 2001 the deceased was transferred to the Swan Valley Centre where he was trialled at two hostels as a voluntary patient. Both placements were unsuccessful due to his physically and verbally aggressive behaviour.

22. At the Swan Valley Centre, the deceased wandered about muttering to himself and drinking excessive amounts of water. He would laugh without reason and, when his mental state deteriorated, he would become very labile – crying and laughing alternately.[3]

23. Staff at the Swan Valley Centre tried to contact the Ringer Soak community in order to send the deceased there, but were told that the people there were not willing to accept the deceased back. He was made an involuntary patient on 8 February 2002.[4]

24. The deceased developed a protruded abdomen and at times suffered from hyponatraemia from the excessive drinking of water. That was controlled by closer management on a locked ward.

25. On 6 August 2002 the deceased was discharged from the Swan Valley Centre and returned to Graylands where he was placed back in Murchison Ward.[5]

[3] Exhibit 1 Volume 1 Tab 15
[4] Exhibit 1 Volume 1 Tab 15 p. 2
[5] Exhibit 1 Volume 1 Tab 14

Murchison Ward was a mixed gender rehabilitation ward, divided into an open section and a secure, or locked, section.

26. The deceased's status as an involuntary patient was maintained because his mental illness could only be treated at an authorised hospital. The treatment was necessary in order to protect him from his drug and alcohol abuse and to protect others from his aggression and sexual inappropriateness. He had a history of noncompliance with his medication.

27. As time went on, the deceased suffered from mild chronic obstructive pulmonary disease.[6]

TREATMENT

28. While at Swan Valley Centre the deceased's psychosis was treated with antipsychotics as required, but they were not administered frequently. Inappropriate behaviour was managed behaviourally as far as possible.

29. When the deceased returned to Graylands, he was managed as an involuntary patient on Murchison's open ward and was allowed to wander the hospital grounds. He was occasionally contained on the closed ward when he became aggressive.

30. The deceased had problems swallowing, so he was on a modified diet and was monitored by a dietician and speech pathologists. His dental hygiene was extremely poor, resulting in his remaining teeth being extracted under general anaesthetic in February 2004. He refused to be fitted with dentures.

31. Members of the Aboriginal Psychiatric Service based at Graylands regularly took the deceased out for excursions. That was his main social support, though it

[6] ts 16

seems that he was visited by friends or relatives from Ringer Soak in November 2003.

32. The deceased was administered psychotropic medications for his psychosis and aggression, but without much success.

33. In June 2005 the deceased was commenced on clozapine, an antipsychotic that can be effective with people who suffer from a treatment-resistant psychosis. As clozapine increases the risk of the lowering of the white blood cell count, blood tests were required regularly. The deceased was on a strict monitoring regime.[7]

34. On 16 June 2005 the doses of other antipsychotics administered to the deceased were lowered with the hope that the clozapine would take over from the other drugs as its dosage increased.

35. Another side effect of clozapine is constipation. To deal with that, on 17 June 2005 the deceased was given an enema and started on a laxative.

36. Checks of the deceased's clozapine levels showed that the deceased tended to metabolise that drug slowly. [8]

37. The strict monitoring regime showed no cardiac contraindication to the administration of clozapine, and no evidence of myocarditis.[9]

DATE OF DEATH

38. The entry in the deceased's integrated progress notes for 12 July 2005 indicate that the deceased spent some time wandering the ward and hospital grounds laughing and speaking to himself incomprehensively, and that he went out with staff of the Aboriginal Psychiatric Service

[7] Exhibit 1 Volume 1 Tab 13 p.2; ts 18
[8] ts 21
[9] ts 20

during the day. He was present for all of his meals. He was pleasant in conveying his wants and was not a management problem.[10]

39. The staff at Murchison Ward noticed that the deceased was not present for the 9.00pm check, but it was his usual practice to socialise at other wards in the evening, so staff were not concerned. It was typical for patients from Murchison ward to remain on other wards until the nightly lock down at 10.00pm and then return to Murchison Ward and be allowed in through a buzzer system.[11]

40. At 10.30pm the deceased had still not returned to Murchison Ward so a search was undertaken. He was quickly found, slumped and unresponsive in a chair on a veranda outside the ward's dining room.[12]

41. Nursing staff administered cardiopulmonary resuscitation and medical staff attended, but the deceased was obviously dead. Rigor mortis indicated that he had been dead for some time.

