Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 12/ 19

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Lorna May WOODS*** *with an inquest held at* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth****, on* ***6 March 2019*** *find that the identity of the deceased person was* ***Lorna May WOODS*** *and that death occurred on* ***10 January 2017*** *at* ***Joondalup Health Campus****, from* ***pulmonary thromboembolism due to deep vein thrombosis and sepsis due to pyelonephritis on a background of metastatic ovarian cancer*** *in the following circumstances:-*

Counsel Appearing:

Mr D Jones assisted the Coroner

Mr Mark Williams (MinterEllison) appeared on behalf of Joondalup Health Campus, Dr P Grolman and Dr C Singam

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INTRODUCTION

1. Lorna May Woods (the deceased) died on 10 January 2017 at Joondalup Health Campus (JHC) as a result of pulmonary thromboembolism due to deep vein thrombosis and sepsis due to pyelonephritis on a background of metastatic ovarian cancer.

2. At the time of her 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 her 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 her 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 6 March 2019.

6. The documentary evidence at the inquest included a report of the deceased's death prepared by the Western Australia Police.[5] Two of the deceased's treating doctors, namely Dr Grolman and Dr Singam, provided written reports[6] and were called as witnesses at the inquest. The Brief comprised one volume.

7. The inquest focused on the care provided to the deceased while she was an involuntary patient at JHC and the circumstances of her death.

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[1] s 61, *Mental Health Act 2014* (WA) & Exhibit 1, tab 3, 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, tab 4, Report – Coronial Investigation Squad
[6] Exhibit 1, tab 9, Report – Dr Grolman & Exhibit 1, tab 10, Report – Dr Singam

THE DECEASED

Background

8. The deceased was born in Subiaco on 31 October 1977 and at the time of her death she was 39 years of age.[7]

9. The evidence of the deceased's early life is somewhat contradictory. According to one account, she was looked after by her grandmother because after the deceased was born, her mother was unable to care for her. On this version of events, after the deceased's grandmother died, the deceased went to stay with her aunt and uncle in York.[8]

10. The deceased is said to have attended York Primary School and was described as intelligent, a good student and athletically gifted. She reportedly fell off her bicycle when she was 9 years of age and was unconscious for nearly a day. Despite the fact that she suffered blurred vision for several months afterwards, no medical attention was apparently sought.[9]

11. The deceased did not complete Year 8 and reportedly drifted to Perth where she began sniffing paint and abusing alcohol and cannabis.[10]

12. According to another account, the deceased had an unhappy childhood, went to multiple schools and had four sets of foster parents. She was allegedly sexually active from 8 years of age and started drinking alcohol at 13 years of age. She began sniffing glue, taking heroin and using cannabis at 15 years of age.[11]

13. On either version, it is clear that the deceased's teenage years were characterised by polysubstance abuse.

14. The evidence establishes that the deceased's longstanding next-of-kin, her cousin Ms Sharon Woods, was very supportive and did everything she could to assist the deceased. It appears that the deceased would often disappear for lengthy periods of time without saying where she was going.

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[7] Exhibit 1, tab 4, Report – Coronial Investigation Squad
[8] Exhibit 1, tab 12, Report – AMHS & exhibit 1, tab 5, File Note – Snr. Cst. Tomney
[9] Exhibit 1, tab 12, Report – AMHS
[10] Exhibit 1, tab 12, Report – AMHS
[11] Exhibit 1, tab 14, Report – RPH

Offending history

15. The deceased's criminal history of minor offences is extensive. As a juvenile, she was convicted of 35 offences, almost all of which were either public order or stealing matters. As an adult, she was convicted of 154 offences which were mainly a mix of public order and stealing type offences.[12]

16. On 5 December 2013, the deceased was admitted to the Frankland Centre, Graylands Hospital pursuant to a hospital order issued under the *Criminal Law (Mentally Impaired Accused) Act 1996* (WA). She had been charged with assaulting a public officer, breaching bail and stealing. She was discharged on a community treatment order on 14 March 2014, having spent some 100 days at the Frankland Centre.[13]

Overview of Medical Conditions

17. Royal Perth Hospital (RPH) records show that during the period 15 May 1993 to 2 March 2016, the deceased was seen in the emergency department on 25 occasions. The presenting problems varied but often related to alleged assaults.[14]

