Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 50/12

I, Barry Paul King, Coroner, having investigated the death of ***Amanda Alison Gilbert*** *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* ***Amanda Alison Gilbert*** *and that death occurred on* ***22 January 2010*** *at* ***Graylands Hospital*** *from* ***bronchopneumonia in a woman with ischaemic heart disease, chronic renal failure and past hypoxic brain injury*** *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 on behalf of Graylands Hospital

Table of Contents

INTRODUCTION

1. Amanda Alison Gilbert (**the deceased**) died on 22 January 2010 at Graylands Hospital (**Graylands**) at the age of 47 from bronchopneumonia on a background of ischaemic heart disease, chronic renal failure and past hypoxic brain injury.[1]

2. She had been admitted to Graylands as an involuntary patient in 1987 and had remained there until her death. She suffered from both mental illness and brain damage.[2] No other facility in Western Australia was willing or able to care for her.[3]

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

4. 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.

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

6. 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.

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

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[1] Ex 1, Vol 1, Tab 7
[2] Ex 1, Vol 1, Tab 11 p.1
[3] ts 82, 83 Ex 1, Vol 3, Tab 2 p.182-183

8. A joint inquest commenced before Coroner D.H. Mulligan in the Perth Coroner's Court on 27 August 2012. Evidence was provided relating to the deaths of two of the other nine deceased persons. The inquest was then adjourned until it recommenced on 11 March 2013 when evidence relevant to another deceased person was adduced.

9. On 13 March 2013 evidence specific to the deceased was adduced. The hearings were completed on 22 April 2013.

10. 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.

11. 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.

12. 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.

13. 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.

14. 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 potentially relevant to the quality of the supervision, treatment and care of the deceased, I have addressed them in the respective findings.

THE DECEASED

15. The deceased was born in England on 13 April 1962 as the fourth child of 8 siblings. She and her family moved to Australia in 1964.[4]

16. The deceased attended Iona Primary School in Mosman Park and St Paul's Primary School in Mount Lawley.[5] She was described as a bright and strong-willed student who related well with her peers. She left school when she was 16 years old and worked in retail clothing shops for a number of years.

17. When the deceased was 14 years old she was referred to a private psychiatrist and diagnosed with an adolescent crisis.[6]

INITIAL ADMISSIONS AT GRAYLANDS

18. In 1980 when the deceased was 18 years old, she moved out of the family home following disagreements with her parents. She began living with her sister in a

[4] Ex 1, Vol 1, Tab 10 p.1
[5] Ex 1, Vol 1, Tab 10
[6] Ex 1, Vol 4, p.30

flat but moved out again soon after disagreements with her and moved in with another young woman in a flat above. She then became fixated on a young man who was seeing her flat-mate. The deceased moved back to the family home. When her affections for the young man were not reciprocated, she persisted in demanding his attention and then began to display psychotic symptoms.[7]

19. The deceased presented at Sir Charles Gairdner Medical Centre psychiatric unit with a history of progressively deteriorating behaviour for three months. She had been withdrawn and sometimes deluded. She had recently become aggressive towards her parents, at one stage driving a car into her mother's leg. At the time, two of her sisters were being treated for serious mental illness. She refused to be admitted to the hospital so was referred to Graylands where she was admitted for a week.[8] She was diagnosed with reactive psychosis or severe anxiety reaction.

20. In May 1981 the deceased was again referred to Graylands from Sir Charles Gairdner Hospital as an involuntary patient. She was treated by a psychiatrist, Dr W C Chiu, who would continue to see her over the next few years both in Graylands and at Balga Clinic. The deceased was suffering thought disorders and hallucinations, and she had been running around naked. Dr Chiu diagnosed her with psychogenic psychosis with features of anorexia nervosa.

21. At this time the deceased was pregnant but she vacillated between acknowledging the pregnancy and denying it. The deceased decided to terminate the pregnancy, which occurred at the end of June 1981[9], following which the deceased's mental state improved rapidly. She was discharged on 3 July 1981 and continued to do well with ongoing review by Dr Chiu at Balga Clinic.

