Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 42 /15

I, Sarah Helen Linton, Coroner, having investigated the death of ***Anna Maria CAMERON*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***3 November 2015*** *find that the identity of the deceased person was* ***Anna Maria CAMERON*** *and that death occurred on* ***27 January 2013*** *at* ***Sir Charles Gairdner Hospital*** *as a result of* ***early bronchopneumonia and hypoxic brain injury following aspiration of food (choking)*** *in the following circumstances:*

Counsel Appearing:

Mr T Bishop, assisting the Coroner.
Ms G Bailey, State Solicitor's Office (appearing on behalf of the North Metropolitan Health Service and Mental Health).

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INTRODUCTION

1. Anna Maria Cameron (the deceased) died on 27 January 2013 at Sir Charles Gairdner Hospital (SCGH). At the time of her death, the deceased was subject to an involuntary patient order under the *Mental Health Act 1996* (WA). Accordingly, under the terms of the *Coroners Act 1996* (WA) the deceased was deemed to be a person held in care. In such circumstances, a coronial inquest is mandatory.

2. I held an inquest at the Perth Coroner's Court on 3 November 2015.

3. The documentary evidence comprised a comprehensive report of the death prepared by a police officer from the Western Australia Police.[1] The author of the report was also called as a witness at the inquest. In addition, evidence was heard from the deceased's treating psychiatrist at the time of her death, Dr Alexander (Sandy) Tait.

4. The inquest focused primarily on the treatment and care provided to the deceased while a patient at Graylands Hospital and the events that led to her hospitalisation at SCGH prior to her death.

THE DECEASED

5. The deceased was born on 8 March 1947 in Ankum, Germany to Polish parents. Not long after she was born she moved with her parents to England. She was joined by a younger brother a few years later.[2]

6. The deceased led a full and active life as a child and teenager. She was highly intelligent and performed well at school. She was known as a loyal and trustworthy friend, and she maintained friendships with childhood friends all her life. She also loved animals and had a great respect for all living creatures.[3]

7. After completing her schooling, the deceased went on to study English and Sociology at Sussex University in Brighton. It was during her second year at university that the deceased experienced her first bout of schizophrenia, which continued to affect her to varying degrees throughout the remainder of her adult life.[4]

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[1] Exhibits 1.
[2] Exhibit 1, Tab 9.
[3] Exhibit 1, Tab 9.
[4] Exhibit 1, Tab 9.

8. After completing her university degree, the deceased worked in a number of jobs, including as a tour guide, which satisfied her love of travelling. In 1974, the deceased travelled to Perth, Western Australia, to visit relatives and Perth then became her home. She found work and made friends here.[5]

9. In August 1980, the deceased met her future husband, Ronald Cameron. They married a little over a year later on 17 October 1981. At the time of their wedding, Mr Cameron was not aware that the deceased had any significant psychiatric issues, although he was aware that she had spent time in Graylands Hospital shortly before they met. In the time he had known her prior to their marriage, she had not been taking medication but had coped quite well, other than appearing a little eccentric.[6]

10. After their wedding, they honeymooned in Bali. About a month later, they travelled to Tasmania. It was at that time that the deceased began acting strangely and showed symptoms of her illness. Mr Cameron eventually came to know of the deceased's diagnosis of paranoid schizophrenia and her history of psychosis.[7] He remained a loving and supportive husband and they were still together in a close marital relationship at the time of her death.

11. Over the next thirty years, the deceased regularly sought psychiatric help for her mental illness. For most of that time, she would have periods of being well and happy and was able to spend up to nine months a year living with her husband in the community. At other times, she experienced intrusive thoughts that affected her impulsive behaviour and caused her to engage in risky behaviour on occasion.[8] One concerning theme was an impulse to light fires and burn her house down. Another recurrent thought was to step into moving traffic.

12. At times when the intrusive thoughts became too overwhelming the deceased would require hospitalisation to stabilise her condition, with various medications trialled. Unfortunately, the deceased's illness proved to be treatment-resistant to a significant extent. Her intrusive thoughts were only ameliorated to a limited extent by her medication.[9] In addition, she was often non-compliant with oral medications, which led to her management on antipsychotic depot medication.

[5] Exhibit 1, Tab 9.
[6] Exhibit 1, Tab 8.
[7] Exhibit 1, Tab 8.
[8] Exhibit 1, Tab 13.
[9] Exhibit 1, Tab 13.

