Coroners Act, 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 49 /2013

I, Evelyn Felicia Vicker, Acting State Coroner, having investigated the death of ***Glenis June Vos****, with an Inquest held at Perth Coroners Court, Court 51, Central Law Courts Building, 501 Hay Street, Perth, on 19 December 2013 find the identity of the deceased person was* ***Glenis June Vos*** *and that death occurred on 24 April 2000 at Graylands Hospital, Brockway Road, Claremont as the result of Focal pneumonia in a woman with emphysema and ischaemic heart disease in the following circumstances -*

Counsel Appearing :

Sgt L Housiaux assisted the State Coroner
Ms R Hartley (instructed by State Solicitors Office) appeared on behalf of Graylands Hospital

Table of Contents

INTRODUCTION

Glenis June Vos (the deceased) was an involuntary patient at Graylands Hospital (Graylands) under the *Mental Health Act 1996*. Overnight from the 23rd to 24th April the deceased's mental state and behaviour were very unsettled. She was agitated and aggressive and required sedating medication. She had to be placed in a secure ward for containment of her aggression.

Once on the secure ward the deceased was given temazepam for insomnia and agitation and was reportedly asleep at the start of the nightshift. She was not recorded as being awake during the night and when checked on the morning of the 25th of April 2000 was found to be deceased.

She was 60 years of age.

Due to the fact of the deceased being an involuntary patient under the terms of the *Mental Health Act 1996* there is a requirement under the *Coroners Act 1996* the circumstances of her death be inquested.

BACKGROUND

The deceased was born in Kalgoorlie on 21 December 1939.

She reportedly did well at school until approximately 14 years of age at which time her performance appeared to deteriorate. She completed a general nursing and midwifery course by her

early 20s and worked for some time as a nurse until she became mentally unwell.

The deceased had numerous stays in hospital for the purpose of psychiatric treatment.

The deceased had three children, however, lost contact with them all.

MEDICAL

The deceased's mental state deteriorated and on 8 February 1958 she was diagnosed as suffering from schizophrenia. She was later diagnosed as suffering from bipolar effective disorder. The deceased was able to remain living in the community until late 1973 when she experienced her first period of hospitalisation at Graylands.

Following her first admission to Graylands the deceased had a further 30 admissions. She effectively became institutionalised and only had short periods of time outside hospital.

By April 2000 the deceased's physical health had also declined and she became very frail and needed to walk with the aid of a Zimmer frame or with the assistance of a wheelchair.

The deceased had a medical history of small strokes, aspiration pneumonia, seizures, respiratory arrest leading to hypoxic brain

injury with residual right upper limb weakness. More recently the deceased suffered repeatedly from bronchitis and pneumonia.

On 6 January 2000 the deceased was admitted to Sir Charles Gairdner Hospital from Graylands with bronchial pneumonia. She was treated with intravenous antibiotics and on 11 January 2000 she was discharged back to Graylands.

On 11 February 200 the deceased was found unresponsive and was admitted to Sir Charles Gairdner Hospital due to a suspected seizure. She was treated and discharged on 16 February 2000. On the 19 February 2000 she was again admitted to Sir Charles Gairdner Hospital after suffering two seizures. On this occasion she was treated until the 24 February 2000 when she was considered well enough to be returned to Graylands. Following a CT scan of her head it was revealed she showed generalised cerebral atrophy. On her discharge on this occasion she was placed in a nursing home in Rockingham but due to persistent behavioural problems which could not be overcome she was returned to Graylands I as an involuntary patient.

In the weeks prior to her death the deceased's mental state fluctuated and she became abusive towards staff and patients.

OVERNIGHT 24-25 APRIL 2000.

On the evening of 23 April and throughout the day of 24 April the deceased was very unsettled and her mood was described as being elevated, agitated and aggressive. The deceased was required to be moved into a locked ward to enable the containment of her aggression.

At 10.15pm on 24 April 2000 the deceased was given 20mg of temazepam for her agitation. Following the commencement of the night shift she was purported to be asleep. On checks overnight the deceased appeared to be sleeping.

