Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 24/18

I, Barry Paul King, Coroner, having investigated the death of ***Wlodzimierz Dudek*** *with an inquest held at* ***Perth Coroner's Court*** *on* ***16 July 2018****, find that the identity of the deceased person was* ***Wlodzimierz Dudek*** *and that death occurred on* ***7 October 2016*** *at* ***Sir Charles Gairdner Hospital*** *from* ***bronchopneumonia and hypoxic brain injury following aspiration of food (choking)*** *in the following circumstances:*

Counsel Appearing:

Sergeant L Housiaux assisted the Coroner

Table of Contents

INTRODUCTION

1. On 4 October 2016 the deceased was eating breakfast on his own at Graylands Hospital (Graylands) when he choked on bread, became unconscious and his heart arrested. Hospital staff administered CPR and ambulance officers took him to Sir Charles Gairdner Hospital, where he was admitted into the intensive care unit (ICU) with a suspected hypoxic brain injury. His condition deteriorated. On 7 October 2016 he was extubated, and he died shortly thereafter.

2. The deceased's death was a 'reportable death' under section 3 of the *Coroners Act 1996* (the Act) because it appeared 'to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury'.

3. Under section 19 of the Act, I had the jurisdiction to investigate the deceased's death because it appeared to me that the death was or may have been a reportable death.

4. As the deceased was under an inpatient treatment order under the *Mental Health Act 2014* (the MHA) at the time of his death, he was an 'involuntary patient' within the meaning of the MHA.[1] He was therefore a 'person held in care' under section 3 of the Act.

5. Section 22(1)(a) of the Act provides that a coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death a person held in care.

6. An inquest into the death of the deceased was, therefore, mandatory.

7. On 16 July 2018, I held an inquest into the deceased's death at the Perth Coroners Court. The documentary evidence adduced at the inquest consisted of an

[1] S21 *Mental Health Act 2014*

investigation report and associated attachments prepared by Senior Constable Jacek Teczar of the Coronial Investigation Squad of the Western Australia Police.[2]

8. Oral testimony was provided by Professor Joseph Lee, a consultant forensic psychiatrist who was responsible for the deceased's treatment at Graylands.[3]

9. Under section 25(3) of the Act, where a death investigated by a coroner is of a person who was held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

10. I have found that the supervision, treatment and care provided to the deceased at Graylands was reasonable and appropriate in the relevant circumstances.

THE DECEASED

11. The deceased was born in Nowy Sacz in Poland on 31 July 1947, so he was 69 years old at the time of his death. He had two sisters, who were both deceased at the time of his death.

12. The deceased grew up and attended school around Nowy Sacz. He went on to obtain a master's degree in chemical engineering from the University of Krakow.

13. The deceased married his first wife, Danuta Dudek, in Poland and they had a son, Tomasz. In 1982, the family moved to Australia and settled in Perth. Soon after they arrived in Australia, the deceased and Danuta separated and divorced.

14. The deceased later married his second wife Regina Michalowska. They divorced after about 14 years, and had no children together.

[2] Exhibit 1, Volumes 1, 2 and 3.
[3] ts 24-39

THE DECEASED'S MEDICAL HISTORY

15. In 1982, when the deceased was 35 years old, he had his first major depressive episode. He was subsequently diagnosed with bipolar affective disorder. From that time, he had predominantly manic relapses with psychosis, often prolonged, and was admitted to several mental health hospitals.[4]

16. Until 2012, the deceased's manic relapses settled with psychiatric treatment; from that time, however, they became more frequent, prolonged and treatment-resistant. The relapses were characterised by marked sexual disinhibition, irritability, intrusiveness, erratic mood swings, aggression and a disturbed sleep-wake cycle.[5]

17. In the last two years of his life, the deceased developed poor memory, poor reasoning, loss of abstraction, deteriorating ability to speak English, poor judgement and impaired executive functioning. These signs and symptoms suggested frontal lobe impairments and frontotemporal dementia. Neuroimaging investigations were inconclusive but showed generalised atrophy involving the temporal lobes.[6]

18. From April 2013 the deceased had frequent admissions to the mental health unit at Joondalup Health Campus (MHU). He had a long admission there from 10 December 2015 to 5 April 2016, after which he was transferred to Graylands as an involuntary patient.

