Coroners Act, 1996
[Section 26(1)]

Western ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 48/2013

*I, Evelyn Felicia Vicker, Acting State Coroner, having investigated the death of **Graeme Ross IBBOTSON**, with an Inquest held at the Perth Coroners Court, Court 51, Central Law Courts Building, 501 Hay Street, Perth, on 19 December 2013 find the identity of the deceased was **Graeme Ross IBBOTSON** and that death occurred on 5 April 2000 at Mill Street Centre, Bentley Hospital, as the result of Ischaemic Heart Disease in the following circumstances -*

Counsel Appearing :

Sgt L Housiaux assisted the Acting State Coroner

Ms R Hartley (instructed by the State Solicitors Office) appeared on behalf of the Bentley Hospital

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INTRODUCTION

At the time of his death Graeme Ross IBBOTSON (the deceased) was an involuntary patient at Mill Street Centre (MSC), Bentley Hospital under the provisions of the *Mental Health Act 1996*. He was 57 years of age.

The provisions of the *Coroners Act 1996* require the death of a person held in care, in this case an involuntary patient under the *Mental Health Act*, be examined by way of inquest to assess the quality of the supervision, treatment and care provided to the deceased person.

BACKGROUND

The deceased was born in Kalgoorlie, Western Australia on 5 March 1943.

He married in Guildford on 1 February 1974 and divorced two years later. He had no children.

The deceased had an extensive medical history including hypertension, hypercholesterolemia, intermittent claudication, myocardial infraction, brainstem transient ischaemic event, and chronic airways disease. He also suffered mental health issues and had been diagnosed with bipolar effective disorder in 1974. He had required hospitalisation for his mental health difficulties on numerous occasions since diagnosis.

THE DECEASED'S HOSPITALISATION

On 27 February 2000 the deceased admitted himself to the MSC for treatment of a bipolar effective disorder. He remained at the centre receiving treatment for his problems until 8 March 2000 when he was transferred to Royal Perth Hospital (RPH) on a Form 6 with wheezing and shortness of breath associated with a productive cough and confusion.

At RPH he was treated with chest physiotherapy, antibiotics and ventolin and nebulisers along with his regular medication. He improved markedly despite continuing to smoke and was transferred back to MSC on 9 March 2000 with a course of prednisolone.

On 15 March 2000 he was again taken to RPH ED for management of worsening shortness of breath, wheeze and cough. He was given intravenous hydrocortisone and salbutamol infusion as well ventolin and atrovent nebulisers. In the morning he was reviewed and again had improved dramatically. He was not recommenced on the prednisolone due to a concern it might exacerbate his psychosis. He was returned back to MSC for management with ventolin and saline nebulisers and a preference he cease smoking.

On the evening of 16 March 2000 he was returned to RPH due to his condition having rapidly deteriorated and his becoming unresponsive, and confused with an oxygen saturation of 84%.

He had been given oxygen and nebulisers at MSC and had improved. He required a chest xray which was reported as showing bibasal atelectasis.

His oxygen saturations improved with treatment, although he remained agitated, aggressive and labile. He was discharged back to MSC on 21 March 2000 with appropriate medication. His diagnosis was non-infective exacerbation of chronic airways limitation and bipolar disorder.

On Monday 5 April 2000 the deceased's physical condition again deteriorated significantly and MSC decided to transfer him back to RPH. The St John Ambulance Service arrived just before 10pm to transfer him to RPH at which time he was described by the psychiatric registrar as declining in condition.

The deceased was in the process of being placed into the rear of the ambulance when he suffered a respiratory arrest. Resuscitation was attempted by both the hospital and ambulance staff but the deceased remained non-responsive and was certified deceased at 10.24pm.

POST MORTEM REPORT

The deceased was examined by Dr Clive Cooke, Chief Forensic Pathologist, at the PathCentre.

The post mortem examination revealed a late middle aged man of medium-heavy build. He had enlargement of the heart, approximately double size, with an area of fibrous scarring of part of the heart muscle (ischaemic heart disease) and arteriosclerotic hardening and narrowing of the arteries on the surface of the heart (coronary arteriosclerosis). There had been previous surgery for arteriosclerotic disease in the aorta. Toxicology revealed therapeutic levels of prescribed medications.

Overall Dr Cooke was satisfied the deceased had died as the result of his heart disease.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 57 year old involuntary patient at the MSC at the time of his death. He was an involuntary patient as the result of his bipolar effective disorder, and during the course of his inpatient stay at MSC he had required transfer to RPH a number of times due to his physical/medical health problems.

He was appropriately monitored and maintained in MSC to ensure he received specialist medical care when necessary by transfer to RPH.

On the evening of 5 April 2000 the deceased's physical condition again deteriorated and the staff at MSC made

arrangements for him to be transferred back to RPH for treatment. During the course of the transfer the deceased arrested and could not be revived.

I find death arose by way of Natural Causes.

SUPERVISION TREATMENT AND CARE OF THE DECEASED

The deceased had been diagnosed as requiring mental health input since 1974. He had a history of familial mental health issues and once diagnosed received treatment for his condition.

He was hospitalised with respect to his mental health issues on a number of occasions and on the last period of his hospitalisation for his mental health issues he also suffered a number of medical issues for which he was appropriately treated at RPH as a member of the community.

The deceased's sister was aware of the deceased's difficulties both from a medical and psychiatric perspective.

I am satisfied the supervision, treatment and care of the deceased while an involuntary patient at the MSC in February to April 2000 was reasonable and appropriate.

E F VICKER
ACTING STATE CORONER
December 2013