Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 33/17

I, Barry Paul King, Coroner, having investigated the death of ***Radwan Kanawati*** *with an inquest held at* ***Perth Coroner's Court*** *on* ***22 August 2017****, find that the identity of the deceased person was* ***Radwan Kanawati*** *and that death occurred on* ***17 October 2014*** *at* ***26 Hinkler Street, Kenwick,*** *from* ***atropine toxicity*** *in the following circumstances:*

Counsel Appearing:

Ms F M Allen assisted the Coroner
Mr C S Bydder and Ms J A Godfrey (State Solicitor's Office) appeared on behalf of the North Metropolitan Health Service and the East Metropolitan Health Service

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INTRODUCTION

1. On 17 October 2014 Radwan Kanawati (the deceased) died after ingesting a toxic quantity of atropine, a prescribed medication.

2. The deceased's death was a 'reportable death' under section 3 of the *Coroners Act 1996* (the Act) because it 'appears 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 subject to a community treatment order under the *Mental Health Act 1996* (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. I held an inquest into the deceased's death on 22 August 2017 at the Perth Coroners Court. The evidence adduced at the inquest comprised documentary evidence and oral testimony. The documentary evidence consisted of an investigation report and associated attachments prepared by Detective First Class Constable B N Tabet of the Coronial Investigation Squad in the Western Australia Police, together with medical reports and records obtained by the Court.[2]

[1] s3 *Mental Health Act 1996* (repealed)
[2] Exhibit 1, Volumes 1, 2 and 3.

8. Oral testimony was provided by:

   a) Dr Winston Choy, one of the deceased's treating psychiatrists at Bentley Health Service;[3]

   b) Dr Natalie Pyszora, a forensic consultant psychiatrist who was the deceased's supervising psychiatrist under the community treatment order;[4]

   c) Nurse Judi Tilley, a clinical nurse specialist at Bentley Health Service in 2014; and

   d) Darrell Andrews, an operations manager at Cam Can Incorporated (Cam Can), an organisation providing support to persons with disabilities.

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 there were deficiencies in the otherwise excellent supervision, treatment and care provided to the deceased.

THE DECEASED

11. The deceased was born in Perth on 26 August 1973, making him 41 years old at the time of his death. He was the youngest of nine children. He was born three months prematurely and was noted to be deaf at the age of three. Hearing aids were fitted but he preferred not to use them. He had learning difficulties but learned to sign and to lip-read.[5]

12. In late 1988 the deceased was referred by a school nurse to Fremantle Hospital with symptoms of psychosis. He was then referred to the Robinson Unit at Hillview Child and

[3] ts 5-24 per Choy, W K C
[4] ts 24-39
[5] Exhibit 1, Volume 1, Tab 11.1

Adolescent Clinic (Hillview) in East Victoria Park, where he stayed for five months.[6]

13. The deceased presented to Fremantle Hospital again in 1989 with affective changes, auditory hallucination and grandiosity. In early November 1989 he indecently exposed himself on two separate occasions, leading to police charges and to the imposition of a good behaviour bond. Later that month, his care was transferred back to Hillview.[7]

14. In January 1990 the deceased was admitted for three months to Heathcote Hospital and was diagnosed with schizoaffective disorder. He was again admitted to Heathcote Hospital in August 1990 after a psychotic relapse following the cessation of prescribed lithium. He was thought to have an underlying intellectual impairment, with an IQ of 75, and was noted to have a personality that included immature traits, poor impulse control and poor social judgement. At the end of that admission he was charged with deprivation of liberty, sexual assault, attempted sexual assault and indecent dealings, all in relation to a five year old girl.[8]

15. The deceased continued to live with his parents, and from 1990 to 2005 he had at least 11 admissions to hospital, primarily Armadale Mental Health Service. In 1994 his diagnosis was bipolar affective disorder. He was prescribed various medications but was sometimes non-compliant with them. He had insulin-dependent diabetes.[9]

16. In 2009 the deceased moved into his own unit in South Perth with the support of his mother. In 2008 and in January 2010 he was admitted to Bentley Hospital with manic relapses. In the latter case he was taken to the hospital by a community mental health nurse subject to a Form1 under the MHA after he smashed furniture in his unit and threw his belongings out. He reported being stressed about his mother's pending holiday to Lebanon and was noted to be agitated and sexually disinhibited.

