Coroners Act, 1996
[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 52/15

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***Pauline Margaret DODD****, with an Inquest held at Perth Coroners Court, Court 51, CLC Building, 501 Hay Street, Perth, on 11 December 2015 find the identity of the deceased was* ***Pauline Margaret DODD*** *and that death occurred on 4 March 2014 at Sir Charles Gairdner Hospital, as a result of Ischaemic Heart Disease in the following circumstances:*

Counsel Appearing :

Sergeant Lyle Housiaux assisted the Deputy State Coroner

Mr D Harwood (Instructed by State Solicitors Office) appeared on behalf of the North Metropolitan Health Service Mental Health.

Table of Contents

INTRODUCTION

Pauline Margaret Dodd (the deceased) was transferred from the Frankland Centre to Sir Charles Gairdner Hospital (SCGH) on 2 March 2014 while under a hospital order to review, issued by the Albany Magistrate following the deceased's erratic behaviour in Albany on 18 February 2014.[1] The deceased was treated for an infection but was difficult to manage due to her deteriorating behaviour. She eventually became unresponsive in the early hours of 4 March 2014 following which she could not be revived.

The deceased was 51 years of age.

At the time of her death the deceased was an involuntary patient at the Frankland Centre under the provisions of the *Criminal Law (Mentally Impaired Accused) Act 1996* sections 5 and 14. She was located at SCGH in the care of two psychiatric nurses. Her involuntary status at the time of death mandates an inquest pursuant to the provisions of the *Coroners Act 1996*, section 22 (1) (a).

BACKGROUND

The deceased was born on 12 November 1962 in Narrogin. She had been married twice and had five children. At the time of her death she was usually resident in Narrogin with her sister and niece following her release from prison for the

[1] Ex 1, tab 14

manslaughter of her second husband. Her family had taken her to the Narrogin Hospital many times for various medical problems.

The deceased had extensive medical records dating back to March 1979 when she was still only 16 years old, but until the offences related to the death of her second husband all of her offences were relatively minor and dealt with by way of fines or community orders. In hindsight many may have been related to underlying mental health issues.[2]

MEDICAL HISTORY

The deceased had rheumatic fever as a child which affected her aortic and mitral valves to the extent she later required mitral and aortic valve replacements and surgery to her tricuspid valve in 2001. She also suffered obstructive sleep apnoea, type 2 diabetes mellitus, obesity, hypercholesterolemia, atrial fibrillation and vitamin D deficiency. She had more recently been diagnosed with bipolar affective disorder with mania, psychosis, borderline and antisocial personality disorder, alcohol abuse and asthma.

The deceased had a number of mental health issues which were first indicated by an admission to Graylands Hospital in September 1989 for four days following a referral from

[2] t 11.12.15, p11

her General Practitioner (GP). She was assessed as an agitated individual with mildly pressured speech and her affect was considered aroused and irritable. There was no evidence of psychotic features despite her threat to obtain a shot gun to shoot members of her family. She was diagnosed with *"adjustment disorder"* with disturbance of conduct and emotions in a woman subjected to major psychosocial pressures.

Almost 10 years later on admission to Graylands Hospital in May 1999 the deceased presented in a similar manner and was described as loud and abusive to staff on admission, but again was not considered to be suffering from any psychosis or significant affective disorder. The psychiatric notes stated the deceased was *"often abrasive, loud, demanding and intrusive"* and again she was discharged five days later with a diagnosis of "*adjustment disorder and personality disorder not otherwise specified.*"[3]

Ten years later the deceased was readmitted to Graylands Hospital following referral by her GP in Wiluna where she was living with her husband. Her GP described her as angry and irritable. She had again been making threats to harm people in the community but no psychotic symptoms were described. She was discharged with a diagnosis of "*adjustment disorder and antisocial and borderline personality traits*" and she was discharged to her sister's

[3] Ex 1, tab 12

address following her husband placing a restraining order on her because of her conduct.