18. The deceased was admitted to RPH on 13 – 27 December 1996 for what appears to be her first psychiatric presentation. At that time her differential diagnoses were: organic affective disorder secondary to polysubstance abuse; and underlying bipolar affective disorder. A diagnosis of psychosis was also considered but discounted due to lack of clinical evidence.[15]

19. The deceased was first admitted to Graylands Hospital[16] in 1997 and was diagnosed with disorganised schizophrenia and found to have an IQ of 64, which is generally regarded as a mild intellectual impairment.[17]

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[12] Exhibit 1, tab 15, Deceased's Criminal Record
[13] Exhibit 1, tab 16, Frankland Centre Discharge Summary
[14] Exhibit 1, tab 14, Report – RPH
[15] Exhibit 1, tab 14, Report – RPH
[16] Exhibit 1, tab 16, Frankland Centre Discharge Summary
[17] ts, 28 (Dr Singam)

20. On 5 May 1999, the deceased had a pelvic ultrasound at RPH which was reported as normal.[18]

21. The deceased was admitted to RPH on 24 – 26 August 1999 after staff at the hostel she was staying became concerned for her welfare. The provisional diagnoses listed on her discharge summary were disorganised schizophrenia and borderline IQ. It appears that the deceased was to have been referred to Graylands Hospital as an involuntary patient but she absconded before this could occur.[19]

22. During her admission to the Frankland Centre in 2014, the deceased's schizophrenia and her intellectual disability were noted. She remained psychotic for the first six weeks of her admission. A chronic urinary tract infection was treated with antibiotics and after 8 weeks of treatment, her urine was clear of infection.[20]

23. After her discharge from the Frankland Centre, the deceased's follow-up care was to have been managed by the Eudoria Street Clinic in Gosnells.[21] It is unclear whether this follow up actually occurred.

24. The deceased was referred to the Specialist Aboriginal Mental Health Service (SAMHS) whilst she was still at the Frankland Centre. After her discharge, staff from SAMHS offered the deceased home visits and ongoing support but she declined these offers. She was discharged from SAMHS on 12 June 2014.[22]

25. On 24 April 2015, the deceased was admitted to RPH complaining of back pain. She was diagnosed with a severe infection in her left kidney. After treatment with intravenous antibiotics, the plan was remove the deceased's left kidney. Despite medical advice that failure to remove her infected kidney could lead to sepsis, multi-organ failure and death, the deceased discharged herself on 29 April 2015.[23]

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[18] Exhibit 1, tab 14, Report – RPH
[19] Exhibit 1, tab 14, Report – RPH
[20] Exhibit 1, tab 16, Frankland Centre Discharge Summary
[21] Exhibit 1, tab 16, Frankland Centre Discharge Summary
[22] Exhibit 1, tab 13, Report – SAMHS (Metropolitan)
[23] Exhibit 1, tab 18, RPH Discharge Summary

26. There are numerous other examples of the deceased presenting for medical treatment and not waiting to be seen or discharging herself against medical advice.[24,25]

27. The deceased's next-of-kin, Ms Sharon Woods regularly offered to book medical check-ups for the deceased, but these offers were routinely declined.[26]

28. The picture that emerges is one where the deceased was offered a range of services and treatments but either did not accept these offers or did not take the advice that was offered. As noted during her admission to the Frankland Centre:

> "*Ms Woods has an intellectual impairment with an overall IQ tested this year and this was only 64* (sic). *This contributes to her poor understanding of the need for treatment and follow-up.*"[27]

DECEASED'S ADMISSION 7 - 8 JANUARY 2017[28,29,30]

29. On 7 January 2017, the deceased was staying at her cousin's home in Joondalup. She complained of nausea and stomach pain and at 7.20 pm, a family member called emergency services. The deceased was taken to the emergency department at JHC.[31]

30. On admission, the deceased was febrile with a temperature of 37.8°C. She had low blood pressure and a rapid pulse (tachycardia). The deceased's provisional diagnosis was urosepsis (infection of the urinary tract) and she was found to be anaemic. As a result, she was given a blood transfusion and intravenous antibiotics.

31. The deceased's blood pressure, which had initially stabilised, suddenly dropped at about 10.00 pm and efforts to stabilise it continued during the night.