[6] Exhibit 1, Volume 1, Tab 9
[7] Exhibit 1, Volume 1, Tab 9
[8] Exhibit 1, Volume 1, Tab 9
[9] Exhibit 1, Volume 1, Tab 11.1

He was admitted for over three weeks and was then discharged to supported accommodation for a trial of one month.[10]

17. In March 2010 the deceased was admitted to Armadale Mental Health Service for four months with a relapse of chronic schizophrenia. He was found to be aggressive, with disinhibited and sexually inappropriate behaviour.[11]

18. In 2011 the deceased committed indecent acts in public and indecently assaulted a female supermarket worker. He had several admissions to Bentley Hospital and was transferred in mid-December 2011 from Hakea Prison to the Frankland Centre at Graylands Hospital after being arrested, charged and placed on remand for exposing himself to a woman and her female toddler. He was then assessed as having an IQ of 64.

THE DECEASED'S ADMISSION TO BENTLEY HOSPITAL

19. On 21 March 2012 the deceased was admitted to Bentley Hospital, where he remained until 13 October 2014. He was initially admitted with a psychotic episode. When that settled he was noted to have limited intellectual capacity, impulsivity and a degree of unpredictability. He made regular verbal outbursts and persistent requests for help in finding a girlfriend. He could become paranoid and was increasingly disorganised. He was periodically secluded due to his aggressive behaviour.[12]

20. While in Bentley Hospital for this prolonged admission the deceased was managed by consultant psychiatrist Dr Stevens and then by Dr Choy.[13]

21. The deceased was prescribed various drugs, including anti-libidinal medication. He would take the drugs himself by attending a medication area at specific times, when he would be provided with the correct dosages. In the last six

[10] Exhibit 1, Volume 1, Tab 19, Bentley Hospital discharge letter 29/01/2010
[11] Exhibit 1, Volume 1, Tab 19, Armadale- Kelmscott Memorial Hospital discharge letter 27/07/2010
[12] Exhibit 1, Volume 1, Tab 11.1
[13] ts 7 per Choy, W K C

months of the admission, he administered himself atropine liquid from a soft 15 ml plastic bottle. The dosage was two drops under the tongue.[14]

22. Cam Can carers regularly took the deceased on day leave. Before they took him out, they would be given his medications to give to him.[15]

23. The deceased was considered to be at a high risk of re-offending against adult and pre-pubescent females. He had an increased sexual drive and lacked the social skills necessary to develop appropriate intimate relationships, had low self-esteem and had no opportunities for friendships with women. He also had poor problem-solving skills and significant problems with impulsivity.[16]

24. The staff at Bentley Hospital found it difficult to manage the deceased's physical health, especially his diabetes, since he would eat junk food impulsively and raise his blood sugar levels. In October 2013 he was admitted to the intensive care unit at Royal Perth Hospital for 10 days with lithium toxicity.[17]

DISCHARGE UNDER A COMMUNITY TREATMENT ORDER

25. In order to address the deceased's needs, representatives of a number of agencies met at Bentley Hospital on a regular basis to co-ordinate his treatment and care. He was assessed by Dr Pyszora from the Community Forensic Mental Health Service and was seen regularly by Dr Gareth Merriman, a private clinical psychologist who provided psychotherapy to reduce his sexual offending. A project of the Disability Services Commission called Patients with Extremely Complex Needs (PECN), became involved and a guardian was appointed from the Public Advocate.[18]

[14] ts 58-59 per Tilley, J
[15] ts 62 per Tilley, J
[16] Exhibit 1, Volume 1, Tab 9
[17] Exhibit 1, Volume 2, Tab 2.2.2
[18] Exhibit 1, Volume 1, Tab 9

26. The multi-agency group agreed that the deceased required 24 hour support in the community to manage his risk of re-offending and to manage the treatment of his mental health. It was considered that an appropriate group home environment was not available and that he required an independent home with 24-hour carer support by a non-government agency specialising in intellectual disability. Arranging for that to happen took a considerable amount of time.[19]

27. PECN was eventually able to obtain funding for a house in Kenwick and a carer for 17 hours a day. The deceased was to be on a community treatment order with Dr Pyszora as the supervising psychiatrist. The deceased's GP would provide his medical health care, Armadale Mental Health Service would provide crisis intervention, and Cam Can would provide carers.[20]