19. During those admissions, the deceased was a very challenging patient. He was aggressive and impulsive, hitting out at others and spitting at people when his demands were not met. He masturbated profusely in public and made inappropriate sexual remarks to female staff members. He had frequent altercations with other

[4] Exhibit 1, Volume 1, Tab 11
[5] Exhibit 1, Volume 1, Tab 11
[6] Exhibit 1, Volume 1, Tab 11

patients, which put him at risk of retaliatory aggression.[7] He had no insight into his condition.[8]

20. The deceased's heightened symptoms occurred cyclically, with marked excitement and agitation lasting about a week, against a background of persisting, less severely disturbed behaviour. The symptoms would resolve on their own and the deceased would spend his time writing copious letters and planning his imaginary weddings.[9]

21. Physically, the deceased had cardiac arrhythmias, cardiac congestive failures, stroke and chronic obstructive pulmonary disease. These co-morbidities made it difficult for treating clinicians to prescribe appropriate medications and treatment.[10]

22. While at the MHU in December 2015, the deceased developed pneumonia, possibly due to ischaemic heart disease. His condition deteriorated suddenly on 9 December 2015, with elevated and irregular pulse rate and elevated blood pressure. A medical emergency team attended and arranged for him to be transferred to a general medical team, with a provisional diagnosis of right lower lobe hospital-acquired pneumonia.

23. On 10 December 2015 the deceased was transferred back to the MHU, and medical reviews confirmed recovery from the pneumonia. However, nursing staff noted that he had difficulty swallowing. On 14 December 2015, a speech pathologist noted mild to moderate oropharyngeal dysphagia (difficulty swallowing) likely related to delirium, and recommended a soft food diet. There had been no previous reports of dysphagia. A CT scan done on that day showed no intracranial pathology to account for his symptoms. The deceased was not compliant with the soft food diet.[11]

[7] Exhibit 1, Volume 1, Tab 15
[8] Exhibit 1, Volume 1, Tab 15
[9] Exhibit 1, Volume 1, Tab 11
[10] Exhibit 1, Volume 1, Tab 13
[11] Exhibit 1, Volume 1, Tab 13

24. By the time the deceased was transferred to Graylands on 5 April 2016, his respiratory symptoms had resolved completely and his medical problems had been stable for months. The discharge summary accompanying the deceased upon his transfer referred to the pneumonia but made no mention of dysphagia.[12] No risk of him choking was identified while he was in Graylands.[13]

25. In mid-July 2016 the deceased was struck in the face by another patient and sustained black eyes and a fractured nose. He was eventually moved to Casson Ward, which catered for patients with significant physical co-morbidities.[14]

26. In August 2016 another patient in Casson Ward reacted to the deceased's intrusive behaviour and struck him in the face, causing him eye socket fractures. He was placed on a 2:1 special, whereby he was monitored by two staff members for his and other patients' protection.[15]

27. That 2:1 observation continued until 22 September 2016, after which the deceased had days when he was more settled and days when he was more aggressive and agitated. He was not identified as a choking risk, and he generally had his meals on his own in the courtyard of the ward because of his tendency to create conflicts with other patients by spitting in their meals and acting aggressively.

EVENTS LEADING UP TO DEATH

28. At about 8.20 am on 4 October 2016, the deceased was sitting in a chair in the courtyard of Casson Ward, eating his breakfast on his own since he had been acting disruptively that morning. There were eight patients and three nurses, including a clinical nurse, in the ward.