There was no referral to community mental health services following any of her admissions to mental health facilities and she had never received psychotropic medication or been placed on a Community Treatment Order under the *Mental Health Act 1996* for the purposes of enforced medication.

In hindsight, her treating psychiatrist, Dr Gosia Wojnarowska, agreed the relatively regular emergence of very erratic and manic behaviour in the deceased over the past 30 years probably indicated she had an underlying mental health diagnosis, possibly bipolar affective disorder, which as she aged became more severe. The fact the deceased was described as well between her behavioural outbursts, and was well thought of by various employers, including the nurse manager at Wiluna Hospital, would indicate earlier intervention with appropriate medication may have been of benefit to the deceased, had she been diagnosed and been medication compliant.

The deceased's functionality decreased following her March 2009 discharge and on 30 May 2009 she set alight her home in Wiluna with her husband inside. The deceased's husband suffered first degree burns to 15% of his body and suffered smoke inhalation in the process of escaping from the burning building. Outside he was confronted by the

deceased who was still threatening him. He then walked to the police station to report the offence, followed by the deceased. Once at the police station both were taken to the Wiluna Aboriginal Medical Centre for medical assessment. The deceased's husband was discharged into the care of other family members while the deceased was arrested for Arson and later, when she described her intention to kill her husband, with attempted murder.

This was the deceased's second husband and they had been married for less than a year with their relationship described as *"volatile"*.[4]

The deceased's husband was later readmitted to hospital and then taken by Royal Flying Doctor Service to Perth for treatment. He did not recover from his injuries and died at Royal Perth Hospital on 30 July 2009. The house had been a Homes West home and was completely destroyed in the fire.

The deceased was referred to the Frankland Centre at Graylands Hospital on 23 June 2009 following those offences. On admission it was noted that her behaviour had been deteriorating in the previous months, and was quite unlike her previous three admissions, at 10 yearly intervals. She was considered to have prominent mood elevation and disorganisation, had been less reliable at work and

[4] Incident Report WA Police

overstated her importance with some evidence of grandiose delusion, but there was no evidence of substance or alcohol abuse.

Her GP had noted her increasingly bizarre behaviour around the March 2009 admission and the events of 30 May 2009 seem to have been a continuation of her aggressive and threatening behaviour. Whereas before, between episodes, the deceased had been coping well, on this occasion it appeared she was no longer functioning effectively. She was diagnosed with bipolar affective disorder and personality disorder, not otherwise specified. She was started on treatment with olanzapine, which appeared successful, and was discharged to Bandyup Prison.[5]

The deceased was imprisoned for three years with respect to the offences she committed and served that time in Bandyup, presumably on medication. On her discharge from prison the deceased returned to her home area of Narrogin and there lived with family members, who reported her behaviour as being difficult to accommodate.

The deceased was often referred to Narrogin Hospital (the hospital) following her release from Bandyup for mainly physical ailments. It was not until November 2013 she was specifically admitted for management of anxiety and

[5] Ex 1, tab 12

depression. She still does not appear to have been referred to any community mental health services.

On 3 December 2013 she presented at the hospital with severe depression and psychosis and it was noted she had regressed mentally. She was described as childlike and almost catatonic. A CT scan of her brain was normal and the organic blood screen negative. She was commenced on antidepressant medication and remained in the hospital for a month to be stabilised. Risperidone was added to her antidepressant and she was discharged home in the company of a family member of 2 January 2014.[6]

The deceased's family members reported the deceased's behaviour had been reasonable during her stay with them up until the early part of 2014 at which time they considered her state of mind to have deteriorated significantly.

The deceased presented again to the hospital on 11 February 2014 with suicidal and homicidal ideation. She was sedated and transferred to the Bunbury Hospital Psychiatric Unit for assessment. The deceased was aggressive towards staff and patients. She remained in Bunbury until 14 February 2014 at which time she was discharged. She was considered able to carry out activities of daily living independently, and appeared compliant with

[6] Narrogin Regional Hospital Records

her treatment regime. She does not appear to have had any community mental health services input.