28. The deceased's medication was not to change on discharge. It included insulin and metformin for diabetes, atropine for hyper-salivation, clonazepam for anxiety/agitation, cyproterone as an anti-libidinal drug, sodium valproate for mood stabilisation, and the antipsychotic medications chlorpromazine and depot zuclopenthixol for thought and mood stabilisation.[21]

29. Prior to the deceased's discharge from Bentley Hospital on 13 October 2014, he was granted alternating days of overnight leave with a carer and was then allowed trial leave for one week. There were teething problems, but the trial was deemed a success. He was discharged as planned and his care was transferred to the Eudoria Clinic in Armadale.[22]

30. A copy of the deceased's discharge letter containing a list of his medications was sent to his GP, but it appears that one was not provided to Cam Can. Cam Can was not provided with a written care plan in which the carers' responsibilities in relation to supervision of the deceased's medications

[19] Exhibit 1, Volume 1, Tab 9
[20] Exhibit 1, Volume 1, Tab 9
[21] Exhibit 1, Volume 1, Tab 11.3
[22] Exhibit 1, Volume 1, Tab 11.3; Exhibit 1, Volume 2, Tab 2.2.2

were spelled out. Rather, there appears to have been an assumption that the carers would simply continue to observe the deceased as he administered his own medication.

31. To the extent that there was any discussion about medications during the multi-agency meetings leading up to the deceased's discharge, that discussion focused on controlling the deceased's diabetes and his insulin requirements.[23] There was no discussion about any perceived need to supervise his use of atropine as he had been using it for six months and was presumed to be capable of self-administering it.[24]

EVENTS LEADING UP TO DEATH

32. On the evening of 16 October 2014 the deceased was at home in Kenwick with his live-in carer, Mr Potaka.[25] The deceased was particularly aggressive that evening. He refused to take his medications and he smashed a bowl containing that night's doses.[26]

33. At about 8.30 pm the deceased became angry and punched his bedroom window, smashing the window and cutting his hand. Mr Potaka took him to a medical centre in Cannington, where a doctor bandaged a small, superficial laceration to the deceased's right index finger.[27]

34. The deceased and Mr Potaka returned home from the medical centre at about 10.00 pm. Mr Potaka asked the deceased to check his blood sugar levels, but the deceased refused. Instead, he went into his room and watched TV.

35. At about 1.30 am on 17 October 2014 the deceased got up and went into the kitchen. He told Mr Potaka that he was

[23] ts 34 per Choy, W K C
[24] ts 16-18 per Choy, W K C
[25] Exhibit 1, Volume 1, Tab 6
[26] Exhibit 1, Volume 1, Tab 13
[27] Exhibit 1, Volume 1, Tab 6; Exhibit 1, Volume 1, Tab 18

hungry, so Mr Potaka cooked him some sausages, which he ate. He returned to his room at about 2.15 am.[28]

36. About 15 minutes later, Mr Potaka checked on the deceased by going to his closed bedroom door. Mr Potaka did not see any light coming from around the door and he did not hear any noise, so he assumed that the deceased was asleep. He then went to bed himself.[29]

37. At about 6.40 am that morning, Mr Potaka went into the deceased's bedroom and found him lying on the floor next to his bed. He was cold to the touch and did not have a pulse. Mr Potaka called for an ambulance.[30]

38. Ambulance officers attended and found no sign of life.[31] At 7.26 am, an ambulance officer certified that the deceased was life extinct.[32]

39. Police investigators attended and examined the scene. They noted that the deceased's medication included two bottles of 1% atropine drops and a 100 tablet blister pack of chlorpromazine with 26 tablets remaining.[33]

40. The investigators found no evidence of criminality in the deceased's death.[34]

CAUSE OF DEATH

41. On 20 October 2014 Chief Forensic Pathologist Dr C T Cooke conducted a post mortem examination of the deceased's body and found arteriosclerotic narrowing of the arteries on the surface of the heart and congestion of the lungs, the latter being a non-specific finding.