[7] Vol 4, p.30
[8] Ex 1, Vol 4, p.22, 29
[9] Ex 1, Vol 4, p.46, 51, 52

22. In May 1982 the deceased was again admitted to Graylands, this time voluntarily after calling Dr Chiu by telephone. She presented with paranoid psychosis and asked to be admitted for more security. She had been raped earlier in the year and had normal reactions to it, but was anxious about a pending preliminary hearing at which she would be questioned by a defence counsel.[10]

23. At Graylands the deceased's paranoid ideations continued for some time as did suicidal ideation. It was discovered that she was pregnant to her boyfriend.

24. The prosecutors in the case against the man who raped the deceased decided not to call her as a witness, and her condition improved considerably as a result. She was discharged after five weeks with a diagnosis of acute schizophrenic episode.

25. In early August 1983 the deceased was admitted to Graylands after a referral from Dr Chiu. By this stage she had an eight month old baby boy. She was again suffering from psychotic delusions and was unable to cope.[11] Her status was changed to involuntary, but she was accommodated in an open ward.

26. The deceased was again diagnosed with an acute schizophrenic episode and a significant depressive component was noted. She was discharged to live with her sister and follow up was organised with Dr Chiu at Balga Clinic.[12]

27. Three months later in November 1983 the deceased was again referred to Graylands as a voluntary patient by Dr Chiu. She had been working in a retail clothing shop and had complained of tiredness. She started taking over-the-counter stimulants which led to a loss of

[10] Ex 1, Vol 4, p.61
[11] Ex 1, Vol 4, p.70-75
[12] Ex 1, Vol 4, p.76

appetite and depression. She could not cope with the worry of caring for her 11 month old son.[13]

28. On this occasion the deceased displayed no psychosis or severe depression. She felt better the day after admission so was discharged with a final diagnosis of situational reaction.[14]

29. In August 1984 the deceased presented voluntarily to Graylands after she had been unable to cope with having to look after her son, four nights of insomnia, adverse reactions to her mother, a poor financial situation and the recent death of her sister's boyfriend.[15]

30. The treating psychiatrist at Graylands noted that the deceased's family history included extremely pathological family dynamics, but social workers could offer no alternative. The deceased was discharged after psychotic symptoms settled quickly following treatment with her usual medications: thioridazine and fluphenazine. Her final diagnosis was acute schizophrenic episode.

31. Four weeks previously, the deceased had been admitted to Sir Charles Gairdner Hospital and had been diagnosed with manic depression. She had been treated with lithium and stelazine, but she had failed to comply with the dosage. This appears to have been the first time at which the deceased was prescribed lithium.[16]

32. From 13 February 1985 the deceased was admitted to Graylands for four weeks when she suffered a manic depressive psychosis characterised by paranoid delusions. During the admission the deceased jumped from an upstairs window with a mattress in a psychotic state, believing she was on a surfboard. She was not hurt.[17]

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[13] Ex 1, Vol 4, p.78
[14] Ex 1, Vol 4, p.79
[15] Ex 1, Vol 4, p.81
[16] Ex 1, Vol 4, p.81
[17] Ex 1, Vol 4, p.90

33. The deceased was treated with modecate and lithium to which she responded well. She was discharged to her parents' home with follow up at Havelock Clinic where she had been attending for months.[18]

SUICIDE ATTEMPT

34. On the evening of 7 April 1985 the deceased was at home with her siblings and her sister's husband. Her parents were out. The deceased's brother found the deceased hanging from the neck with twine cord just outside a playroom. The family members had no inkling that the deceased had intended to commit suicide.

35. Her brother-in-law cut her down and administered cardiopulmonary resuscitation until ambulance officers attended and took the deceased to Royal Perth Hospital. The deceased survived the suicide attempt, but she had suffered hypoxic damage to her brain.[19] This significantly altered her mental state and left her permanently unable to care for herself due to a severely impaired cognitive and memory functions.

