Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 36/19

I, Barry Paul King, Deputy State Coroner, having investigated the death of ***James Ronald Chi*** *with an inquest held at the* ***Broome Courthouse*** *on* ***2 July 2019 and 3 July 2019****, find that the identity of the deceased person was* ***James Ronald Chi*** *and that death occurred on* ***26 June 2017*** *at* ***Broome Hospital*** *from* ***chronic obstructive pulmonary disease and coronary artery atherosclerosis*** *in the following circumstances:*

Counsel Appearing:

Sgt L Housiaux assisted the Coroner

Mr N S Barron (Aboriginal Legal Service) appeared for the deceased's family

Ms N Eagling (State Solicitor's Office) appeared for the WA Country Health Service

Table of Contents

INTRODUCTION 2
THE DECEASED 3
DECEASED MEDICAL HISTORY 4
THE DECEASED'S MENTAL HEALTH 6
EVENTS LEADING UP TO DEATH 7
CAUSE OF DEATH 9
HOW DEATH OCCURRED 10
COMMENTS ON SUPERVISION, TREATMENT AND CARE 10
SUBMISSIONS 14
RECOMMENDATION 17
CONCLUSION 17

INTRODUCTION

1. On 26 June 2017, James Ronald Chi (the deceased) died in the emergency department at Broome Hospital from chronic obstructive pulmonary disease and coronary artery atherosclerosis. He was 69 years old.

2. Because the deceased was an involuntary patient under the *Mental Health Act 2014*, an inquest into his death was required under the *Coroners Act 1996,* and a coroner was obliged to comment on the quality of his supervision, treatment and care while he was an involuntary patient.[1]

3. On 2 July 2019 and 3 July 2019, I held an inquest at the Broome Courthouse. The evidence adduced at the inquest established that the care provided to the deceased while an involuntary patient was generally of a high standard.

4. The documentary evidence comprised a brief of evidence[2] which included a report by Constable Alex Cordiner of the Western Australia Police, together with statements, reports and medical records.[3] Following the inquest, I received (via Ms Eagling) an email chain from Dr Sue Phillips, the Acting Regional Medical Director of WA Country Health Service – Kimberley, in which she addressed two issues that arose in the inquest.[4]

5. Oral evidence was provided by (in order of appearance):

   a. Constable Cordiner;[5]

[1] ss3, 22(1)(a) and 25(3) *Coroners Act 1996*
[2] Exhibit 1
[3] Exhibit 1, Tab 2
[4] Exhibit 2
[5] ts 5 – 12 per Stewart, D A

b. Dr Huu Duy Tran, a regional psychiatrist in the Kimberley who had treated the deceased ;[6]

c. Dr Gemma Johnston, a junior doctor who had provided care to the deceased at Mabu Liyan;[7]

d. Josephine Gray, the Aboriginal Co-ordinator for mental health workers at Mabu Liyan from 2013 to 2017;[8]

e. Dr Luke Edwards, a locum doctor in the emergency department of Broome Hospital in June 2017;[9] and

f. Dr Jodi Eatt, a psychiatric registrar at Mabu Liyan in 2017.[10]

6. Following the evidence, Sergeant Housiaux, Mr Barron and Ms Eagling made helpful oral submissions.

THE DECEASED

7. The deceased was born in Broome on 1 March 1948, so he was 69 years old when he died. His mother was Bardi and Scottish, and his father was of Chinese and Japanese heritage.

8. The deceased was raised in Broome and was educated in Catholic schools before going to university in Perth to study engineering. He abandoned his studies to return to Broome, where he became involved in the growing music scene. In 1981, he and several other musicians

[6] ts 8 – 21 per Tran, H D
[7] ts 21 – 31 per Johnston, G M
[8] ts 32 – 45 per Gray, J
[9] ts 48 – 49 per Edwards, L J
[10] ts 50 – 58 per Eatt, J S

from Broome formed a band, Kuckles, while studying at the Centre for Aboriginal Studies in Music in Adelaide.[11]

9. The deceased became one of Australia's most celebrated playwrights with his musicals Bran Nue Day and Corrugation Road; the former being written in collaboration with Kuckles, as well as Scrap Metal, The Pigram Brothers and friends. He was presented with the Red Ochre Award at a ceremony in Broome in 1997, and in 2004 he was declared a State Living Treasure as a creator of landmark Indigenous theatre and as an ambassador for the cultural diversity and energy of Broome.[12]

