Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 55/ 12

I, Barry Paul King, Coroner, having investigated the death of ***Tom Foski*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on* ***25 February 2014****, find that the identity of the deceased person was* ***Tom Foski*** *and that death occurred on* ***6 May 2012*** *at* ***Sir Charles Gairdner Hospital*** *from* ***congestive cardiac failure in association with ischaemic and hypertensive heart disease*** *in the following circumstances:*

Counsel Appearing:

Ms M. Smith assisting the Coroner
Ms R Hartley (State Solicitors Office) appearing on behalf of the Health Department of WA, Graylands Hospital, Dr F. Rosell, Mr J. Cass, Mr P. Ibbertson and Dr G. Dell.
Ms B. Burke (Australian Nursing Federation) appeared for Mr D. Roberts

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INTRODUCTION

1. Tom Foski (**the deceased**) died on 6 May 2012 from congestive cardiac failure while he was a patient at Graylands Hospital (**Graylands)**.

2. As the deceased was an involuntary patient under the *Mental Health Act 1996* at the time of his death, he was a 'person held in care' under section 3 of the *Coroners Act 1996*.

3. Section 22 (1)(a) of the *Coroners Act 1996* 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.

4. An inquest to inquire into the death of the deceased was therefore mandatory.

5. 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.

6. The death of the deceased was investigated together with the death of nine other persons who immediately before death had been persons held in care as involuntary patients at Graylands under the *Mental Health Act 1996*.

7. A joint inquest commenced before Coroner D.H. Mulligan in the Perth Coroner's Court on 27 August 2012. Evidence specific to the deceased was adduced on 3, 4 and 17 April 2013. The joint hearings were completed on 22 April 2013.

8. Coroner Mulligan became unable to make findings under s.25 of the *Coroners Act 1996,* so I was directed by Acting State Coroner Evelyn Vicker to investigate the deaths.

9. To remove any doubt of my power to make findings under s.25, on 25 February 2014 I held another inquest into the death of the deceased. The evidence adduced in that inquest was that which had been obtained by Coroner Mulligan, including exhibits, materials and transcripts of audio recordings of the inquests. Interested parties who were present at the inquests before Coroner Mulligan were invited to make fresh or further submissions. All of the parties indicated their agreement with the appropriateness of the procedure I had adopted.

10. I should note that there was a great deal of evidence adduced at the inquest that was related to general or systemic issues pertinent to Graylands. That evidence was adduced to investigate whether those issues had a bearing on any or some of the deaths and to allow the coroner to comment on the quality of supervision, treatment and care of the deceased patients. For example, evidence of the condition of the buildings at Graylands containing wards was provided in order to allow the Court to investigate whether the physical environment of the wards would have been more therapeutic had the buildings been refurbished.

11. That general evidence was useful in providing an overview of the context in which the deceased persons were treated for their mental illnesses; however, in my view many of the issues the subject of that evidence were not sufficiently connected with all the respective deaths for me to comment on those issues under s.25 (2) or (3) of the *Coroners Act 1996* generally as if they did.

12. I have therefore not addressed those general issues separately from a consideration of each death. Rather, where I have come to the view that the issues were connected with the death or were relevant to the quality of the supervision, treatment and care of the deceased, I have addressed them in the respective findings.

THE DECEASED

13. The deceased was born in Bitola, Macedonia on 25 January 1961. He had one sibling, an older sister named Vera.[1]

14. The deceased's name at birth was Trajce Josifovski, but when he came to Western Australia with his mother and sister in August 1971 he began to use the name Tom Foski. It is not known whether he changed his name by deed poll, but his sister made clear that he was known as Tom Foski, including by Centrelink.[2]

15. When the deceased came to Australia, he and his sister went to school at Biralee Primary School before going on to Balcatta Senior High School.

16. He finished school in year 10 and obtained work in a factory and a laboratory, then as a postman.

17. The deceased may have had a slight intellectual impairment. When he was 16 or 17 years old he began to display symptoms of mental illness, including delusions.