36. As the deceased was unmanageable in a medical ward, she was transferred to Graylands from Royal Perth Hospital on 3 May 1985. She was successfully treated with haloperidol and lithium for her mania.[20]

37. A grave concern at the time was a lack of facilities for brain damaged young adults in Western Australia.[21] The deceased was assessed for rehabilitation at the Shenton Park rehabilitation facility, but little could be offered her there.[22]

38. Graylands was seen as the only alternative, but attempts were made to locate an alternative.

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[18] Ex 1, Vol 4, p.96
[19] Ex 1, Vol 1, Tab 10 p.3, Ex 1 Vol 4, p.101
[20] Ex 1, Vol 4, p.105
[21] For example: Ex 1, Vol 4, p.106, 109, 110-111, 148, 149
[22] Ex 1, Vol 4, p.109

39. After a month's trial placement at the Beverly Rural Unit starting in late August 1985, she was transferred there from Graylands on 19 September 1985 and settled in well initially.[23]

40. The deceased progressed well at the Beverly Rural Unit until January 1986 when her lithium and haloperidol were ceased and her behaviour began to deteriorate. By May 1986 staff at the facility had determined that the deceased was unsuitable for their facility, so they transferred her back to Graylands.[24]

41. A place was then sought for the deceased in a head-injured ward of the Inglewood Home of Peace and the deceased was eventually transferred there in April 1987.[25]

42. On 2 June 1987 the deceased was returned to Graylands because she could not be managed at the Inglewood Home of Peace. She had wandered off into the street, stripped in front of male visitors, urinated in inappropriate places, and had stolen other patients' property.[26] Given a lack of alternatives, her long term prognosis was intensive hospital care.[27]

43. On 3 June 1987 the deceased was admitted into Murchison Ward at Graylands, the mixed-gender long-stay unit.[28]

1987 TO 1997

44. The deceased was a difficult patient for the staff at Graylands to manage. She was impulsive, labile, sometimes aggressive, provocative and interfering with other patients.

[23] Ex 1, Vol 4, p.140
[24] Ex 1, Vol 4, p.161
[25] Ex 1, Vol 4, p.177
[26] Ex 1, Vol 4, p.263, 275
[27] Ex 1, Vol 4, p.262
[28] Ex 1, Vol 4, p.232

45. Alarmingly, the deceased suffered frequent and regular assaults from other patients. Most were minor in nature, but some were sufficiently serious to require treatment. There were at least 111 incidents of assaults on the deceased from March 1988 to July 1997. A large proportion of these incidents were provoked by the deceased intruding or interfering with other patients or their property. Many were also unprovoked, being the result of other patients' mental states. As time went on, the deceased also became aggressive to other patients and to staff.[29] Staff regularly placed the deceased in seclusion as a means of settling her down.

46. The deceased was also found in sexually compromising situations with male patients while in Graylands. In 1991 and 1992 in particular, she was regularly found in a state of undress in the male toilets with a male patient. A letter apparently written in 1997 by a consultant psychiatrist at Graylands contains the assertion that there had been 26 reported incidents when the deceased was the victim of attempted sexual assaults by male patients over a six month period.[30]

47. Over time, the deceased also began to suffer from falls due to an unsteady gait which was a function of her brain damage. It seems that the first serious injury the deceased received from a fall was in August 1994 when she lacerated her lip.[31] Worse injuries occurred later.

48. The unsuitability of the deceased's placement in Murchison Ward was, not surprisingly, recognised by the medical staff looking after her. Staff treating the deceased made further efforts to find a more appropriate environment for the deceased.

49. In 1994, a team led by Dr Craig White made an application for the deceased to be placed in a nursing home. In order to submit the application, an approval

[29] Ex 1, Vol 3, Tab 2 p.83, 101-106
[30] Ex 1, Vol 3, Tab 2 p.134
[31] Ex 1, Vol 5, Tab 3 p.41

had to be obtained from a geriatric assessment team, so one was sought. Graylands was informed by letter from psychogeriatrician Dr N F Hills that the approval was refused, apparently because of a mistaken view that the deceased did not require assistance with the activities of daily living.[32]

50. Dr White wrote to the Minister for Health to review the refusal under the National Health Act. The letter stated that the deceased had significant physical disabilities and required placement in a nursing home to protect her from frequent assaults and to provide her with a high level of care.[33]

51. In addition, the acting Director of clinical service at Graylands, Dr Carolyn Graham, wrote to Dr Hills to request a further review of the deceased's case, citing several reasons why the deceased would be better placed in a nursing home, including the need for protection from assaults.[34] As a result, the deceased was re-assessed by Dr Hills who, in a letter to Graylands dated 19 December 1994, confirmed his earlier assessment on the basis that the deceased required a level of special nursing care and attention that was beyond the care which could reasonably be expected of any nursing home.[35]