Just two days later the deceased was readmitted to the hospital to stabilise her medication because she was noncompliant.

On 18 February 2014 the deceased was extremely aggressive towards herself and others. Following release from the hospital she was observed in Narrogin town site behaving erratically. She threatened to kill nurses in the hospital and herself. She was reviewed by medical staff and discharged into police custody following assaulting the nurses. She was taken to Narrogin Police Station and charged with her earlier offences. She was refused bail and taken to court where she was referred to the Frankland Centre by Hospital Order.

This was later re-confirmed by the Albany Magistrates Court on 25 February 2014.

EVENTS LEADING TO DEATH

The deceased arrived at the Frankland Centre on 18 February 2014. She was extremely aroused, shouting and screaming and waving her hands.

On examination by a consultant psychiatrist she continued to be abusive and uncooperative with pressured speech. She was highly disorganised.[7]

The deceased refused a physical examination but allowed vital sign observations. Her antidepressant medication was ceased and was replaced with an antipsychotic and clonazepam (tranquiliser).

The deceased continued with her aggressive behaviour and on 20 February 2014 needed to be placed in seclusion following an incident with a male patient and staff. Her observations were all normal. She remained hostile and refused proper physical examination. Her troponin level was elevated but on consultation with the cardiology registrar at SCGH it was not considered to be indicative of cardiac abnormality. The deceased did not complain of chest, jaw or arm pain, but did complain of chronic back pain.

Her behaviour and condition elicited a response of two to one (two nurses, one patient) nursing, pending her next court appearance. Although her psychotic symptoms were still present she did not cause any major management problems on the ward. She was monitored for her INR and

[7] Ex 1, tab 12

repeat troponin levels and provided melatonin to assist with her sleep.[8]

On Thursday 25 February 2014 the deceased appeared in person at the Albany Magistrates Court for the charges relating to Narrogin Hospital. A hospital order was issued for her assessment by a psychiatrist at the Frankland Centre to assess her status under the *Criminal Law (Mentally Impaired Accused) Act 1996*. She was returned to the Frankland Centre.[9]

The deceased's family remained in contact with the deceased whilst she was at the Frankland Centre and she complained of being treated badly and having needles.[10]

On 27 February 2014 the deceased fell in the courtyard at the Frankland Centre and responded very adversely when the nurses tried to help her. She apparently had an aversion to being touched.[11] The deceased was screaming, shouting and spitting at those trying to assist her, although her blood pressure was 110/80, her pulse 88 and her oxygen saturations were 100% when assessed.

The deceased got up and walked to the interview room with the help of nursing staff. An ECG was performed and showed fibrillation and possible septal myocardial infarct

[8] Ex 1, tab 12
[9] Ex 1, tab 14
[10] Ex 1, tab 9 & 10
[11] t 11.12.15, p16

according to the reading. Her treating psychiatrist contacted the cardiologist at SCGH who viewed the faxed ECG but did not agree there was a cardiac problem with the deceased.

During the ECG procedure the treating psychiatrist noticed a small superficial skin infection under the deceased's right breast. The deceased would not allow proper examination due to aversion to being touched. She was resistant to the psychiatrist assessing the infection in full although an antibiotic was prescribed.

Following this extreme reaction the deceased was independently mobile, was walking around the ward and appeared to be in a happy mood without complaint, with her vital signs remaining normal.

The deceased's mental state continued to fluctuate and she was highly aroused, verbally aggressive and continued with her aggression toward staff members. On 28 February 2014, aside from hitting staff, she defecated in public. Her two to one nursing continued.

The following day the deceased's mental state appeared improved, although the two to one nursing continued. The deceased appeared to be mixing well with other patients and staff, but at 9:45pm she approached the nursing staff and complained of pain in her breast. She asked for the staff to

look at the infection and it appeared to have become worse. Calamine lotion was applied to the area and the duty medical officer was asked to examine her. Her temperature was slightly elevated but all other vital signs were normal. The deceased was referred to SCGH emergency department by ambulance. The Frankland Centre was advised the deceased was to be admitted.