18. At one stage he went to Port Hedland to live with his sister and her husband for a few months. He was engaged by a mining company there, but that did not work out for him.

19. The deceased returned to Perth and lived with his mother in her flat. When the deceased was in his early twenties he became aggressive and difficult for his mother to manage. She grew afraid of him so she went back to Macedonia to live.

20. The deceased remained in his mother's flat and was provided with food and clean laundry by his sister who lived nearby with her husband.

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[1] ts 22
[2] ts 39-40

1986 TO 2003

21. Much of the following history was provided by the deceased's treating consultant psychiatrist for the last four years of his life, Dr Georgina Dell. The information came from Dr Dell's personal experience and from her review of the deceased's clinical files at Graylands.[3] Other information was obtained from his sister, who provided a statement to coronial investigators[4] and who gave evidence at the inquest held by Coroner Mulligan.[5]

22. In 1986 the deceased was admitted to Graylands for the first of 21 times prior to his final admission. He was diagnosed with mild mental retardation and antisocial personality disorder.[6]

23. Also in 1986, while the deceased was living at his mother's flat he set it on fire, which resulted in him being prosecuted for arson and being imprisoned for two years. It seems that his mental condition deteriorated further while in prison.

24. Once discharged from prison, the deceased was treated within the Royal Perth Hospital outpatient system while receiving day to day management and financial assistance from his sister. Among other things, she was able to arrange for him to receive payments from Centrelink, presumably for disability pension because of his mental illness.[7]

25. In 1988 the deceased was diagnosed with schizophrenia and was noted to have intellectual impairment. As time went on, he was also diagnosed with chronic paranoid schizophrenia. He suffered from treatment-resistant psychotic symptoms, especially chronic delusions, risk of aggression when more unwell, lack of insight into his illness and recurrent non-compliance with antipsychotic medication. In 1993 he was diagnosed with non-insulin-

[3] Ex 1, Vol 1, Tab 11
[4] Ex 1, Vol 1, Tab 7
[5] ts 22-48
[6] Ex 1, Vol 1, Tab 11
[7] Ex 1, Vol 1, Tab 1, Tab 7

dependent diabetes mellitus and was often non-compliant with the required diabetic medication and diet.[8] The deceased was also a heavy smoker.

26. The deceased was accommodated in hostels from time to time, but all of the placements were unsuccessful. He was then accommodated in his own unit. In 1995 the Public Trustee took over management of his finances.

27. In 1996, in an attempted suicide or possibly because of delusions about an ability to fly[9], the deceased jumped from his seventh storey flat and sustained head injury, fractured legs and perforation of the bowel. He was in a coma for six to eight weeks, had many operations, including an emergency laparotomy on his bowel, and spent almost two years in rehabilitation regaining the ability to walk.[10]

28. While the deceased eventually recovered well from the injuries suffered in the fall, he developed a large incisional abdominal hernia following the laparotomy.[11] He refused to have it treated.

29. In 1998 while the deceased was admitted for psychiatric care, he had a minor posterior myocardial infarction and was diagnosed with ischaemic heart disease.

FINAL ADMISSION TO GRAYLANDS

30. In early August 2003 the deceased was living in a flat in Northbridge after having been discharged from Graylands for about six weeks. He was receiving depot antipsychotic medicine from the Royal Perth Hospital Department of Psychiatry outpatient service but still suffered psychotic symptoms. He became increasingly unwell and suffered an ongoing period of delusions and aggression. On 6 August 2003 he was abusing and threatening people at a bank and when police attended

[8] Ex 1, Vol 1, Tab 11
[9] ts 28
[10] Ex 1, Vol 1, Tab 7
[11] Ex 1, Vol 1, Tab 11

he spat at them and threatened to blow up the world. Police took the deceased to a doctor who referred him to Graylands involuntarily under the *Mental Health Act 1996.*[12]

31. The deceased was admitted to Graylands as an involuntary patient and placed in a secure ward. He was ascertained to be incapable of returning to independent living because of his risk to the community from his aggression and because he could not look after himself or comply with his medications.[13]

32. Over the following year the deceased remained chronically psychotic. His medical problems included hypertension, ischaemic heart disease, non insulin dependent diabetes mellitus and the large abdominal hernia. He was managed as an acute patient while he was waiting to be placed in a long-term rehabilitation ward.[14] In June 2004 he suffered another myocardial infarction which was complicated by a pulmonary oedema.