52. Dr Hills also said that it was painfully obvious that the deceased required an intensive rehabilitation program. He expressed the view that the deceased required a small, structured, intensive rehabilitation effort, but that he did not know of anyone who could provide one adequately.[36]

53. In 1996 clinical psychologists at Graylands contacted the Disability Services Commission to seek a grant to enable a social trainer to be engaged to improve the

[32] Ex 1, Vol 3, Tab 2 p.48
[33] Ex 1, Vol 3, Tab 2 p.51-52
[34] Ex 1, Vol 3, Tab 2 p.54-56
[35] Ex 1, Vol 3, Tab 2 p.57-59
[36] Ex 1, Vol 3, Tab 2 p.59

deceased's quality of life.[37] That commission rejected the application on the basis that the provision of staff providing services to patients was the responsibility of the Health Department.[38] This impasse highlighted a systemic anomaly whereby a patient diagnosed with both a mental illness and a mental disability would not receive assistance for the disability even where it was the dominant problem.

54. Over this time the treating team also tried a number of strategies to address the problems in managing the deceased, including changes to the deceased's medication, behavioural programs, seclusion and constant supervision. Because of the staffing ratios, the use of special nursing whereby a nurse was assigned specifically to a patient required funding out of the general budget allocation so could not be maintained for long.

55. In January 1997 a psychiatric registrar at Graylands wrote to the Office of Public Advocate for assistance in the reassessment of the deceased's placement.[39] In May 1997 the Public Advocate was appointed as the deceased's limited guardian with functions to determine her accommodation and to advocate on her behalf to seek assistance and funding for her accommodation and care.[40] The Office of the Public Advocate agitated for Graylands to seek funding for a renovation to Murchison Ward to change two large rooms into four smaller ones in order to separate the deceased from other patients.[41]
56. More importantly, the Office of the Public Advocate was instrumental in obtaining the allocation by the Health Department of funding to provide for one-to-one nursing care of the deceased commencing in 1997. The implementation of that care effectively dealt with the situation in which the deceased was subject to assaults from other patients, but it was seen by Graylands staff

[37] Ex 1, Vol 3, Tab 2 p. 89
[38] Ex 1, Vol 3, Tab 2 p. 96
[39] Ex 1, Vol 3, Tab 2 p.136
[40] Extra material file Tab 7 p.6-7
[41] Ex 1, Vol 3, Tab 2 p.149

as a short to medium term solution. The long term solution was seen to be placement in a specialist care facility,[42] but that never happened.

1998-2008

57. During the period from 1998 to 2008 the deceased suffered several falls, a number of which required attendance at Sir Charles Gairdner Hospital for treatment of injuries.[43]

58. Around January 2006 the night staff at Graylands began to monitor the deceased because of her frequent falls.

59. Earlier, during 1996 the deceased's creatinine levels were noted to be slightly raised indicating possible kidney impairment. The creatinine levels were monitored regularly and by September 1997 they were seen to be improving. By May 1998 the levels were rising again, so her lithium medication was stopped since it was known to be a risk of causing renal failure.[44]

60. On 19 August 1998 the deceased was admitted to Sir Charles Gairdner Hospital with aspiration pneumonia. While there she developed malignant hypertension, acute renal failure and diabetes insipidus. The pneumonia and the hypertension were difficult to control. Both the renal failure and the diabetes insipidus were thought to be secondary or precipitated by her previous lithium use.[45]

61. Following that episode, the deceased's cognitive and personality functions deteriorated further. She remained at Graylands as there was nowhere else for her.

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[42] Ex 1, Vol 3, p.156-158, 172
[43] Ex 1, Vol 2, p.1,13,17,19,33-Vol 3, p.34-36
[44] Graylands IPN 14/5/98
[45] Ex 1, Vol 2, p.25

62. Over the next few years the deceased was managed with anti-hypertensive medication, an altered diet and supervision at meal times to reduce the risk of aspiration. Her high blood pressure remained difficult to manage. In the latter half of 1999 the deceased's blood pressure and renal function improved,[46] but both deteriorated after that.