10. The deceased had much support from his long-term partner, Glenice Allan, with whom he had two children.

DECEASED MEDICAL HISTORY

11. The deceased was a lifetime cigarette smoker. He developed chronic obstructive pulmonary disease (COPD) with emphysema but, despite receiving repeated advice to quit, was still unwilling to stop smoking. He was not otherwise known to misuse drugs.[13]

12. The deceased's medical history also included coronary artery disease, type 2 diabetes, renal dysfunction, malnutrition, gastroesophageal reflux disease, and pseudo bowel obstruction from chronic constipation. All of these conditions were treated with medications and diet modification.[14]

[11] https://readingaustralia.com.au/authors/jimmy-chi/
[12] https://readingaustralia.com.au/authors/jimmy-chi/; https://www.abc.net.au/news/2017-06-27/brand-nu-dae-playwright-jimmy-chi dies- age-69/8654418
[13] Exhibit 1, Tab 12
[14] Exhibit 1, Tab 12

13. From about 2013, the deceased developed significantly disabling Parkinsonism, with tremor, bradykinesia and postural instability, in the context of long exposure to first generation antipsychotic depot medications. Treatment was limited by the anticholinergic side-effects of anti-Parkinson's medication. [15] Dr Johnson noted that it was a fine line of balancing his medications and his side effects.[16]

14. In the deceased's last admission commencing in late 2014, the features of Parkinsonism appeared to increase. This dramatically affected his eating and drinking, as well as his ability to play guitar. He began to shuffle when walking, with a flexed-forward, stooped posture which rendered him a high falls risk. He was provided with a walking frame for mobility.[17]

15. The deceased also had a significant weight loss during the first part of that admission. He lost about 12 kilograms over about a year and a half, but then put weight back on from about mid-2016.[18] In the last two months of his life, his weight again dropped due to a loss of appetite associated with his mood disorder.[19]

16. In about early March 2017, the deceased had an infective exacerbation of his COPD with *Pseudomonas aeruginosa*. Following a course of antibiotics, the infection resolved, but he remained increasingly short of breath. He was prescribed a salbutamol nebuliser.[20]

17. On 21 March 2017, after speaking with the deceased and Ms Allan, the deceased's psychiatrist, Dr Coates, made a standing 'not for cardiopulmonary resuscitation'

[15] Exhibit 1, Tabs 12 and 30
[16] ts 24 per Johnson, G M
[17] Exhibit 1, Tab 15
[18] Exhibit 1, Tab 15
[19] Exhibit 1, Tab 12
[20] Exhibit 1, Tab 15

order under which the deceased would receive medical management for reversible issues but would not be intubated, receive CPR or be medically transferred out of the Kimberley.[21]

THE DECEASED'S MENTAL HEALTH

18. In 1969, the deceased was involved in a serious motor vehicle accident which rendered him unconscious for three weeks and left him with a brain injury and a personality change, presumably from frontal lobe deficits.[22]

19. In the 1970's, the deceased was diagnosed with treatment resistant bipolar affective disorder.[23] Childhood trauma may have contributed to his mental illness.[24]

20. The deceased's mental illness became increasingly difficult to manage despite the use of medications. His bipolar cycles became more frequent and extreme.[25]

21. In the last 12 years of his life, the deceased had 23 admissions to hospital for bipolar disorder, predominantly for manic relapses. Depressive relapses were managed in the community, where Ms Allan cared for him with the help of other family members who provided respite care. He was not able to function independently and would not comply with his medication, including the medication for his numerous medical conditions.[26]

[21] Exhibit 1, Tab 14
[22] Exhibit 1, Tab 12
[23] Exhibit 1, Tab 12
[24] Exhibit 1, Tab 9
[25] Exhibit 1, Tab 9
[26] Exhibit 1, Tab 9

22. As noted, the deceased's last admission to Mabu Liyan commenced in late 2014. He was assessed as requiring high level residential aged care and, in early 2015, had a successful four weeks of respite care in an aged-care facility in Broome, Germanus Kent House. However, an attempted discharge to an open section of that facility in June 2015 was unsuccessful because he left it after one night and refused further medication despite assertive follow-up in the community. He was then re-admitted to Mabu Liyan with exacerbation of chronic mania and psychosis, with rapid cycling.[27]

23. Apart from a brief period where the deceased was admitted to the general ward in Broome Hospital for general medical and surgical issues, he remained in Mabu Liyan until his death. Long term aged-care was required, so a further trial at Germanus Kent House was planned for 12 July 2017, but the deceased's acceptance of that plan vacillated as he would sometimes express his preference to live at Mabu Liyan.[28]

24. The deceased was granted supervised leave from Mabu Liyan. He was not allowed to leave without supervision because of the risks due to physical frailty and his poor insight and judgement.