CAUSE OF DEATH

42. Forensic pathologist Dr J White carried out a post mortem examination of the deceased on 14 July 2005. Her external examination showed no evident injuries.[13]

43. On internal examination Dr White found marked dilation of the small and large intestines but all bowels appeared viable with no evidence of ischaemia or an obvious obstructive cause. The deceased's heart appeared small and there was mild narrowing and thickening of all three coronary arteries. The lungs appeared mildly congested and the kidneys were mottled and congested. [14]

[10] ts 22
[11] ts 22
[12] ts 22
[13] Exhibit 1 Volume 1 Tab 10 p.3
[14] Exhibit 1 Volume 1 Tab 10 p.1

44. Microscopic examination showed ischaemic heart disease. There was no evidence of aspiration of vomit into the airways or inflammation of the heart or lungs.

45. A toxicology analysis showed levels of prescribed medicines, with clozapine present at 1mg/l.[15]

46. Neuropathology indicated a developmental abnormality of both sides of the brain.[16]

47. Dr White concluded that the cause of death was unascertainable. She advised that, given her findings and her understanding of the circumstances surrounding the deceased, the possible explanations for a cause of death would include epileptic seizure, cardiac arrhythmia and paralytic ileus/bowel obstruction.[17]

48. Dr White noted that clozapine has been associated with myocarditis but that there was no evidence of myocarditis on microscopy.

49. In these circumstances, the cause of death must remain unascertainable.

MANNER OF DEATH

50. While the cause of death cannot be ascertained with any precision, there is little doubt that the deceased died as a result of natural causes, and I so find.

QUALITY OF THE SUPERVISION, TREATMENT AND CARE OF THE DECEASED

51. In the course of the inquest relating to the deceased, evidence was adduced as to the facilities and the level of medical and nursing staff on Murchison ward.

[15] Exhibit 1 Volume 1 Tab 11 p.1
[16] ts 30
[17] ts 31-32

52. Senior Consultant Psychiatrist Dr Georgina Dell described the unit as being not at all home-like. She said that there are issues with privacy and that it is too crowded. She said that it is not set up for rehabilitation.[18] Dr Dell noted that there have been lots of improvements, with new bathrooms and paintings, but the courtyard areas are poor and the ward remains too crowded and lacking in privacy.

53. In Dr Dell's opinion, a new purpose built unit would need to be built, or the existing building would need to be gutted and only half the number of patients be accommodated there.[19] Dr Dell's opinion was echoed by many other professional staff in relation to Graylands as a whole, except for Ellis Ward which is a modern purpose-built facility.

54. Since the time of the deceased's death, a review of the public mental health facilities and services was undertaken by Professor Bryant Stokes, following which a number of initiatives have been implemented by the Western Australian government to provide more facilities and staff and better governance to meet the growing demand for mental health care. Evidence obtained in 2013 that replacement of out-of-date infrastructure will not likely occur soon on any significant scale[20]; however, the Mental Health Commission's website does list a number of projects to provide more facilities external to Graylands.

55. The timing and the nature of major projects such as the replacement or substitution of buildings is dependent on matters outside the scope of this investigation, so I can only comment that the evidence before me indicates that there will be an increasing demand for facilities and services, the provision of which have apparently not received as high a priority in the past as was warranted. The statistics of the incidence and effect of mental

[18] ts 12
[19] ts 14
[20] General Evidence, Ex 1, Vol 1, Tab 4; Tab 6, p12

illness provided in Professor Stokes' 2012 report make sobering reading in that regard. It is hard to imagine that the statistics for those matters have improved since then.

56. As to the manner in which patients are cared for, Dr Dell thought that the level of nursing staff at Murchison ward at the time of the deceased's death was the lowest for any inpatient unit in Western Australia. She said that the level has increased a little since then, but that it was still the lowest level at Graylands. However, she did not suggest that the deceased received an inappropriately low level of care as a result.

57. Dr Dell said that it is difficult to engage in active rehabilitation and take people out into the community with the level of staff there at the time of the inquest. However, she noted that Aboriginal patients were fortunate in a sense because they had the Aboriginal Psychiatric Service. In the deceased's case, the Aboriginal Psychiatric Service would take him off the ward two or three times a week.[21]

58. Notwithstanding the criticisms by Dr Dell and others of the nature and state of the buildings at Graylands, there is no basis for a conclusion that any shortcomings with the infrastructure at Graylands at the material times had any negative effect on the deceased's treatment and care.

59. In my view, the evidence available relating specifically to the deceased established that he was provided with an acceptable level of supervision, treatment and care.

B P King
Coroner
11 April 2014

[21] ts 12