63. In July 2007 the deceased saw renal physician Dr Wai Lim at Sir Charles Gairdner Hospital. Dr Lim diagnosed the deceased as suffering from 'chronic renal impairment secondary to renovascular disease/hypertensive nephrosclerosis +/- lithium toxicity'.[47]

64. By the beginning of 2008 the deceased's renal condition was considered terminal. Following extensive discussions with Dr Lim and the deceased's family, it was decided to manage this condition without dialysis because of the deceased's inability to cooperate with the procedure. Graylands continued to care for the deceased in liaison with the renal unit at Sir Charles Gairdner Hospital.

2008 TO 2010

65. The deceased's physical health declined progressively over the next two years. She became more frail and unsteady. She suffered from episodes of anorexia and vomiting.[48]
66. In the latter half of 2009 the deceased became increasingly agitated and aggressive towards staff, and she continued to suffer from anorexia and vomiting. Her kidney function declined further.

67. In early January 2010 Graylands staff contacted Dr Lim to inquire whether any conservative interventions could

[46] Ex 1, Vol 3, p.219
[47] Ex 1, Vol 2, p.10-11
[48] Ex 1, Vol 1, Tab 11

improve her clinical state, but his view was that none were available.

68. On 20 January 2010 the deceased's blood pressure was low and she was unsteady when walking.

69. The next day her blood pressure remained low, her pulse was slow and she was vomiting.[49] Following the administration of medication, she stopped vomiting and was able to tolerate fluids. Her blood pressure and pulse improved a bit but were still low. She had a restless night.

70. At about 6.00am on 22 January 2010 the deceased had a chesty cough and had vomited a little. At about 8.00am she was found collapsed and unresponsive in her room. Resuscitation was attempted without success and she was declared life extinct at 8.20am.[50]

CAUSE AND MANNER OF DEATH

71. Chief Forensic Pathologist Dr C T Cooke conducted a post mortem examination of the deceased on 29 January 2010 and arranged for further examinations including neuropathology.

72. Dr Cooke found enlargement of the heart and scarring of the heart muscle consistent with past ischaemia. There was also narrowing of the arteries on the surface of the heart and features of heart and kidney failure. Microscopic examination confirmed ischaemic heart disease, chronic renal failure and bronchopneumonia in the lungs.[51]

73. An examination by neuropathologist Dr V A Fabian found a cavitating lesion in the left caudate nucleus and adjacent putamen extending to involve the globus pallidus. As I understand it, the lesion was the result of

[49] Ex 1, Vol 6, Tab 12 p.2
[50] Ex 1, Vol 1, Tab 11 p.2
[51] Ex 1, Vol 1, Tab 7

the hypoxia which the deceased suffered when she hanged herself in 1985.[52]

74. Dr Cooke concluded, and I find, that the deceased died from bronchopneumonia in a context of ischaemic heart disease, chronic renal failure and past hypoxic brain injury.[53]

75. To the extent that the cause of the deceased's renal failure was related to the administration to her of lithium, it is clear that the lithium was necessitated by the deceased's mental illness.

76. In these circumstances I find that the deceased died as a result of natural causes.

QUALITY OF SUPERVISION TREATMENT AND CARE

77. There is no doubt that the deceased was a difficult case for medical and nursing staff at Graylands to manage. As well as requiring treatment for her psychiatric problem, she also required constant care for behavioural issues stemming from the brain damage arising from the hypoxia suffered in 1985. In addition, she had several significant physical health issues that required ongoing care.

78. While at Graylands for the first ten years of her last admission, the deceased was assaulted frequently and regularly, both physically and sexually. That it was likely that she provoked or instigated many of those assaults is, of course, not relevant since she needed protection from the effects of her own psychotic or disinhibited behaviour.

79. In my view, the evidence available to me makes clear that the staff at Graylands did what they could to manage the deceased appropriately with the resources available to them. Graylands was not an appropriate

[52] Ex 1, Vol 1, Tab 8
[53] Ex 1, Vol 1, Tab 7

environment for her, but no other facility was willing or able to care for her. There was no facility in Western Australia that could provide suitable care for a relatively young person suffering from mental illness and brain damage.