25. The last order for continuation of the deceased's status as an involuntary patient under an inpatient treatment order was made on 19 June 2017.

EVENTS LEADING UP TO DEATH

26. In the week or so before his death, the deceased appeared to be in high spirits. Psychiatrists Dr Frukacz

[27] Exhibit 1, Tab 30
[28] Exhibit 1, Tabs 12 and 38

and Dr Eatt reviewed him on 21 June 2017, at which time he reported that he was feeling physically stronger, with an improved mood. They thought that a recent depressive episode was resolving and that he had become euthymic.[29]

27. On 22 and 23 June 2017, the deceased's mood was polite and pleasant. He was compliant with his medication, and his mood was mildly elevated. He was singing in his room and was laughing while engaging with staff.[30]

28. On 24 June 2017 the deceased's mood elevated further. His singing increased in volume and he was dancing. He was laughing hysterically at times and playing loud music. That night, he slept intermittently and regularly yelled out before settling after midnight. The next day, he remained elevated and was bright, reactive and compliant with his medication. Observations of his vital signs were all within his normal range.[31]

29. On the morning of 26 June 2017, the deceased was more reactive and elevated, but was still pleasant and polite. At 1.35 pm, Dr Frukacz and Dr Eatt reviewed him and noted that he had been singing loudly and was disinhibited. He reported feeling fatigued and he denied elevation. He was tangential in thought, with religious and cultural themes. They felt that his mood was still going upward.[32]

30. On the afternoon of 26 June 2017, the deceased became breathless after an outburst in which he was yelling.

[29] Exhibit 1, Tab 18
[30] Exhibit 1, Tab 18
[31] Exhibit 1, Tab 18
[32] Exhibit 1, Tab 18

Nursing staff administered salbutamol and at about 4.30 pm activated a medical emergency team call.[33]

31. Dr Eatt, who was nearby, quickly attended the deceased's room in response to the call. She became concerned that the deceased was in peri-arrest. He was unresponsive, he had increasing difficulty in breathing, and his oxygen saturation was low, so she arranged for him to be moved on his bed to aid his respiration, and she prepared for intravenous access while oxygen was delivered.[34]

32. The emergency medical team, which included Dr Edwards, arrived and transferred the deceased to the resuscitation bay in the emergency department at about 5.00 pm. By that time, the deceased had agonal breathing and worsening bradycardia. Due to the 'not for resuscitation' order, the medical team took no further steps to resuscitate him. Within minutes, he had no breath sounds, heart sounds or pulse, and his pupils were fixed and dilated. Dr Edwards certified his death at 5.03 pm.[35]

CAUSE OF DEATH

33. On 6 July 2017, forensic pathologist Dr D M Moss performed a post mortem examination of the deceased and found severe chronic lung disease (emphysema/chronic obstructive pulmonary disease) as well as moderate to severe hardening and narrowing of the blood vessels over the surface of the heart (coronary artery atherosclerosis). The kidneys showed severe scarring.[36]

[33] Exhibit 1, Tab 19
[34] Exhibit 1, Tabs 18 and 38
[35] Exhibit 1, Tab 19
[36] Exhibit 1, Tab 7

34. Toxicological analysis showed clozapine and valproic acid at therapeutic levels. Olanzapine was also detected.[37]

35. Dr Moss formed the opinion, which I adopt as my finding, that the cause of death was severe chronic obstructive pulmonary disease and coronary artery atherosclerosis.[38]

HOW DEATH OCCURRED

36. I am satisfied that the deceased smoked tobacco for several decades, leading to chronic obstructive pulmonary disease which, in combination with coronary artery atherosclerosis, caused his death.

37. I find that death occurred by way of natural causes.

COMMENTS ON SUPERVISION, TREATMENT AND CARE

38. As noted, the deceased spent several years in Mabu Liyan and was also admitted occasionally to Broome Hospital's general medical ward.