ADMISSION TO SIR CHARLES GAIRDNER HOSPITAL (SCGH)

The deceased was admitted to SCGH in the early hours of 2 March 2014 for assessment of what was thought to be an abscess on her right breast. Due to the fact the deceased was a patient detained under the *Criminal Law (Mentally Impaired Accused) Act 1996* at the Frankland Centre she was escorted by two psychiatric nurses from the Frankland Centre. The two nurses remained with her at all times.

On her initial presentation the deceased behaved very aggressively which required a code black (personal threat and refers to a person threatening or attempting to harm self or others). It was noted she had already been treated with oral antibiotics and that the cellulitis appeared to be worsening although there was no drainable infection. It was considered from the ultrasound the cellulitis may be compatible with mastitis, without drainable collection.

The deceased was admitted under the surgical team and treatment commenced with intravenous antibiotics, following the ultrasound examination, in an attempt to find the extent of the infection.

Several code blacks were called following the deceased's admission due to her verbal and physical aggression. She was treated with Quetiapine, Clonazepam and Buprenorphine.

On 3 March 2014 it was noted the deceased appeared to have laboured breathing but refused oxygen. She was quite, sedated and drowsy, causing her to sleep a lot.

At approximately 3:45am on 4 March 2014 the deceased stopped breathing and become unresponsive. Cardiopulmonary resuscitation was instigated when she was found to be apnoeic with fixed and dilated pupils and no heart sounds. Full resuscitation included ventilation and CPR, but persistent pulseless electrical activity was noted on the monitor.

The deceased was pronounced dead approximately one hour later.

POST MORTEM REPORT

The post mortem examination of the deceased was performed by Dr Gerard Cadden, Forensic Pathologist, PathWest medical laboratories on 8 March 2014.

Dr Cadden noted the deceased had an enlarged heart with long standing adhesions secondary to her previous cardiac surgery. The prosthetic aortic and mitral valves were all noted, as was multifocal scarring of the heart muscle with evidence of focal coronary atherosclerosis.

Toxicology revealed multiple medications, some at therapeutic or low therapeutic levels with olanzapine at an appropriate level for treatment. There was no alcohol or illicit drugs noted and warfarin was indicated.

At the conclusion of his post mortem examination Dr Cadden formed the view the deceased had died as a result of ischaemic heart disease.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 51 year old aboriginal lady who had a medically traumatic childhood involving rheumatic fever which later affected her cardiac status.

She had been adopted at 18 months of age and started using alcohol and cannabis in her late adolescence. She

had her first child at 18 and then four other children before that marriage ended. She moved to Wiluna with her second husband, who died following a fire started by the deceased.

The deceased's initial diagnoses for adjustment disorder and antisocial personality disorder appear, in hindsight, to have been misconceived. It would seem to be more likely her initial admission to Graylands Hospital in September 1989, when she was only 26 years of age, may have been one of the first indicators she was developing bipolar affective disorder. Thereafter, at 10 year intervals, the deceased's usual presentation as a well-functioning individual deteriorated to the extent she was referred back to Graylands hospital by her GP with loud, abusive, combative and aggressive behaviour. This was quite out of the normal range for the deceased's usual presentation between these 10 yearly episodes.

The last of these episodes of significant deterioration appears to have occurred on 12 March 2009 when she was readmitted to Graylands Hospital for 11 days after threatening people in the community in Wiluna. While there were no psychotic symptoms and there was some evidence of delusions, the deceased was again discharged with a diagnosis of adjustment disorder and antisocial and borderline personality traits. There is no evidence of there being any follow up by community mental health services, probably due to the lack of a mental health diagnosis.

It was following this discharge the deceased did not stabilise, but continued with unpredictable behaviour to the extent that in May 2009 she set fire to the house in which her husband was sleeping. This continuation of adverse behaviour following discharge was unlike any of her prior bouts of unwellness. It would seem to indicate a diagnosis made later in 2009, that the deceased suffered bipolar affective disorder, may have been more appropriate earlier.[12] I accept the diagnosis and treatment of mental health issues has always been complicated, and hindsight is often helpful.