33. In 2005 and 2006 the deceased's mental health symptoms and behaviour fluctuated markedly. He developed polydipsia (the excessive drinking of fluids) but his sodium levels were generally normal. His medical problems now included congestive heart failure and chronic obstructive pulmonary disease caused by his heavy smoking.[15]

34. Over the next year the deceased spent more time on open wards though his mental state and behaviour were mostly unchanged.

35. In February 2008 the deceased was transferred to the long stay team in Murchison Ward which had both an open and a secure rehabilitation ward. Though he was initially difficult to manage, over time he settled

[12] Ex 3 Vol 6
[13] Ex 1, Vol 1, Tab 11
[14] ts 89-90
[15] Ex 1, Vol 1, Tab 11

sufficiently for the team to consider him for the Community Options project, a new high support psychiatric accommodation available in the community.[16]

36. Throughout 2008 the deceased remained chronically psychotic and delusional. His polydipsia was becoming a concern due to the associated risks of hyponatraemia (low sodium levels) and exacerbations of his congestive heart failure.[17]

37. In 2009 and 2010 the deceased's medical problems remained reasonably stable and his mental state and behaviour had settled enough for him to stay on the open ward. In August 2010 he was accepted on a trial at a Community Options house on extended daily leave, but staff were unable to control his polydipsia and he was admitted to Sir Charles Gairdner Hospital for hyponatraemia and congestive cardiac failure. Upon discharge he returned to the Community Options house, but his psychotic symptoms, aggression, polydipsia and non-compliance with medication resulted in a return to Graylands.[18]

38. In November 2010 the deceased was again admitted to Sir Charles Gairdner Hospital following a collapse. A pulmonary embolism was suspected but he refused a lung scan.[19]

39. In February 2011 the deceased was given another trial at the Community Options house but, after recurrent admissions to Sir Charles Gairdner Hospital for congestive heart failure, hyponatraemia and pulmonary embolisms over the next three months, in July 2011 he was returned to Graylands and his trial at the house was terminated. In August 2011 he was again found collapsed with hyponatraemia and congestive heart failure.[20]

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[16] Ex 1, Vol 1, Tab 11
[17] Ex 1, Vol 1, Tab 11
[18] Ex 1, Vol 1, Tab 11
[19] Ex 1, Vol 1, Tab 11
[20] Ex 1, Vol 1, Tab 11

40. In December 2011 the deceased was kept in the secure area of Murchison Ward West indefinitely in order to supervise him in an effort to control his polydipsia, but on 29 December 2012 he was admitted at Sir Charles Gairdner Hospital again with hyponatraemia, swelling ankles and shortness of breath.[21]

41. In February 2012 he was placed on 15 minute observations to try to stop his fluid consumption and his sodium level was checked regularly. He was allowed access to the grounds with an escort in order to ensure that he did not obtain fluids while out of the ward. On 3 April 2012 the deceased again collapsed with acute pulmonary oedema. Apart from treatment for that condition, he was also started on insulin injections for diabetes.[22]

EVENTS LEADING UP TO THE DEATH

42. In late April 2012 the deceased's weight increased alarmingly by over 10 kilograms in two weeks, possibly from fluid retention due to his congestive heart failure, or from consumption of fluids or from the use of insulin.[23] That weight change was recorded by a nurse but not brought to the attention of the deceased's medical officer, Dr Francisco Rosell.[24] Because of the deceased's large abdominal hernia, his weight gain around his abdomen would not have been readily apparent[25].