At 7.30am on 25 April 2000 the deceased was found unresponsive when attempts were made to rouse her. The medical officer on duty certified the deceased life extinct and the consultant psychiatrist was notified. The doctor noted the deceased appeared to have been dead for several hours.

POST MORTEM REPORT

A post mortem examination was conducted on the deceased by Dr Clive Cooke, the Chief Forensic Pathologist.

Dr Cooke determined after performing various investigations and receiving the results that the cause of death of the deceased was focal pneumonia in a woman with emphysema and ischaemic heart disease.

Toxicology detected a number of medications consistent with the deceased's therapeutic care at Graylands.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 60 year old woman who suffered from mental health issues from the age of 21. At that time she was diagnosed as suffering from schizophrenia which later was defined as bipolar effective disorder.

From the time of her diagnosis the deceased spent the majority of her time in Graylands with periods at normal medical institutions.

She was made an involuntary patient on 11 March 1995 and remained so until the time of her death.

While in Graylands the deceased suffered periods of medical illness for which she was adequately treated. Overnight from the 24-25 April 2000 the deceased had been extremely unsettled and was sedated in a locked ward to enable her to rest. It would seem this may have been part of the commencement of her deterioration due to pneumonia and emphysema.

In the morning she was located deceased and at post mortem was identified as suffering ischaemic heart disease.

I find death arose by way of natural causes.

COMMENTS ON THE DECEASED'S SUPERVISION TREATMENT AND CARE

The deceased was treated on numerous occasions at Sir Charles Gairdner Hospital between 1984 and 1999. Her first admission related to an overdose and she was managed in the Intensive Care Unit until her conscious state improved. Other admissions related to her chest, urinary and lower respiratory tract infections. The deceased had been treated with electro-convulsive therapy on two occasions at Graylands Hospital in 1996 and was tried again in October 1997 with some improvement. She had a family history of Huntington's Chorea and CT scans revealed cerebral atrophy.

In September 1998 the deceased was transferred to Sir Charles Gairdner Hospital as a result of aspiration pneumonia and the following day she suffered a respiratory arrest. Following that arrest she had persistent upper right limb weakness which was thought to be due to hypoxic brain injury. She was discharged back to Graylands on 24 September 1998 where she was managed on the hospital ward in the open section of Murchison Unit. A cerebral perfusion study was subsequently performed which demonstrated mild to moderately decreased profusion to the cerebral hemisphere, particularly involving the frontal and temporoparietal region. The radiologist reported this as being indicative of cerebrovascular disease.

The deceased again suffered a chest infection in 1999 and was admitted to Sir Charles Gairdner Hospital. She again suffered a respiratory arrest and on transfer to ICU a percutaneous tracheostomy was required to maintain her airway. She remained in a poor condition and was transferred back to Graylands in November 1999 for proper care. As a result of her dysplaysia she required a soft diet with thickened fluids.

The deceased remained very frail and following another bout of pneumonia in January 2000 required further admission to Sir Charles Gairdner Hospital. While in hospital the deceased suffered recurrent multiple falls receiving minor head injuries. She had an urgent cranial CT scan which showed generalised cerebral atrophy with no focal brain lesions. She was admitted to the ward and provided with sodium valporate.

On this occasion the deceased was discharged to a nursing home on 24 February 2000, but after two days of unsettled behaviour was returned to Graylands. The deceased's mental state fluctuated and she became very irritable, verbally abusive, paranoid and at times physically violent. She had numerous falls and required intensive physiotherapy and assisted supervised mobilisations. Her mental state continued to fluctuate including aggressive behaviour. This required sedative medication.

It is clear the deceased received extensive input for her mental health issues and was transferred to tertiary institutions for care when her medical condition deteriorated when she required specialised treatment. The deceased was unable to be maintained in a nursing home and required the level and type of care which could be provided at Graylands.

I find the deceased's supervision, treatment and care was adequate.

E F VICKER
ACTING STATE CORONER
20 December 2013