Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 28/ 19

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Timothy James CHANDLER*** *with an inquest held at* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth****, on* ***26 July 2019*** *find that the identity of the deceased person was* ***Timothy James CHANDLER*** *and that death occurred on* ***25 December 2017*** *at* ***Fiona Stanley Hospital****, from* ***multiple organ failure and pulmonary thromboemboli complicating generalised sepsis in a man with cellulitis*** *in the following circumstances:-*

Counsel Appearing:

Ms A Barter assisted the Coroner

Ms E O'Donnell (State Solicitor's Office) appeared on behalf of the South Metropolitan Health Service

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INTRODUCTION

1. Timothy James Chandler (the deceased) died on 25 December 2017 at Fiona Stanley Hospital (FSH) from multiple organ failure and pulmonary thromboemboli complicating generalised sepsis in a man with cellulitis.

2. At the time of his death the deceased was subject to an Inpatient Treatment Order in a general hospital under the *Mental Health Act 2014* (WA) (MHA)[1] and accordingly, immediately before his death, the deceased was an "involuntary patient".[2]

3. Pursuant to the *Coroners Act 1996* (WA), the deceased was therefore a "*person held in care*" and his death was a "*reportable death*". In such circumstances, a coronial inquest is mandatory.[3]

4. Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[4]

5. I held an inquest into the deceased's death on 26 July 2019.

6. The documentary evidence at the inquest included a report of the deceased's death prepared by First Class Constable Allen, who gave evidence at the inquest.[5] The deceased's intensive care consultant, Dr Saw, provided a statement[6] and gave evidence at the inquest. The Brief comprised one volume.

7. The inquest focused on the care provided to the deceased while he was an involuntary patient at FSH and the circumstances of his death.

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[1] s 61, *Mental Health Act 2014* (WA) & Exhibit 1, Vol. 1, Tab 11, Form 6B: Inpatient Treatment Order
[2] s 4, *Mental Health Act 2014* (WA)
[3] s 3 & 22(1)(a), *Coroners Act 1996* (WA)
[4] s 25(3), *Coroners Act 1996* (WA)
[5] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigation Squad
[6] Exhibit 1, Vol. 1, Tab 13, Statement - Dr Saw

THE DECEASED

Background

8. The deceased was born in Cambridge in the United Kingdom on 20 May 1965. He came to Western Australia in 2000 and at the time of his death he was 52 years of age.[7]

9. In 1999, the deceased received a diploma in human services and his hobbies were said to include: playing the guitar, poetry and writing. He lived with a friend for about 24 years and was unemployed at the time of his death.[8]

10. The deceased was described as an intelligent and articulate man who had a strongly held belief system, which was apparently shared by his housemate. One aspect of his belief system was that he did not value the advice or support of medical doctors. He reportedly had not visited a doctor for at least 15 years prior to his death.[9]

11. The deceased said he ate a vegan diet and he denied alcohol and drug use.[10] However, there is evidence that he had used cannabis and smoked cigarettes.[11]

Overview of medical conditions

12. Very little is known about the deceased's medical history. A search by police failed to locate any medical records relating to care provided to him prior to his death.[12]

Assessment by ambulance officers

13. An ambulance arrived at the deceased's home at 6.48 pm on 13 December 2017. The deceased gave a history of his stomach enlarging over several weeks causing mobility issues. He told officers he had been sitting on his couch for 3 weeks only getting up to use the toilet or kitchen.[13]

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[7] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigation Squad, p2
[8] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigation Squad, p2
[9] Exhibit 1, Vol. 1, Tab 2, Report - Coronial Investigation Squad, pp2-3
[10] Deceased's medical notes - Fiona Stanley Hospital
[11] Exhibit 1, Vol. 1, Tab 12, ED Progress notes (14.12.17)
[12] ts 26.07.19 (Allen), pp5-6 and see also: Exhibit 1, Vol. 1, Tab 13, Statement - Dr Saw, para 20
[13] Exhibit 1, Vol. 1, Tab 9, St John Ambulance Patient Care Record, p2