43. On the morning of 3 May 2012 the deceased was reviewed by Dr Dell and Dr Rosell. They noted that his ankles were swollen with oedema. That afternoon the oedema had improved but had not resolved, so on the morning of 4 May 2012 Dr Rosell prescribed a diuretic.[26]

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[21] Ex 1, Vol 1, Tab 15
[22] Ex 1, Vol 1, Tab 11
[23] ts 136
[24] ts 137
[25] ts 136-137
[26] ts 135

44. On the morning and early afternoon of 6 May 2012 the deceased spent most of his time sitting in the lounge. At about 3.30pm that afternoon a patient knocked on the window of the nurses' station in Murchison Ward and told Philip Ibbertson MHNC and Comfort Boyah EN that the deceased was lying on the floor of the men's toilet.[27]

45. The two nurses found the deceased as described. Nurse Ibbertson commenced cardiopulmonary resuscitation while Nurse Boyah activated the 55 emergency call for the emergency team, who were located in Murchison Ward. Another nurse, Jeffrey Day MHNC, assisted Nurse Ibbertson. The emergency team attended quickly as did the duty medical officer, Dr Ahmadullah Fazli.

46. Ambulance paramedics also attended in a short time because they had been dropping off a patient at Graylands when Nurse Boyah made the emergency call. They conveyed the deceased to Sir Charles Gairdner Hospital and continued resuscitation on the way, but the deceased did not respond.[28]

47. At Sir Charles Gairdner Hospital the deceased received continued cardiopulmonary resuscitation but could not be revived. He was declared deceased at 4.30pm.

CAUSE AND MANNER OF DEATH

48. Forensic pathologist Dr Jodi White conducted a post-mortem examination of the deceased on 8 May 2012. Dr White found a markedly enlarged and hypertrophied heart with underlying moderate to severe coronary artery disease. The lungs were heavy and fluid laden with a large right sided pleural effusion, ascites and peripheral oedema. The kidneys were markedly scarred and the liver was congested.

49. Dr White concluded that the cause of death was congestive cardiac failure in association with ischaemic

[27] Ex 1, Vol 1, Tab 24
[28] Ex 1, Vol 1, Tab 17

and hypertensive heart disease. I accept Dr White's conclusion as the cause of death.

50. I find that the manner of death was natural causes.

QUALITY OF SUPERVISION, TREATMENT AND CARE

51. The deceased was undoubtedly a difficult patient to manage, but I am satisfied on the evidence available to me that the treatment and care of the deceased with respect to his psychiatric and medical conditions was reasonable and appropriate. The eight thick volumes of Graylands medical and nursing records chronicling the considerable amount of time and energy expended on the deceased's care and management during his last admission make this clear.[29]

52. An example of the personal commitment of the staff at Graylands can be seen in Dr Rosell's evidence when he noted that in 2012 the deceased became upset about having to undergo blood tests, so Dr Rosell would regularly have to beg the deceased to do the test, which became routine for him for the last year of the deceased's life.[30]

53. Dr Rosell also described how, in addition to a weekly formal review, he would check on the deceased's physical state two or three times a week when he went to Murchison Ward to see other patients and on every Friday before he left for the coming weekend.[31]

54. It is also worth noting that the deceased's sister considered that the deceased was well looked after from a physical perspective.[32]

[29] Ex 3
[30] ts 132
[31] ts 13
[32] ts 46

55. However, one aspect of the deceased's care which deserves comment was the deceased's inability to use his own funds to improve his quality of life, especially in relation to the major complaint for patients at Graylands: boredom.

56. As described previously, in 1995 the deceased's finances began to be managed by the Public Trustee.[33] The deceased received a disability support pension through Centrelink, but for the last few years of his life he was not charged for his care at Graylands.[34] The only time he paid any fees was when he was on trial leave to the Community Options house in 2010 and 2011.[35]

57. It appears that the pension which the deceased received by 2012 may have amounted to around $750 a fortnight. The Public Trust provided him with a fortnightly allowance of $260 to cover his tobacco and food from the kiosk at Graylands, and clothing was purchased for him with the help of the welfare officer at Graylands who would request the extra funding from the Public Trust.[36] If the deceased did not spend his allowance, it would build up to the point where Graylands staff would transfer the accumulated funds back to the Public Trustee. In that way, $3,500 of the deceased's allowance was sent back to the Public Trust in 2008 and 2009.[37]

58. As a result of these arrangements, the deceased was able to accumulate over $60,000 in his Public Trust account by the time he died. The question arising is whether that money would have been better used for the deceased's pleasure or distraction.