39. Dr Tran said that the biomedical care and the conventional psychiatric care provided to the deceased did not deviate from usual practice and was of a very good standard. Some aspects of his care, such as access to timely tertiary care like further investigation and specialist consultations, could have been improved, but these issues were due to Broome's remote location.[39]

[37] Exhibit 1, Tab 8
[38] Exhibit 1, Tab 7
[39] Exhibit 1, Tab 36

40. Dr Tran went on to say that the deceased's social and emotional wellbeing, which had a considerable bearing on his mental state and quality of life, were not optimal, particularly towards the end of his life. Dr Tran said that this was related to long-term residence in an involuntary institutional setting instead of an appropriately configured and resourced facility providing supported accommodation.[40]

41. In Dr Tran's view, Mabu Liyan was not appropriate as supported accommodation for Aboriginal people with mental health problems because it is part of the conventional health institution instead of being a purpose-built facility that could be culturally safe and accessible for patients like the deceased.

42. In addition, Dr Tran considered that because Mabu Liyan is an institution and the deceased was necessarily admitted and treated as an involuntary patient, the way in which he interacted with the system and the way in which staff were able to care for him had a bearing on his mental health.

43. On 3 July 2019 the Court was provided with a viewing of Mabu Liyan. While it is clearly in a hospital setting and is limited in size and access to the natural world outdoors, there are a number of initiatives such as Aboriginal artwork to assist to make Aboriginal patients feel more at home. I note, too, Ms Gray's evidence that 'Well, before Mabu Liyan, we had nothing.'[41]

44. There was evidence that Mabu Liyan had separate funding from the Broome Hospital's general medical wards, which led to delays or lack of services. In particular, it was suggested that the deceased had

[40] Exhibit 1, Tab 36
[41] ts 41 per Gray, J

difficulty accessing physiotherapy[42] and was not provided with a shower chair from the hospital, though one was loaned.[43]

45. In her email of 10 July 2019, Dr Phillips agreed that Mabu Liyan equipment and resources are funded by a different directorate from the one funding the general ward's equipment and resources, but it was a surprise to the hospital's executive to hear of evidence about difficulty in obtaining a chair for the deceased.[44]

46. As to physiotherapy, Dr Phillips stated that Broome Hospital Allied Health are not funded to provide in-patient services to Mabu Liyan, but all members of the Broome community, including patients at Mabu Liyan, are eligible to receive physiotherapy from the Broome Hospital Physiotherapy Department by referral as outpatients. She said that the deceased was referred in March 2017 and was seen again in May 2017, after which further treatment was not required. On that basis, she contended that the issues raised at the inquest did not exist previously and do not exist now.

47. Both Dr Tran and Dr Eatt made the point that there was no supported accommodation in the Kimberley region for people such as the deceased who suffered mental illness. There were facilities in the Perth region which could have provided for the deceased's physical health and mental health needs, but his spiritual and cultural needs could not be met. In particular, being in Broome was a priority for him.

48. Dr Tran and Dr Eatt also considered that the facilities available in Perth may have struggled to manage the deceased's physical needs.

---

[42] Exhibit 1, Tab 38; Exhibit 2
[43] ts 57 per Eatt, J S
[44] Exhibit 2

49. Despite Dr Tran's view about the lack of appropriate supported accommodation for the deceased in the Kimberley, he, Dr Eatt and Ms Gray each expressed the view that the deceased was in the best place available for him at the time. The staff at Mabu Liyan were very accommodating to the deceased's needs and wishes. There were Aboriginal staff members across various disciplines, including mental health workers, integrated into the unit – the only mental health unit in Western Australia where that occurs. They would regularly take the deceased on escorted outings.[45]

50. Ms Gray said that the deceased was viewed as a treasured elder who was well-respected by the Aboriginal workforce at Mabu Liyan. His frailties meant that he could not participate in all of the programs offered there, but he was included as much as possible. She said that she felt that the team 'went above and beyond to care for the Mr Chi on a one-to-one basis'[46] and provided him with 'the best cultural care for such a special person'.[47]

51. Ms Gray felt that, on a bigger scale, cultural governance of Mabu Liyan was missing. She saw a need for Aboriginal people to be involved in the management and leadership of Mabu Liyan, but she said that positive changes were happening, such as the membership of the Aboriginal Mental Health Co-ordinator in the unit's new leadership group. While these issues are clearly important, in my view they do no bear directly on the standard of care provided to the deceased at Mabu Liyan.

[45] ts 34 – 35 per Gray, J
[46] ts 35 per Gray, J
[47] ts 43 per Gray, J

52. Given the foregoing, I am satisfied that the treatment and care of the deceased while an involuntary patient under the *Mental Health Act 2014* was generally at a very high standard in the circumstances. The personalised care he received as described by Ms Gray was exemplary in my view. To the extent that there were shortcomings, they did not appear to be significant overall. Certainly, there is no suggestion in the evidence that the deceased would have received better treatment or care elsewhere.

