Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 36/15

I, Sarah Helen Linton, Coroner, having investigated the death of ***Charles William MAPP*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***1 October 2015*** *find that the identity of the deceased person was* ***Charles William MAPP*** *and that death occurred on* ***16 June 2014*** *at* ***Sir Charles Gairdner Hospital*** *in circumstances* ***consistent with pneumonia in an elderly man with advanced lung cancer*** *in the following circumstances:*

Counsel Appearing:

Sgt L Housiaux assisting the Coroner.
Mr L Nicholls (State Solicitor's Office) appearing on behalf of the Office of the Public Advocate and the North Metropolitan Health Service Mental Health

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INTRODUCTION

1. Charles William Mapp (the deceased) died on 16 June 2014.

2. At the time of his death, the deceased was an involuntary patient within the meaning of the *Mental Health Act 1996* (WA). He had been cared for at Graylands Hospital for many years.

3. By virtue of his status as an involuntary patient, the deceased came within the definition of a 'person held in care' pursuant to s 3 of the *Coroners Act 1996* (WA). In such circumstances, a coronial inquest is mandatory.[1] Accordingly, I held an inquest at the Perth Coroner's Court on 1 October 2015.

4. The documentary evidence tendered at the inquest comprised a comprehensive report of the death prepared by the Western Australia Police.[2] The author of the report, Senior Constable Fiona Thorp, also gave oral evidence at the inquest.

5. In addition, the deceased's treating psychiatrist, Dr Joseph Lee, was also called as a witness at the inquest.

6. Both Dr Lee and Senior Constable Thorp confirmed in their evidence that the deceased's death was expected, given his diagnosed lung cancer, and no concerns had been raised by any person in relation to the circumstances of his death nor his care or supervision in the years preceding his death.

BACKGROUND HISTORY

7. The deceased was born on 18 August 1931. After leaving school, he qualified as a carpenter-joiner and worked in his father's furniture factory. His hobbies included motorcycle racing and shooting. He was known to be intelligent and hard-working, but also had a quick temper and anger management issues. He suffered a slight head injury in a motorcycle accident but it was not thought at the time to have caused any significant brain injury.[3]

8. The deceased married in January 1952, when he was nearly 21 years old. The marriage was initially happy and they had three children in short succession.[4]

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[1] Section 22(1) (a) *Coroners Act*.
[2] Exhibit 1.
[3] Exhibit 1, Tab 19.
[4] Exhibit 1, Tab 19.

9. However, sometime in 1956, discord arose in the marriage, due to issues of domestic violence associated with alcohol abuse. They separated on 22 March 1957 and Mrs Mapp and the three children went to live with Mrs Mapp's parents in North Perth. The deceased was very upset about the separation and made several unsuccessful attempts to persuade his wife to return home.[5]

10. On the evening of 2 April 1957, the deceased took a loaded Luger pistol to the North Perth house. After speaking to his wife and parents-in-law inside the house for a short time, the deceased shot and killed his wife, mother-in-law and father-in-law while his children slept nearby. He then tried to commit suicide by shooting himself in the head. He sustained serious head injuries but did not die.[6] The deceased was taken by ambulance to Royal Perth Hospital and underwent surgery. He had sustained frontal lobe damage to his brain but made a good recovery and was discharged approximately one month later.[7]

11. The deceased was charged and convicted of the wilful murder of his wife in June 1957. He was sentenced to death in accordance with the relevant legislation in force at the time, which was commuted by the Governor the following month to a sentence of imprisonment with hard labour.[8]

12. The deceased's mental health was under close observation by psychiatrists from shortly after his brain surgery throughout his first few years of incarceration. He initially showed no evidence of mental disease as a result of his brain injury, but over time he began to exhibit symptoms of psychosis and paranoia. He was transferred to Claremont Hospital[9] on 9 July 1968 and by September 1968 some psychiatrists were satisfied the deceased was suffering from paranoid schizophrenia.[10]