59. In particular, it was suggested that some of those funds could have been used to pay for a private carer to take the deceased on regular excursions, for example, to a

[33] Ex 1, Vol 1, Tab 31
[34] ts 118
[35] Ex 1, Vol 1, Tab 34
[36] Ex 1, Vol 1, Tab 34
[37] ts 169

coffee shop given the deceased's love of 'proper coffee'. Up until about four years before his death, the deceased could walk to a local café for a coffee, but in the final three years he could not do so because of his lack of fitness and his shortness of breath.[38]

60. According to Ms Lenka Bottger, the deceased's welfare officer at Murchison Ward, 95% of rehabilitation patients at Graylands have their finances administered by the Public Trustee.[39] While on its face the suggestion that the deceased and other patients like him at Graylands should be able to use their own funds to engage a private carer seems reasonable, the evidence demonstrated several complicating factors.

61. One factor is the question of whether providing more money to a patient would be detrimental from a clinical perspective. Dr Dell said that in the deceased's case, the experience at Graylands was that if he were given more money he would buy more tobacco and would smoke more, which was a big concern because of his congestive heart failure and chronic obstructive pulmonary disease. He would also buy sugary snacks, which was also of concern given his diabetes.[40]

62. Another factor was the confidentiality that attached to a patient's account with the Public Trustee. If Graylands staff considered supporting a purchase by a patient, they had no way to know how much money the patient had to spend unless the patient told them, and the patients would often not know themselves.[41]

63. In addition, if a patient might in future be moving into other accommodation where they would be paying rent, the Public Trustee would be concerned about ensuring that there was sufficient money for rent and associated costs such as bond and furniture.

[38] ts 55
[39] ts 177
[40] ts 117
[41] ts 118

64. Despite these considerations, Dr Dell considered that patients who were unlikely to move back into the community should use their Public Trust funds to improve their quality of life. She said that she had approved the purchase of such things as TVs, computers, Playstations and special beds.

65. However, as to the employing of private carers, there had been many problems. It was difficult to find carers who are willing and available. Carers were also untrained in mental health and could be difficult to match up with patients. There was a high turnover of those who were available, which was difficult for someone like the deceased who would take some time to get to know the carer only to then lose him or her. There were also the obvious risk and responsibility issues.[42]

66. In these circumstances, the potential use by the deceased of his own funds in order to employ a carer was likely to have been more difficult than might first appear. But this is not to say that steps should not be taken to endeavour to use a patient's surplus funds to that end if possible and practicable from a clinical and financial perspective.

67. It seems to me that it may be practicable for a procedure to be implemented whereby case managers at Graylands are able, with the consent of a patient's guardian or responsible next of kin, to obtain details of a patient's funds at the Public Trustee's Office. Once armed with that information, the case managers could consider whether and how those funds could be used to provide improvements to the patient's environment, including through the engagement of carers where appropriate. Consultation with the patient and further consultation with the Public Trustee might lead to identified improvements being implemented.

[42] ts 119

68. I therefore make the following recommendation.

RECOMMENDATION

I recommend that case managers of long term mental health inpatients whose finances are controlled by the Public Trustee's Office consult with the Public Trustee with a view to implementing a process of exchange of information in order to use funds held on behalf of the patients to improve the patients' quality of life.

CONCLUSION

69. The deceased suffered the debilitation of mental illness from his late teens, terribly affecting his life and the lives of his family members.

70. He also suffered many physical problems, most of which were connected in some way to his mental illness.

71. While reasonably young, he died from the effects of those physical problems, especially heart disease, despite receiving appropriate ongoing care and treatment at Graylands.

Barry King
Coroner
11 April 2014