14. The deceased reported a one week history of pain in his legs, feet and groin and that yellow-white fluid had been running down his legs from his groin. He confirmed he had not seen a doctor for "*a decade*".[14]

15. On examination, ambulance officers found the deceased's pulse was raised and that he had pressure sores and "*pus*" on his heels, feet and legs. The deceased's care was then handed over to another crew who helped him onto a stretcher and gave him pain relief. The deceased was eventually taken to FSH by ambulance, arriving at about 8.41 pm.[15]

Assessment in the emergency department at FSH

16. The deceased was reviewed in the emergency department at FSH. He complained of increasing weight and decreasing mobility over the past seven months and a 3 week history of testicular pain. His testicles and penis were found to be swollen and reddened with the skin ulcerated and he was initially thought to have Fournier's gangrene of the scrotum, penis and legs. This is a serious condition that requires antibiotic treatment and surgery.[16,17,18]

17. The deceased was assessed as clinically very unwell and he was refusing medical treatment including CT scans and possible surgery. After review by the emergency department consultant, it was decided to have the deceased assessed by a psychiatrist to determine if he had the capacity to make treatment decisions.[19]

Inpatient Treatment Order

18. At 3.40 am on 14 December 2017, a registrar assessed the deceased and completed a Form 1A under section 26 of the MHA, requiring the deceased to submit to an examination by a psychiatrist. The reason for the referral was that the deceased's refusal to accept treatment for his acute medical condition was placing his life at risk.[20]

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[14] Exhibit 1, Vol. 1, Tab 11(Tab 9), St John Ambulance Patient Care Record, p2
[15] Exhibit 1, Vol. 1, Tab 11(Tab 9), St John Ambulance Patient Care Record, pp1-3
[16] Exhibit 1, Vol. 1, Tab 12, FSH medical notes (13-14.12.17)
[17] Exhibit 1, Vol. 1, Tab 14, Statement – Dr Kandanarachichi, paras 9-10
[18] ts 26.07.19 (Saw), p7 & p14
[19] Exhibit 1, Vol. 1, Tab 12, FSH medical notes (13-14.12.17)
[20] Exhibit 1, Vol. 1, Tab 10, Form 1A - Referral for examination by psychiatrist (14.12.17)

19. In accordance with the Form 1A, the deceased was examined by the on-call psychiatrist at FSH at 4.35 am on 14 December 2017. The psychiatrist noted it was unusual to be called in for a capacity assessment in the early hours of the morning.[21] The fact that this occurred was a reflection of the concerns of medical staff that without treatment, the deceased would die.[22]

20. The on-call psychiatrist spoke to the deceased and at times, his housemate. He found that the deceased had an intricate belief system his housemate shared. The deceased said he didn't like the name Timothy and that the "*creator*" had told him he could call himself "*Coo-Cha*". He said his belief system had come to him from people in the United States who contacted him via the internet to tell him he was their stolen son.[23]

21. The deceased said he'd been told to do a ceremony otherwise the spirits would attack him and if someone took his blood, he had to do the appropriate song and dance or he would suffer pain and compromise his moral compass. The deceased said he could pick up other people's thoughts and that the creator spoke to him. He also said people had unique colours and took on colours from their food.[24]

22. Initially, it was unclear whether the deceased's capacity was affected by delirium.[25] After a detailed examination, the on-call psychiatrist concluded that the deceased was suffering from a psychotic illness, likely to be a delusional disorder or perhaps schizophrenia.[26]

23. On the basis that the deceased presented as "*floridly, acutely psychotic*" and that his belief systems were "*interfering with his decision-making*", the on-call psychiatrist formed the view that the deceased needed to be made the subject of an Inpatient Treatment Order.[27] The order was signed at 6.40 am on 14 December 2017.[28]