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[24] Exhibit 1, tab 14, Report – RPH
[25] Exhibit 1, tab 20, Deceased's Medical Notes
[26] Exhibit 1, tab 4, Report – Coronial Investigation Squad
[27] Exhibit 1, tab 16, Frankland Centre Discharge Summary
[28] Exhibit 1, tab 9, Report – Dr Grolman
[29] Exhibit 1, tab 20, Deceased's Medical Notes
[30] ts, 8-17 (Dr Grolman)
[31] Exhibit 1, tab 6, St John Ambulance Patient Care Record

32. The deceased was reviewed by the Hospital's surgical team at 1.00 am on 8 January 2017. An ultrasound of the deceased's abdomen found large solid masses in both ovaries, fluid (ascites) in her abdomen and deposits in her peritoneal cavity that were highly suspicious of metastatic cancer.

33. The ultrasound also found possible metastases in her lungs and identified her shrunken left kidney as a possible source of her sepsis.[32]

34. The surgical team did not consider their input was appropriate at that time and the deceased was referred to the gynaecology team. At 3.00 am, the deceased declined a detailed examination but she was reassessed and examined at 7.25 am. At that time, the deceased appeared to be agitated was assessed as being thought disordered. She was placed on one to one (special) nursing observations and a psychiatric review was requested.

35. The deceased was seen by Dr Walker (psychiatric registrar) at 9.00 am on 8 January 2017. After an assessment which was comprehensively documented in the deceased's notes, Dr Walker expressed his diagnostic impression in the following terms:

> "*relapse of chronic schizophrenia secondary to non-compliance and illicit substance use in the context of metastatic ovarian cancer, sepsis and delirium on background of intellectual impairment*".[33]

36. Although the deceased initially agreed to remain at JHC for treatment, she attempted to leave later in the morning. As a consequence, she was reviewed by Dr Walker at 11.00 am on 8 January 2017. Dr Walker assessed the deceased's mental state and noted her lack of insight. After discussing her case with the on-call psychiatrist, Dr Walker made a referral under the MHA requiring the deceased to be examined by a psychiatrist.[34,35]

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[32] Sepsis is a life-threatening illness that develops when chemicals the immune system releases into the bloodstream to fight an infection cause inflammation throughout the entire body instead.
[33] Exhibit 1, tab 9, Report – Dr Grolman & Exhibit 1, tab 20, Deceased's Medical Notes
[34] Exhibit 1, tab 20, Deceased's Medical Notes
[35] ts, 29-30 (Dr Singam)

37. Meanwhile, the deceased's likely diagnosis of metastatic ovarian cancer was discussed with a gynaecological oncologist at King Edward Memorial Hospital (KEMH). It was felt that the deceased was too unstable for transfer to KEMH and that her prognosis was poor. Nevertheless, a procedure called abdominal paracentesis was suggested in order to obtain a diagnostic tissue sample.

38. A CT scan of the deceased's chest showed blockages of the arteries in both lungs (bilateral pulmonary emboli) and as a result, the deceased was started on a blood thinner (heparin). A CT scan of the deceased's brain was reported as normal.

39. After a review by the intensive care team, the deceased was transferred to JHC's high dependency unit (HDU) at 9.15 pm on 8 January 2017.

PLACING THE DECEASED ON A TREATMENT ORDER[36,37]

40. The deceased was reviewed by Dr Singam at 10.55 am on 9 January 2017 and found to be thought disordered and suffering from a psychotic illness made worse by delirium.

41. Pending approval from the Chief Psychiatrist, Dr Singam made an inpatient treatment order in a general hospital under the MHA[38] on the following grounds:

    i. the deceased's schizophrenia and her serious medical issues needed to be treated and there was a significant risk to her health and safety because of her refusal to accept care;

    ii. as a result of her mental illness, the deceased's decision making capacity was impaired and she did not properly comprehend her circumstances;

    iii. treatment in the community was not an option because the deceased was too unwell physically;

[36] Exhibit 1, tab 10, Report – Dr Singam & Exhibit 1, tab 3, Inpatient Treatment Order
[37] Exhibit 1, tab 20, Deceased's Medical Notes & ts, 31-34 (Dr Singam)
[38] s 61(1)(a), *Mental Health Act 2014* (WA)

iv. the deceased's mental health had not been treated for at least two years and the deceased did not appreciate that she needed treatment; and

v. less restrictive options were not appropriate and the deceased need a general hospital environment to address her physical health.