13. The deceased later returned to prison for a period of time before being released on parole on 18 April 1974 on the condition that he be admitted as a patient to Graylands Hospital. He absconded from the hospital on 15 September 1974 and was apprehended in Kalgoorlie three days later. He admitted he had been trying to head to the east coast at the time. [11]

[5] Exhibit 1, Tab 19.
[6] Exhibit 1, Tab 19.
[7] Exhibit 1, Tab 19.
[8] Two other charges of wilful murder in relation to the deceased's parents-in-law were discontinued by the prosecution following his conviction and sentence: Exhibit 1, Tab 19.
[9] Which was known as Claremont Hospital for the Insane: Exhibit 1, Tab 19.
[10] Exhibit 1, Tab 19.
[11] Exhibit 1, Tab 20.

14. He returned to the hospital but absconded again on 18 November 1975. His parole was cancelled and a warrant was issued for his arrest. He was eventually located in mid-1976 in Queensland after being taken into police custody and referred for psychiatric treatment as a restricted patient for a period of 12 months. It is unclear whether he had committed an offence in Queensland prior to his apprehension. It was decided by the Western Australian Parole Board to leave him in the care of the Queensland authorities.

15. It is unclear what happened after that 12 month period expired in the late 1970s. What is clear is that the deceased eventually returned to Western Australia. The Health Department of Western Australia records indicate that the deceased was again admitted to Graylands Hospital in 1982 and had multiple admissions from that time until the early 1990s.[12]

16. He spent approximately one year living in Tasmania from 1992 to 1993 but apparently came into conflict with the law there and returned to Western Australia in mid-1993.[13]

17. At that time, he came to the attention of the Guardianship and Administration Board due to his long, chronic history of mental illness and his frequent admissions to Graylands Hospital. In 1993, the Public Trustee was appointed by the Board as the deceased's financial administrator.[14] He had a considerable amount of savings, partly due to an inheritance from his father's estate, which meant he could afford to live independently.

18. Unfortunately, the deceased was unable to live independently in the community for any period of time, as he was unable to properly care for himself. He was prone to hoarding and did not maintain good hygiene, which led to complaints by neighbours regarding vermin and bad smells.[15]

19. As independent living was not a viable option, the possibility of supported accommodation was then explored. Many attempts were made between periods of hospitalisation to place the deceased in appropriate supported accommodation but he proved to be a placement problem as his poor impulse control, sexual disinhibition and antisocial behaviour meant each accommodation attempt failed.[16] Although he had a long-standing diagnosis of chronic schizophrenia, it was felt his behavioural problems were secondary to his frontal lobe

[12] Exhibit 1, Tab 11.
[13] Exhibit 1, Tab 15.
[14] Exhibit 1, Tab 11.
[15] Exhibit 1, Tab 11 and Tab 15.
[16] Exhibit 1, Tab 15.

syndrome rather than his schizophrenia. Hence, he could not be treated adequately with antipsychotics. In the circumstances, the deceased's only option was to remain a psychiatric inpatient indefinitely.[17]

FINAL YEARS OF CARE

20. By January 2013, the deceased was 81 years old and had been an involuntary patient at Graylands Hospital for the past nine years. His delusional beliefs with a religious theme persisted unabated and he was a challenging patient to care for, with frequent explosive temper outbursts.[18] As a result, he was generally managed in the secure ward in his later years. Nevertheless, he was allowed to spend time on the hospital grounds alone and had carers taking him out regularly.[19]

21. The deceased's physical health was also declining and he was noted to have diabetes, incontinence, ulcerated legs and dysphasia and was on a modified diet to prevent choking.[20] Given his declining health, Graylands Hospital made a guardianship application on his behalf. On 24 January 2013, the Public Advocate was appointed by the State Administrative Tribunal for 12 months as the deceased's guardian with the function to make decisions on his behalf about his medical treatment and the services he should access.[21]

22. In November 2013, the deceased was admitted to Sir Charles Gairdner Hospital (SCGH) with a suspected stroke. During this admission, a chest x-ray and CT scan revealed he had terminal lung cancer. Meetings were held between the medical team and his delegated guardian and the decision was made, due to his mental state and medical co-morbidities, to treat his cancer conservatively.[22] The deceased was told of his diagnosis and the treatment decision, although he apparently didn't really accept these.[23]

23. The deceased was assessed as being at high risk of aspiration due to the effects of the stroke, so attempts were made to insert a nasogastric tube but he did not tolerate it.