80. Following the commencement in 1997 of funding for one-to-one care, there was a vast improvement in the deceased's care since the assaults were curtailed and she could be accommodated in an open ward.

81. Dr G M Dell, a consultant psychiatrist who treated the deceased at Graylands for many years including the last eight years of her life, noted that once the deceased had one-to-one nursing care, there were no concerns for her supervision or the provision of daily living needs. The funding for the one-to-one care was not made permanent, but from 2004 there was an acceptance that it would be in place.[54]

82. The evidence indicates that the deceased received regular care from health professionals including dieticians, speech pathologists, dentists, clinical psychologists, social workers, occupational therapists and podiatrists. She was provided with regularly updated nursing care plans and team meetings were held regularly to organise her on-going management.

83. The deceased was administered lithium at Graylands off and on from 1988 because it improved her quality of life. From 1993 lithium was prescribed continuously, and the lithium levels together with creatinine levels were monitored relatively closely with the realisation of the potential that lithium can lead to renal failure.

84. There was no evidence to suggest or imply that the administration of lithium was in itself inappropriate or that the dosages prescribed were too high.

[54] ts 15/4/13 p.80

85. In 1998 the deceased's prescription to lithium was halted when a reduction in her kidney function was noted in her regular blood tests. She was admitted to Sir Charles Gairdner Hospital with a resistant form of aspiration pneumonia and while there developed malignant hypertension, acute renal failure and diabetes insipidus, possibly from the lithium.

86. Unfortunately, her kidney function continued to decline. In 2005 she was diagnosed with osteoporosis, vitamin D deficiency and hyperparathyroidism secondary to chronic renal impairment. In 2007 her renal function deteriorated further and contributed to her death in January 2010.

87. I am satisfied on the evidence available to me that the treatment and care of the deceased at Graylands with respect to her mental illness, her mental disability and her chronic renal failure was appropriate in the circumstances.

RECENT PLACEMENT OPTIONS

88. Dr Dell provided evidence about the current situation. She described the following beneficial changes:[55]

    a. Graylands has had segregated wards since 2000, so the deceased would not be in danger of sexual exploitation if she were admitted today;

    b. Graylands has more wards than just Murchison Ward available to move patients if a different environment is required;

    c. in 2010 Graylands was reconfigured into two streams, acute beds and a clinical rehabilitation service so there are many more wards and some increases in staff;

[55] ts 81- 84

d. Brightwater aged care facility now has a program for young people under 18 years of age with intellectual disabilities or brain injury;

e. some nursing homes have developed high dependency units; and

f. there is beginning to be some planning for patients suffering from both mental illness and brain injuries to be placed at Community Options group homes. Evidence relevant to Graylands generally indicated that the waiting list for a place in a Community Options home is 12 months.

89. Dr Dell's view was that, if a patient with the deceased's problems were to come into the mental health system now, she would be managed on a different ward with one-to-one nursing care, or she may be able to be placed at Brightwater or a high dependency unit at a nursing home.[56]

90. The gravamen of that evidence is that, at the time Dr Dell provided evidence in April 2013, the situation for young people suffering mental illness and organic brain damage has improved somewhat since the deceased was admitted to Graylands.

CONCLUSION

91. The story of the deceased's life is both sad and distressing. She suffered from the terrible misfortune of mental illness from a young age. At 23 years of age her suffering was compounded when she hanged herself, causing hypoxic brain damage.

92. From that time the deceased was completely dependent on institutions, primarily Graylands. Her ongoing symptoms caused her to provoke and annoy other patients and left her vulnerable to physical and sexual

[56] ts 84, 85

assaults. As time went on, she became violent and aggressive both to other patients and to her carers.

93. For ten years, a lack of sufficient funding meant that the health system in Western Australia was unable to provide the deceased with the level of supervision and care she needed. Graylands, as the only institution able or willing to care for the deceased, made the best of difficult circumstances.

94. Once funding was allocated to provide one-to-one nursing, the physical violence suffered by the deceased was alleviated, and she was provided with the benefits of ongoing constant care and attention for several years.

95. However, there is no doubt that the deceased's adult life was an unmitigated tragedy.

B P King
Coroner
11 April 2014