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[21] Exhibit 1, Vol. 1, Tab 15, Statement – Dr Beer, paras 13, 17 & 23
[22] Exhibit 1, Vol. 1, Tab 15, Statement – Dr Beer, paras 13, 17 & 23
[23] Exhibit 1, Vol. 1, Tab 15, Statement – Dr Beer, paras 36-40 & 44
[24] Exhibit 1, Vol. 1, Tab 15, Statement – Dr Beer, paras 41-42
[25] Exhibit 1, Vol. 1, Tab 15, Statement – Dr Beer, paras 22 & 43
[26] Exhibit 1, Vol. 1, Tab 15, Statement – Dr Beer, paras 22 & 43
[27] Exhibit 1, Vol. 1, Tab 15, Statement – Dr Beer, paras 46 & 50
[28] Exhibit 1, Vol. 1, Tab 11, Inpatient Treatment Order in general hospital (14.12.17)

DECEASED'S TREATMENT 14-25 DECEMBER 2017

Admission to the acute medical unit

24. The deceased was transferred to the acute medical unit (AMU) at FSH on 14 December 2017. When reviewed by the consultant physician on 15 December 2017, the deceased was noted to have heart failure. After review by the cardiology team it was thought this was related to fluid overload, rather than a heart attack.[29] Subsequently, a cardiologist confirmed the view of the deceased's intensive care consultant that the deceased had long standing right sided heart damage secondary to sleep apnoea.[30]

25. The deceased's scrotal swelling was diagnosed as cellulitis and treated with antibiotics and he was given medication to reduce his fluid overload and to guard against pulmonary embolism (blood clots in the lungs). On 16 December 2017, the deceased appeared to be improving and there was no evidence of pulmonary embolism.[31]

26. The AMU provides more intensive care than a general medical ward and 50% of patients are transferred out of the AMU within 48 hours. This had been the plan for the deceased, had his condition continued to improve.[32]

27. On 17 December 2017, the deceased's condition suddenly deteriorated and his blood pressure became dangerously low. A medical emergency team call was made and he was transferred to the intensive care unit at FSH (ICU).[33]

Admission to the intensive care unit

28. On his admission to the ICU, the deceased's main medical issue continued to be his cardiac function. The deceased's fluid overload, caused by his cardiac condition, also resulted in his kidney function deteriorating.[34]

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[29] Exhibit 1, Vol. 1, Tab 14, Statement - Dr Kandanarachichi, paras 16-18
[30] ts 26.07.19, (Saw), p9
[31] Exhibit 1, Vol. 1, Tab 14, Statement - Dr Kandanarachichi, paras 18-22
[32] Exhibit 1, Vol. 1, Tab 14, Statement - Dr Kandanarachichi, paras 24-26
[33] Exhibit 1, Vol. 1, Tab 14, Statement - Dr Kandanarachichi, paras 27-28
[34] Exhibit 1, Vol. 1, Tab 13, Statement - Dr Saw, paras 16-17

29. A cardiology review confirmed that the deceased's right heart failure was primarily due to sleep apnoea but was also exacerbated by sepsis and by pulmonary emboli, which by that stage had been detected. By 18 December 2017, the deceased was assessed as critically unwell and his prognosis was "*guarded*" meaning that there was a likelihood that he would die.[35,36]

30. The deceased received a range of treatments including medication to support his blood pressure and to improve his heart function, nebulisers to reduce pressure on the right side of his heart and medication to improve his heart rhythm. The deceased also received dialysis for acute kidney failure and he was on blood thinners, antibiotics and medication to remove fluid from his system. The deceased also required non-invasive support to help his breathing.[37,38]

31. Whilst he was in the ICU, the deceased was reviewed by the cardiology, urology, plastic surgery and psychiatric teams. Although when he was first admitted to FSH, surgery was a possible option, given his condition in ICU, surgery would have been very risky and indeed Dr Saw said that subjecting the deceased to a general anaesthetic would have been "heroic".[39,40]