42. Microscopic examination of the major body tissues and neuropathological examination of the brain showed no

[28] Exhibit 1, Volume 1, Tab 6; Exhibit 1, Volume 1, Tab 4.4
[29] Exhibit 1, Volume 1, Tab 6; Exhibit 1, Volume 1, Tab 4.4
[30] Exhibit 1, Volume 1, Tab 6
[31] Exhibit 1, Volume 1, Tab 13
[32] Exhibit 1, Volume 1, Tab 2
[33] Exhibit 1, Volume 1, Tab 4.4
[34] Exhibit 1, Volume 1, Tab 4.1

significant abnormalities. Blood sugar levels were normal. Microbiology testing identified *Staphylococcus aureus* as a post mortem overgrowth.

43. Toxicological analysis showed atropine at 0.5% in mortuary admission preserved blood, 12 mg/L in the urine, 1.5 mg/kg in the liver and 17 mg/kg in the stomach contents. Chlorpromazine was found at 0.04 mg/L and zuclopenthixol was found at 0.02 mg/L in mortuary admission preserved blood.

44. Following further investigations, on 8 January 2016 Dr Cooke formed the opinion, which I adopt as my finding, that the cause of death was atropine toxicity.[35]

HOW DEATH OCCURRED

45. In March 2016, Professor D A Joyce, a physician in clinical pharmacology and toxicology, provided the Court with a report examining the relationship between the drugs detected in the post mortem specimens taken from the deceased and the cause of death. Professor Joyce based his conclusion on Dr Cooke's reports, the toxicological report, police information and a report to the Court from Dr Choy.[36]

46. Professor Joyce explained that atropine is the prototype of antimuscurinic drugs. It is derived from the plant deadly nightshade or one of its close botanical relatives. It is available in eye drops, in some preparations to treat diarrhoea, and as an injection for some heart rhythm disturbances. In rare cases, larger size tablets are used in hospital management of some severe poisonings.[37]

47. Professor Joyce stated that the atropine concentrations found in the deceased exceeded conventional therapeutic administration by 50 or 100-fold. He said that the chlorpromazine and zuclopenthixol levels were high but would not have posed any risk to the deceased in the

[35] Exhibit 1, Volume 1, Tab 14
[36] Exhibit 1, Volume 1, Tab 17.3
[37] Exhibit 1, Volume 1, Tab 17.3

absence of the atropine. They would, however, have increased the risk of toxicity from the atropine.[38]

48. Professor Joyce concluded in his report that the deceased's blood concentrations of atropine would ensure serious toxicity and the risk of lethality and, as mentioned, the presence of chlorpromazine and zuclopenthixol would have increased that risk. However, he considered that further things needed to be done, including the measurement of atropine in the stomach contents, the liver and urine, and the check of any available electrocardiogram (ECG) in the Bentley Hospital notes to see whether the deceased was predisposed to a lethal cardiac arrhythmia from those drugs.[39]

49. Following the receipt of a further toxicological analysis and an ECG, Professor Joyce provided a supplementary report in which he stated that the concentrations of atropine in the blood and liver were consistent with lethal poisoning and that detection of 15mg of atropine in the stomach contents confirms that the drug was taken orally. He also said that the ECG showed normal electrical complexes, so that there was no reason to suspect a contribution to death from the chlorpromazine and zuclopenthixol.[40]

50. Professor Joyce concluded that atropine poisoning was the most likely cause of death and that the atropine was taken by mouth. He calculated that the dose taken by the deceased was at least 6 to 8 ml of the solution.[41]

51. On the basis of the foregoing, it is clear that the deceased orally ingested a lethal quantity of his atropine medication.

52. There is no evidence to suggest that Mr Potaka had somehow caused the deceased to ingest the atropine. Mr Potaka's manager, Mr Andrews, said that Mr Potaka had a lot of experience working with men who were troubled and had frustration and anger issues, and he had excellent skills in managing those issues. Mr Andrews said that he

[38] Exhibit 1, Volume 1, Tab 17.3
[39] Exhibit 1, Volume 1, Tab 17.3
[40] Exhibit 1, Volume 1, Tab 17.1
[41] Exhibit 1, Volume 1, Tab 17.1

had a remarkably thick skin for dealing with angry outbursts and things like that.