42. As Dr Singam noted, it would have been appropriate to transfer the deceased to a mental health facility had she not required treatment for her serious medical conditions.

43. As recorded in the notes, the Chief Psychiatrist subsequently approved the inpatient treatment order proposed by Dr Singam.[39]

44. Because the deceased did not have the capacity to make decisions about her medical care, the deceased's cousin, Ms Sharon Woods assumed that role.

45. I am satisfied that the decisions taken pursuant to the MHA, namely to have the deceased examined by a psychiatrist and then to place her on an involuntary inpatient order were appropriate and timely.

DECEASED'S ADMISSION 9 - 10 JANUARY 2017[40]

46. In light of the deceased's condition, a "do not resuscitate" order was made by Dr Samuelraj[41] at 4.30 pm, on 9 January 2017. At 5.00 pm, a doctor from the HDU spoke to Ms Sharon Woods and obtained verbal consent for the paracentesis procedure which had been booked for 11.00 am the next day.

47. At 7.00 pm, the deceased's urine output was still minimal, her blood pressure was low and her peripheral circulation was impaired. These signs pointed to a deterioration in the deceased's condition and concerted efforts were made to address these issues.

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[39] s 61(2)(b), *Mental Health Act 2014* (WA) & ts, 41-42 (Dr Singam)
[40] ts, 18-19 (Dr Grolman)
[41] Exhibit 1, tab 20, Deceased's Medical Notes

48. Over the next few hours, the deceased's condition continued to decline and her lactate levels increased, indicating potentially fatal acidosis. The deceased's liver showed signs of acute injury possibly secondary to ischaemia. The impression was overwhelming sepsis and shock from which the deceased would be unable to recover.[42]

49. The deceased's family were contacted and were at her bedside when her heart stopped beating at 3.25 am. The deceased was declared dead at 3.40 am on 10 January 2017.[43]

CAUSE AND MANNER OF DEATH[44]

50. A forensic pathologist conducted a post mortem of the deceased's body on 12 January 2017 and found blood clots blocking the vessels in both lungs (pulmonary thromboembolism) and in the veins of both legs (deep venous thrombosis).

51. The deceased's left kidney was shrunken and contained a collection of pus (pyelonephritis). There were tumours in both of the deceased's ovaries with apparent spread within the pelvis and abdomen (metastatic ovarian malignancy).

52. On 27 June 2017, the forensic pathologist issued a supplementary report following microscopic examination of tissues. That examination confirmed the earlier post mortem findings. Toxicological analysis found a number of medications in the deceased's system which were consistent with her medical care whilst she was in hospital.[45]

53. After conducting the post mortem the forensic pathologist expressed the opinion that the cause of death was pulmonary thromboembolism due to deep vein thrombosis and sepsis due to pyelonephritis on a background of metastatic ovarian cancer.

54. I accept and adopt that conclusion and I find that the deceased's death occurred by way of natural causes.

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[42] Exhibit 1, tab 9, Report – Dr Grolman & ts, 20-22 (Dr Grolman)
[43] Exhibit 1, tab 9, Report – Dr Grolman & ts, 21-22 (Dr Grolman)
[44] Exhibit 1, tab 7, Post Mortem Report
[45] Exhibit 1, tab 8, Toxicology Report

QUALITY OF SUPERVISION, TREATMENT AND CARE

55. The deceased had a complex medical and mental health history. The evidence establishes that on numerous occasions the deceased did not take up offers of treatment and support.

56. The deceased lacked insight into her health issues and had a limited understanding of the need for treatment and follow-up. As a result, the deceased's mental health issues, particularly her schizophrenia, were not effectively managed. A further consequence was that any chance that the deceased's ovarian cancer might have been detected at an earlier stage was lost.[46]

57. There seems little doubt that the deceased's itinerant lifestyle, her mental health issues and her mild intellectual disability were the main reasons why she did not avail herself of the treatment and support services she was routinely offered.

58. The deceased's inability to actively engage with medical and mental health services made it virtually impossible for her to be provided with a consistent and high quality level of care.

59. When she presented to JHC, the deceased was very unwell. She had multiple medical conditions that required urgent attention, including sepsis and metastatic ovarian cancer.

60. Every effort was made to treat the deceased's numerous presenting issues and she was referred to medical specialists in a timely and appropriate manner.

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

M A G Jenkin
Coroner
12 March 2019

[46] ts, 22-23 (Dr Grolman)