32. Initially there was some improvement in the deceased's condition, but his condition remained critical and he required extensive medical support. At about 3.30 am on 25 December 2017, his blood pressure suddenly dropped and despite treatment, it dropped again at 4.30 am. The deceased then suffered a cardiac arrest and went into "*pulseless electrical activity*", and despite attempts to resuscitate him, he could not be revived.[41,42]

33. The deceased was declared dead at 5.05 am on 25 December 2017.[43]

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[35] Exhibit 1, Vol. 1, Tab 13, Statement - Dr Saw, paras 19 & 22
[36] ts 26.07.19, (Saw), p10
[37] Exhibit 1, Vol. 1, Tab 13, Statement - Dr Saw, paras 23-24
[38] ts 26.07.19, (Saw), p10
[39] Exhibit 1, Vol. 1, Tab 13, Statement - Dr Saw, para 25
[40] ts 26.07.19, (Saw), p10 & p14
[41] Exhibit 1, Vol. 1, Tab 13, Statement - Dr Saw, paras 26-32
[42] ts 26.07.19, (Saw), p 11
[43] Exhibit 1, Vol. 1, Tab 3, Death in Hospital form

CAUSE AND MANNER OF DEATH

34. The deceased's next of kin objected to an internal post mortem examination and so a Forensic Pathologist (Dr White) reviewed the deceased's hospital notes and conducted an external examination on date 27 December 2017.[44]

35. The examination found the deceased had considerable peripheral oedema (swelling) and ulcerative cellulitis of his abdominal apron, groin, genitalia, lower legs and ankles.[45]

36. The forensic pathologist noted that hospital investigations showed decompensated biventricular heart failure with gross oedema and shock, multiple bilateral segmental pulmonary thromboemboli (blood clots in the lungs), severe scrotal and lower limb cellulitis and anuric kidney failure. The deceased was morbidly obese and his weight was recorded as 159 kilograms.[46]

37. Toxicological analysis found a number of medications in the deceased's system which were consistent with his hospital medical care. Alcohol and common drugs were not detected.[47]

38. Dr White expressed the opinion that the cause of death was multiple organ failure and pulmonary thromboemboli complicating generalised sepsis in a man with cellulitis.[48]

39. I accept and adopt that conclusion.

40. I find that the deceased's death occurred by way of natural causes.

[44] Exhibit 1, Vol. 1, Tab 6, Post Mortem Report
[45] Exhibit 1, Vol. 1, Tab 6, Post Mortem Report
[46] Exhibit 1, Vol. 1, Tab 6, Post Mortem Report
[47] Exhibit 1, Vol. 1, Tab 7, Toxicology Report
[48] Exhibit 1, Vol. 1, Tab 6, Post Mortem Report

QUALITY OF SUPERVISION, TREATMENT AND CARE

41. As a result of the deceased's intricate belief system, he had not been seen by a doctor for many years. The deceased's refusal to actively engage with medical services, as a result of his deeply held belief system, made it impossible for him to be provided with a consistent and high quality level of medical care.

42. When the deceased presented to FSH on 13 December 2017, he had multiple complex medical conditions that required urgent attention. He was very unwell and had severe heart failure, cellulitis and sepsis.

43. The deceased was assessed by a psychiatrist and found to lack the capacity to make treatment decisions because of a psychotic condition. He was placed on an Inpatient Treatment Order under the MHA. In my view, the deceased's placement on the treatment order was both timely and appropriate. Medical staff had grave concerns that without treatment the deceased would die.

44. Every effort was made by the deceased's treating doctors, nurses and allied health professionals to treat his numerous serious medical issues. He was appropriately referred to medical specialists, including general medicine, urology, cardiology, plastic surgery and psychiatry, in a timely manner.

45. Despite a number of aggressive interventions and treatments, the deceased's condition continued to deteriorate and he ultimately succumbed to his co-morbidities.

46. Having regard to all of the evidence before me, I am satisfied that the supervision, treatment and care provided to the deceased while he was an involuntary patient at FSH was both reasonable and appropriate.

M A G Jenkin
Coroner
02 August 2019