[12] Exhibit 1, Volume 1, Tab 14
[13] Exhibit 1, Volume 1, Tab 11
[14] Exhibit 1, Volume 1, Tabs 11 and 15
[15] Exhibit 1, Volume 1, Tab 15

29. At 8.30 am the clinical nurse and an enrolled nurse went into the courtyard to ensure that there were no altercations with the deceased when other patients went outside. They found the deceased leaning backwards in the chair with his head extended and a piece of bread visible in his mouth.[16] His pants were pulled down slightly and his genitals were exposed, indicating that he had likely been masturbating.[17]

30. The nurses called a code blue and other staff members attended. The deceased was placed on the floor and suctioned, and CPR was administered. A defibrillator was attached and a shock was delivered. The medical emergency team attended and assisted with the resuscitation attempts. Ambulance paramedics arrived within minutes and took over.

31. The ambulance paramedics returned the deceased's spontaneous circulation and took the deceased to the emergency department at Sir Charles Gairdner Hospital, where he was intubated and assessed before being transferred to the ICU.

32. The deceased made no meaningful recovery over the next three days. Following meetings on 7 October 2016 between ICU medical staff and the deceased's family, and a subsequent discussion between staff and the Public Guardian, the deceased was extubated and provided with palliative care until he died late that night.

CAUSE OF DEATH

33. On 13 October 2016, Chief Forensic Pathologist Dr C T Cooke conducted a post-mortem examination of the deceased and found congestion of the lungs, with pneumonia in the bases of both lungs. The brain showed softening consistent with hypoxic brain injury. The heart

[16] Exhibit 1, Volume 1, Tab 12; Graylands Hospital medical notes
[17] Exhibit 1, Volume 1, Tab 11

was enlarged, with scarring of the heart muscle, indicating a previously healed heart attack.[18]

34. Dr Cooke formed the opinion, which I adopt as my finding, that the cause of death was bronchopneumonia and hypoxic brain injury following aspiration of food (choking).[19]

HOW DEATH OCCURRED

35. On the basis of the evidence available, I am satisfied that the deceased aspirated food and developed hypoxic brain injury and bronchopneumonia, which caused his death.

36. I find that death occurred by way of accident.

COMMENTS ON THE SUPERVISION, TREATMENT AND CARE OF THE DECEASED

37. It is open to question whether the supervision of the deceased by Graylands nursing staff was inadequate since the deceased was allowed to choke on food while he was in their care.

38. It appears to me that, since the deceased was not known to Graylands staff to be at risk of choking, there was no reasonable need for them to monitor him constantly while he ate breakfast. Not surprisingly given his psychiatric history, staff members providing him care were primarily concerned with protecting him and others from acts of aggression.

39. The deceased's choking episode appeared to have effectively been a one-off incident that was accidental and unpredictable.

[18] Exhibit 1, Volume 1, Tab 6
[19] Exhibit 1, Volume 1, Tab 6

40. In those circumstances, I am satisfied that the supervision, treatment and care provided to the deceased in so far as it related to how death occurred was reasonable and appropriate.

41. As to the treatment and care provided to the deceased generally while at Graylands, it is clear that he was an extremely difficult and challenging patient to manage.

42. It might be thought that he should have been protected from other patients by being isolated at all times; however, Professor Lee said that the deceased was managed away from other patients so far as possible, and (he agreed) that patients could not be locked away in their rooms. He said that the deceased derived benefit and enjoyed interacting with others.[20]

43. I accept Professor Lee's evidence on that issue. I am satisfied that the supervision, treatment and care of the deceased generally was reasonable in the circumstances.

CONCLUSION

44. The evidence at the inquest established that the deceased developed a profoundly debilitating mental illness at a relatively early age. He received various forms of treatment over decades as mental health clinicians attempted to find an effective way to manage his symptoms.

45. At best, clinicians were able to identify the cyclical nature of the symptoms and to take steps to reduce the likelihood that they would result in physical harm to the deceased or others.

46. The deceased presented clinicians with a difficult challenge, but I am satisfied that the care, treatment and supervision he was provided was reasonable and appropriate.

[20] ts 15 and 16 per Lee, J W Y

47. The circumstances of the deceased's death would no doubt have come as a complete surprise to those responsible for his care.

B P King
Coroner
19 September 2018