13. Over the final few years of her life, the deceased began to be overwhelmed by her symptoms more often, with increasing number and length of in-patient admissions. From about September 2011, the deceased started spending even more time in Graylands Hospital due to increasingly intrusive thoughts.[10] Nevertheless, her husband observed that changes to the deceased's medication led to an improvement in her paranoia and her willingness to accept treatment, which he saw as a very positive step.[11]

LAST ADMISSION TO GRAYLANDS HOSPITAL

14. The deceased's final admission to Graylands Hospital on 29 July 2012 was her 45th admission since 1996. Her admission was precipitated, again, by intrusive thoughts to burn her house down. Her admission was unusual in that, as with her previous admission, she had been compliant with her medication and was not delusional, but was still experiencing intrusive and obsessive thoughts. There was concern that after some years of relative stability the deceased was starting to show evidence of functional decline.[12] Mr Cameron and the deceased's treating doctors agreed that there was a need to look at the deceased's treatment regime afresh.[13]

15. The deceased was initially admitted as a voluntary patient and managed on the open ward. She was restarted on her depot Risperidone medication and oral medications. During her admission, a mood stabiliser was also trialled but it was ceased due to side effects.

16. The deceased was allowed periods of daily leave and weekend leave in the care of her husband over this time. On 18 August 2012, while on daily leave with her husband, she impulsively jumped into Fremantle Harbour.[14] On another occasion on 9 September 2012, she walked out in front of a car and sustained some bruising to her sternum but was otherwise unharmed.[15] Although the deceased acknowledged these acts were intentional, she denied feeling suicidal on these occasions and couldn't explain her actions.[16]

17. In light of her demonstrated impaired judgment, a decision was made on 13 September 2012 to transfer the deceased to a secure

[10] Exhibit 1, Tab 8.
[11] T 21; Exhibit 1, Tabs 9 and 10; Discharge Summary Graylands Hospital 29.07.2012 – 27.01.2013.
[12] Exhibit 1, Tab 13; Discharge Summary Graylands Hospital 29.07.2012 – 27.01.2013.
[13] T 22.
[14] Exhibit 1, Tab 8 and Tab 13
[15] Exhibit 1, Tab 11 and Tab 13.
[16] Exhibit 1, Tab 13.

ward for observation due to the potential she might act on her intrusive thoughts and engage in impulsive behaviour and harm herself.[17] A Form 1 was completed that day and Form 6 'Involuntary Patient Order' was completed the following day. The involuntary patient order was extended on two occasions, permitting her detention as an involuntary patient until 3 June 2013.[18]

18. Attempts were made over this time to reintegrate the deceased into the community and settle her at home, but she continued to display impulsive behaviour, which put herself and others at risk. As standard acute treatment and discharge no longer seemed to be working, the deceased's treating practitioners began to look at the option of prolonged hospital care with the Clinical Rehabilitation Service.[19]

19. Dr Tait explained at the inquest that schizophrenia is a neurodevelopmental disorder and, in some individuals, the symptoms become worse as they get older and are less responsive to treatment. However, with a more structured approach, including psychosocial interventions and access to new antipsychotics, a significant percentage of these individuals can have their symptoms reduced and their quality of life improved. That was the role of the Rehabilitation Team, who would undertake a full psychosocial assessment over several weeks to try and see whether they could make alterations to the treatment regime to address the unmet needs of the individual.[20]

20. The deceased was assessed and fulfilled the criteria for the Rehabilitation Team. On 7 January 2013, the deceased's care was transferred to Dr Tait as head of the Clinical Rehabilitation Service. Arrangements were made to transfer her to the Murchison unit, which is a long stay unit, once a bed became available.[21]

21. The deceased went on weekend leave with her husband on 18 January 2013 and returned to Graylands on 21 January 2013.

22. On her return, she was transferred to the Murchison Unit in an open ward. The plan was for the Rehabilitation Team to undertake more detailed physical and psychological assessments to see if anything else could be done biologically or psychosocially

[17] Exhibit 1, Tab 13.
[18] Exhibit 1, Tab 18.
[19] T 5.
[20] T 7.
[21] Exhibit 1, Tab 13.

for the deceased.[22] Dr Tait was optimistic about what could be done for the deceased by the team as she presented really well, with good social skills and insight into her illness and had good family support.[23] Unfortunately, the events of the following day intervened before the Rehabilitation Team could put any of their plans into effect.