It seems possible that had a bipolar affective disorder been recognised earlier, and the deceased appropriately medicated, some of her later mental health issues could have been ameliorated. The fact the deceased was usually a well-functioning individual between episodes may have implied she would have been medication compliant had the opportunity arisen earlier. This is speculation. There is no way of knowing whether the deceased would have been compliant with medication. Medication was not prescribed due to the diagnoses, her difficulties were described as personality disorders not generally responsive to medication.

Following the deceased's conviction for the manslaughter of her husband and her psychiatric assessment surrounding

[12] t 11.12.15, p11

those events in Frankland Centre the deceased was diagnosed and medicated. She does not appear to have been of great concern while at Bandyup Prison and appropriately medicated with olanzapine.

Following the deceased's release from Bandyup Prison she returned to the Narrogin area where she had family. Her behaviour fluctuated.

In the months prior to her deterioration in February 2014 the deceased's family noticed she was quite abrasive and difficult in her behaviour. It is not clear whether she was compliant with her medication regime. The deceased's behaviour deteriorated to the extent she could not be managed in Narrogin and she was referred to Frankland Centre by Court Order.

On 19 February 2014 in the Frankland Centre her antidepressant medication was ceased and replaced with olanzapine, the medication she had originally being prescribed in 2009, and clonazepam.

It does not appear this change in medication benefited the deceased greatly. She continued to have aggressive and hostile behaviour but was probably also experiencing some physical deterioration.

Due to the deceased's aversion to physical medical examination it was difficult for those attempting to care for the deceased in Frankland Centre to make adequate medical diagnosis with respect to her physical care. There is no doubt every attempt was made to treat her effectively for her physical difficulties when she would allow it.

The difficulty with examining the deceased when she developed an infection in her breast, and the physiological stress her behaviour and physical ailments would have contributed to her functionality impeded diagnosis of the extent of the deceased's cardiovascular issues.

Medical staff at the Frankland Centre sought appropriate input from cardiology at SCGH when they were concerned the deceased was displaying cardiac symptoms. However it was not until Frankland Centre transferred the deceased due to concern with her infection that SCGH became actively involved in her physical care. The deceased was investigated for the extent of the infection and provided with IV antibiotics but her physical state deteriorated.

She suffered a cardiac arrest and died as a result of her heart disease on 4 March 2014.

I find death occurred by way of Natural Causes.

COMMENTS OF THE SUPERVISION, TREATMENT AND CARE OF THE DECEASED

The deceased suffered rheumatic fever as a child and this affected her cardiac health as an adult. She also suffered with mental health issues which were diagnosed as bipolar affective disorder in 2009. She had lived with alcohol abuse and asthma. All factors which would adversely affect her already compromised physical health.

Despite this the deceased functioned well in the community between periods of instability and was well thought of by her employers. Eventually her mental health deteriorated to the extent she could no longer function in the community. Her family found her difficult to deal with. I accept the treatment for mental health issues has always been problematic but wonder whether earlier diagnosis may have improved the deceased's life.

Review of the deceased's medical files indicate she was treated for her physical disabilities appropriately to the extent she would allow it.

By the time of her final admission to Frankland Centre as an involuntary patient she had been diagnosed with bipolar affective disorder and was treated appropriately. Her mental health issues were understood and treated. She was cared for by two nurses to one patient in an effort to stop

her from harming herself or others but unfortunately died as a result of her extensive heart disease.

The deceased's supervision, treatment and care while an involuntary patient in February/March 2014 were adequate. It is unfortunate medication for her mental health issues was not instituted due to a lack of diagnosis many years earlier.

I find the deceased's supervision, treatment and care as an involuntary patient in February/March 2014 was of a satisfactory standard.

E F Vicker
Deputy State Coroner
5 February 2016