53. M Potaka's statement regarding his care of the deceased leading up to the time he found the deceased's body also belies any suggestion that he caused or contributed to the death. Several of the details in his statement were corroborated by independent evidence, including the records obtained from St John Ambulance and from the Cannington Medical Centre.[42]

54. As to the possibility that the deceased intentionally committed suicide, there is also no evidence to suggest that the deceased was suicidal on the night he died. Dr Choy said that he had not been actively suicidal for the time Dr Choy had been in contact with him.[43] Dr Pyszora said that she was as confident as she could be that the deceased's overdose was not an attempt at self-harm or suicide.[44]

55. It is also extremely likely that the deceased was unaware that the atropine solution was toxic, given that Dr Choy, Dr Pyszora and Nurse Tilley were all likewise unaware.[45] That they were unaware also supports the unlikelihood that Mr Potaka caused the deceased to ingest the atropine with an intention to cause his death.

56. There is however, evidence indicating the likelihood that the deceased impulsively took an overdose of the atropine without any understanding of its potential effect.

57. Dr Choy said that he suspected that it was an impulsive or unconsidered act or a miscalculation by the deceased.[46]

58. Dr Choy said that the use of atropine, which is the most commonly used agent to treat hyper-salivation in mental health settings, is an 'off-label' use in that it is not part of the standard product information guidelines that the

[42] Exhibit 1, Volume 1, Tabs 13 and 18
[43] ts 16 per Choy, W K C
[44] ts 52-53 per Pyszora, N M
[45] ts 30 per Choy, W K C; ts 44 per Pyszora, N M; and ts 69 per Tilley, J respectively
[46] ts 16 and 31 per Choy, W K C

manufacturer of the drug supplies to potential prescribers or users of it.[47]

59. Dr Choy said that he was astounded to learn how easy it was to empty a plastic bottle of atropine without having to apply much pressure.[48] He also agreed that it was unlikely that the deceased had been told to ensure that he should never take more than two drops at a time.[49]

60. Dr Pyszora also agreed that it was likely that the deceased squeezed out a whole bottle of atropine. She said that, while he might have had the capacity to understand that something was dangerous if it had been explained to him, like getting out of a moving car, in the moment he might not stop himself from doing it.[50]

61. In these circumstances I am satisfied that, without an intention to end his life, the deceased administered himself a toxic quantity of atropine, which caused his death.

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

COMMENTS ON THE SUPERVISION, TREATMENT AND CARE OF THE DECEASED

63. The evidence established that the staff at Bentley Hospital, the members of the multi-agency group and Mr Potaka put in a considerable amount of time and effort to provide the deceased with the best possible supervision and care in the community. I do not underestimate the difficulties they faced, given the severity and complexities of the deceased's condition. The human and material resources that went into the planning and implementation of his care were a testament to the dedication and professionalism of those involved.

64. Unfortunately, in my view the supervision and care was deficient to the extent that the deceased was provided with

[47] ts 15 and 19 per Choy, W C K
[48] ts 31 per Choy, W K C
[49] ts 30-31 per Choy, W K C
[50] ts 53 per Pyszora, N M

atropine in toxic quantities and was left to administer it to himself from a container which facilitated an over-dose.

65. The root causes of this situation were the lack of awareness that atropine was potentially lethal and the lack of communication from the multi-agency group to Cam Can carers to ensure that they supervised the deceased's medications.

66. The evidence did not canvass possibly appropriate steps to reduce the likelihood of a similar situation arising again, so I do not consider that I am in a position to make a formal recommendation. However, I do suggest that:

    a) heath care providers review the oral use of atropine and the provision of atropine to patients to self-administer;

    b) clear warnings of the danger of toxicity from overdosing orally ingested atropine be placed on atropine containers, and similar warnings be conveyed to carers and patients; and that

    c) atropine for oral use not be provided or stored in soft, squeezable containers.

CONCLUSION

67. The deceased had severe and permanent mental health problems. A significant effort was made to manage his condition to enhance his quality of life and to reduce the risk to himself and the community. It was a tragedy for him and for all those involved in his care that, a short time after he was placed in an environment devoted to those goals, he died from an avoidable accident.

68. While there were shortcomings in the deceased's care which, in hindsight, allowed that accident to occur, there is no doubt that such shortcomings were the result of understandable assumptions rather than incompetence or lack of goodwill.

69. The deceased's death and his care leading up to it highlight the often crippling nature of severe mental illness and the potential obstacles in attempting to manage it.

B P King
Coroner

23 February 2018