THE CHOKING INCIDENT

23. Mr Cameron spoke to the deceased at about 3.00 pm on 22 January 2013 for approximately half an hour. She seemed upset and agitated during the call. She told her husband she was disappointed she had been moved to a new ward. She mentioned during the call that she thought she would assault someone. [24]

24. At approximately 4.30 pm, about an hour after the call ended, the deceased approached a registered nurse, Nurse Angel Kray, on the Murchison ward and told her that she felt like she wanted to attack someone. Nurse Kray asked the deceased if she wanted some PRN medication, and she agreed. After speaking to the nurse co-ordinator, Nurse Kray gave the deceased 1 mg of Lorazepam, which was on her PRN medication chart.[25]

25. Just after 5.00 pm, the deceased was eating a sandwich for her early evening meal when she choked. Nurse Kray saw the deceased walking over and asked if she was okay. She then saw that the deceased's cheeks were puffed out and bloated and her lips were tinged blue. The deceased sat on the sofa as Nurse Kray called out to the nurse co-ordinator that she thought the deceased was choking. He approached and hit the deceased on the back to try to dislodge the food while Nurse Kray called a code blue emergency.[26]

26. The on-call medical officer, Dr Rosell, was on the ward at the time and he arrived within one minute.[27] The deceased presented with a complete blockage of her airways and appeared unable to open her mouth or follow instructions to spit out the ingested food. The medical staff applied a physical manoeuvre to dislodge the obstruction but this was not successful. At this time, the deceased lost consciousness and Dr Rosell was able to gain access to the deceased's mouth and throat and clear some of

[22] T 5.
[23] T 7.
[24] Exhibit 1, Tab 8.
[25] Exhibit 1, Tab 16.
[26] Exhibit 1, Tab 16.
[27] Exhibit 1, Tab 13.

the food from her throat with his finger. Dr Rosell then administered mouth to mouth resuscitation to improve the deceased's colour and force oxygen into her system. An airway device was then inserted.[28]

27. Despite these steps, the deceased was asystole (no cardiac electrical activity) and not breathing so full cardio pulmonary resuscitation was commenced by medical staff. When ambulance officers arrived, they cleared the deceased's airway of all food particles using forceps and administered adrenalin and cardioversion shocks. After the second shock was administered at 5.43 pm, the deceased re-established a strong heart rhythm and her colour returned. Once her pulse and respiratory rate were stable, the deceased was taken by ambulance to SCGH.[29]

ADMISSION TO SCGH

28. The deceased arrived at the Emergency Department at SCGH at 5.59 pm. On arrival, her Glasgow coma score was 6 out of 15. She was assessed as having a hypoxic arrest secondary to airway obstruction. The deceased was admitted into the Intensive Care Unit [30]

29. On the ward, the deceased developed seizures, which were a poor prognostic sign. However, her initial CT brain scan did not show any pathology. An EEG performed on 24 January 2013 showed epileptiform wave forms and she was diagnosed as having status epilepticus secondary to hypoxic brain injury. It was felt that her prognosis was very poor and the likelihood of having independent life was very slim.

30. On 25 January 2013, it was noted that the deceased had a fever and she was started on antibiotics for likely aspiration pneumonia. Her case was discussed with her family and it was agreed that sedation (implemented for the seizures) should be discontinued. After ceasing sedation, the seizure activity deteriorated and the deceased remained unconscious. A decision was then made to provide the deceased with palliative care. She died on the morning of 27 January 2013 in the company of her family.[31]

[28] Exhibit 1, Tab 13.
[29] Exhibit 1, Tab 13 and Tab 17.
[30] Exhibit 1, Tab 11.
[31] Exhibit 1, Tab 11.

CAUSE AND MANNER OF DEATH

31. On 30 January 2013, a post mortem examination was conducted by the Chief Forensic Pathologist, Dr Cooke. Following a number of investigations, including microscopic examination, neuropathology examination and toxicological analysis, Dr Cooke formed the opinion the cause of death was early bronchopneumonia and hypoxic brain injury following aspiration of food (choking).[32]

32. I accept and adopt the conclusion of Dr Cooke as to the cause of death.

33. Given the hypoxic brain injury was precipitated by the deceased choking on her food, I find that the manner of death was accident.

QUALITY OF SUPERVISION, TREATMENT AND CARE

34. Under s 25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

35. I note that the deceased's husband expressed his satisfaction with the care provided by the staff of the Intensive Care unit at SCGH and his gratitude for their thoughtfulness and empathy during the deceased's last few days. He was also grateful to the staff at Graylands Hospital for their care of the deceased over the many years that the deceased was a patient there.[33]

36. The deceased's illness was difficult to treat and it is apparent that the doctors at Graylands Hospital tried many alternative medications and methods of managing the deceased in an attempt to allow her as much time as possible at home with her family. Sadly, over the years her condition deteriorated and her ability to cope in the community reduced over time.

37. The real question to be answered at this inquest was whether the deceased's choking could and should have been predicted or prevented.