SUBMISSIONS

53. Sergeant Housiaux submitted that the now current Royal Commission into Aged Care Quality and Safety had held hearings in Broome in June 2019 and that the findings of that commission may affect any recommendations I may wish to make in relation to the care provided to the deceased, particularly relating to the lack of suitable supported accommodation for patients in circumstances to those of the deceased.[48]

54. In my view, there is no good reason why I should not proceed to comply with my duty under the *Coroners Act 1996* to make findings and to comment on the quality of the supervision, treatment and care provided to the deceased.

55. I also do not consider that I should delay exercising my discretion to make comments or recommendations in order to await the report of the Royal Commission into Aged Care Quality and Safety. That is especially so because I strongly doubt that my one recommendation below will be inconsistent with any to come from the Royal Commission.

[48] ts 59 per Housiaux, L

56. Mr Barron said that the deceased's family were grateful to Mabu Liyan staff and accepted that what was offered to the deceased was the best that could be done in the circumstances, but that they had concerns about two issues that were within the scope of the inquest.[49]

57. The first issue was the difficulty in accessing services that were otherwise available at Broome Hospital, such as physiotherapy. Mr Barron indicated that the family would support a recommendation to remove barriers in order to ensure that the full suite of services at the hospital could be provided to patients at Mabu Liyan.[50]

58. In my view, the evidence provided by Dr Phillips, though untested, provides some assurance that, if there were barriers to the provision of services to Mabu Liyan, the hospital executive is now aware of the issue and could reasonably be expected to deal with them if they arise again. In these circumstances, I make no recommendation in relation to this issue.

59. The second issue raised by Mr Barron was the lack of long-term supported accommodation for mental health patients in the Kimberley. He submitted that the family would support a recommendation that would call for such accommodation to be developed in the region in consultation with the community and, in particular, the Aboriginal community.[51]

60. In relation to Mr Barron's submission, Ms Eagling acknowledged that the evidence was consistent in identifying a need for such a facility, but she noted that in the deceased's case, his frailties were such that the types of facilities discussed may not have been suitable.

[49] ts 60 per Barron, N S
[50] ts 61 per Barron, N S
[51] ts 61 per Barron, N S

In addition, she noted the evidence that Mabu Liyan was the best place available to him in Broome.[52]

61. In my view, the evidence establishing the desirability of supported accommodation was doubtlessly consistent, and I have no difficulty accepting that it was reliable; however, it was necessarily one-sided. That is, the evidence identified a reasonable need, but it did not address the questions of feasibility or the potentially greater desirability of similar facilities in other parts of WA.

62. I note in particular the State Coroner's reference to a submission that had been made to her in the Inquest into the Deaths of Thirteen Young People and Children in the Kimberley Region:

> The Department of Premier and Cabinet also submit that Government cannot provide a whole range of services to every community in regional and remote Western Australia. It is necessary for Government to concentrate its finite resources to achieve greatest benefit and is consequently unable to provide the same level of services and infrastructure where populations are small and highly dispersed.[53]

63. In other words, I have qualms about making definitive recommendations when the implementation of them would be almost entirely dependent on an allocation of government funding.

64. That said, given the clear evidence of the desirability of supported accommodation in the Kimberley, I make the following recommendation:

---

[52] ts 62 – 63 per Eagling, N

[53] https://www.coronerscourt.wa.gov.au/I/inquest_into_the_13_deaths_of_children_and_young_persons_in_the_kimberley_region.aspx paragraph 1225

RECOMMENDATION

That relevant government agencies consider the desirability and feasibility of establishing a facility providing long-term supported accommodation for mental health patients in the Kimberley region.

CONCLUSION

65. The deceased was a celebrated artist and a respected member of the Broome community who died from a debilitating physical disease after spending years in Mabu Liyan with increasingly severe mental illness.

66. The treatment and care which the deceased received was of a high standard in the circumstances, not least because of the cultural input relating to his care and the dedication and the commitment of those who looked after him.

67. However, the inquest into his death provided a reminder, if one is needed, that there is a need for increased availability of mental health facilities across Western Australia. I add my voice to those advocating the provision of such facilities as soon as is reasonably practicable.

B P King
Deputy State Coroner
30 August 2019