38. The deceased's husband mentioned that he had observed on occasions in the past that the deceased would swallow food or drinks down the 'wrong way' and splutter.[34] However, he had not

[32] Exhibit 1, Tab 3.
[33] Exhibit 1, Tab 9.
[34] T 23; Exhibit 1, Tab 8.

seen any concerning signs in her eating behaviour on the last weekend she spent at home.[35]

39. Dr Tait indicated that at the time he began caring for the deceased he was not aware of any documented information to suggest the deceased was prone to episodes of choking while eating.[36]

40. After the event, Dr Tait gave some thought to why the deceased choked on her food on this day. Dr Tait hypothesised that, given an aspect of the deceased's illness was her impulsiveness with some disinhibition, this may have led to her eating her food too fast and contributed to her choking.[37] It might also have led her to put too much food in her mouth at one time.[38] This would be consistent with the behaviour the deceased's husband had previously observed.

41. Dr Tait also gave evidence that the deceased may have been more susceptible to choking as she had been prescribed neuroleptic medication for many years. Dr Tait had observed that the deceased had exhibited some symptoms of mild speech disorder when he interviewed her, which indicated she may have been experiencing something called tardive dyskinesia. It involves involuntary muscle movements affecting her tongue and lips and could perhaps affect the coordination of her swallowing reflexes. This is something Dr Tait would have explored further as part of the deceased's full physical assessment, but that opportunity never came.[39]

42. It could also be that the deceased choked because of a combination of impulsively putting too much food in her mouth and some mild impairment of her muscle coordination around her mouth.[40]

43. As noted above, these were all possibilities considered by Dr Tait after the deceased choked that day.[41] They were not matters he or other hospital staff had thought about prior to that day, as the deceased did not have a known history of choking on her food. Dr Tait described what happened to the deceased as "a real shock" because the deceased was fully ambulant and cooperative. Because it was so shocking and unexpected, he gave considerable thought afterwards to why it happened, to see if anything could have been done differently. In the end, he

[35] T 23.
[36] Exhibit 1, Tab 13.
[37] T 8; Exhibit 1, Tab 13.
[38] T 12.
[39] T 11; Exhibit 1, Tab 13.
[40] T 12.
[41] T 14.

reached the conclusion that her death could not have been anticipated or reasonably prevented, given what was known about her condition at that time.[42]

44. If the deceased had been known to be at risk of choking, some thought would have been given to changing the deceased's diet to a long-term soft diet and supervision while she ate.[43] However, as Dr Tait observed, such diets are pretty bland and he doubted whether it would have been something that the deceased would have wanted to have imposed upon her.[44]

45. As to the care that was provided to the deceased once it was apparent that she was choking, Dr Tait considered the medical staff at Graylands Hospital to have taken all appropriate steps to try to dislodge the obstruction and enable her to breathe again. Dr Roselle happened to be on the ward when the code blue was called and was able to attend very quickly. Unfortunately, the food was so far down her trachea that he could only dislodge a small amount, after she had become unconscious. It required the use of the long forceps by the ambulance team to remove the bulk of the obstruction and by that time, her brain had been deprived of oxygen to such an extent that it could not recover. Her medical treatment was to a high standard, but sadly the final outcome was unavoidable.[45]

46. In the circumstances, I am satisfied that there was nothing that the Department did or failed to do that contributed to the deceased's death.

CONCLUSION

47. The deceased was a 65 year old lady with a long diagnosed history of mental illness. Throughout her life, the deceased had the unconditional love and support of her family, her husband and sister-in-law, as well as from friends.[46] This ensured that she was always loved and cared for, but did not avoid the need for periods of hospitalisation when her symptoms increased.

48. The deceased did have long episodes when she was well enough to live in the community, but those periods gradually reduced over time. Shortly before her death, her symptoms had become so overwhelming that she was requiring a much higher level of supervision and it looked likely she would have to reside at

[42] T 14.
[43] T 12.
[44] T 14.
[45] T 14 – 15.
[46] Exhibit 1, Tab 9.

Graylands Hospital for a longer than usual period of time to give her doctors a chance to reassess her treatment regime. The deceased expressed some unhappiness at the increasing restriction on her choices but was nevertheless generally accepting of her need for treatment.

49. The events leading to the deceased's death that day were unexpected and not easily predicted. She was provided with immediate medical treatment of a high standard but it was not enough to save her. The suddenness of her death was a shock to her husband and family as well as her doctors. However, the deceased's husband graciously accepts that the doctors did their best and it was simply a tragic accident.

S H Linton
Coroner
18 November 2015