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[17] Exhibit 1, Tab 15, Medical Summary 24.10.2002.
[18] Exhibit 1, Tab 8.
[19] Exhibit 1, Tab 8 and Tab 13.
[20] Exhibit 1, Tab 11.
[21] Exhibit 1, Tab 11.
[22] Exhibit 1, Tab 8 and Tab 11.
[23] Exhibit 1, Tab 8.

24. He was transferred back to Graylands Hospital for ongoing care.[24] For quality of life reasons, he was allowed to eat and drink as desired, although a moist puree diet was prescribed. It was decided that comfort measures should be implemented if he did aspirate.[25]

25. On 12 December 2013, a Mental Health Review Board hearing was conducted and it was determined that the deceased should remain an involuntary patient. Residential aged care was considered but his treating doctor believed his behaviours were too complex for that environment.[26]

26. The deceased did not show any overt signs of clinical worsening until April 2014, when he complained of chest pain. A chest x-ray showed worsening of the tumour. His prognosis was 'weeks to months'. He was commenced on pain medication and on 29 May 2014 a 'not for resuscitation order' was completed by the Public Advocate as his guardian.[27]

27. On 11 June 2014, the deceased had a brief period of delirium but then appeared to recover. The following morning, ward staff noted he appeared confused, unwell and breathless. He requested, and was given, an ice cream and then appeared to choke on it. A code blue was called and he was transferred to SCGH where the decision was made to treat him palliatively, consistent with the 'not for resuscitation' order. He died on 16 June 2014.[28]

CAUSE AND MANNER OF DEATH

28. On 18 June 2014, a Forensic Pathologist, Dr White, conducted a post-mortem examination of the deceased. The examination showed a large tumour in the right lung, which was confirmed on microscopic examination as invasive squamous cell carcinoma. An evident acute pneumonia was also confirmed. Toxicology showed medications at levels consistent with the deceased's palliative medical care.[29]

29. At the conclusion of all investigations, Dr White formed the opinion that the cause of death was pneumonia in an elderly man with advanced lung cancer (squamous cell carcinoma).[30]

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[24] Exhibit 1, Tab 10.
[25] Exhibit 1, Tab 10.
[26] Exhibit 1, Tab 11.
[27] Exhibit 1, Tab 8, Tab 11 and Tab 13.
[28] Exhibit 1, Tab 5, Tab 8 and Tab 11.
[29] Exhibit 1, Tab 6 and Tab 7.
[30] Exhibit 1, Tab 6.

30. I accept and adopt the conclusion of Dr White as to the cause of death.

31. Dr Lee confirmed at the inquest that the deceased's death was entirely expected. The manner of his death following aspiration of food (in the context of increasing signs of his lung cancer worsening) was not unexpected either, given he had been deemed to be at high risk of aspiration as a result of his stroke.[31]

32. In the circumstances, and noting that the stroke precipitated the aspiration risk, I find that the manner of death was natural causes.

QUALITY OF SUPERVISION, TREATMENT AND CARE

33. 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.

34. The Public Advocate, Ms Pauline Bagdonavicius, conducted a review of the files of the Office of the Public Advocate following the deceased's death. Based upon her review, Ms Bagdonavicius expressed the view that the treatment approach to the deceased's terminal cancer was appropriate, noting that staff from Graylands Hospital worked collaboratively with the Ambulatory Palliative Care Team and the Office of the Public Advocate in regard to the deceased's palliative treatment. She also noted that the deceased's transfer to SCGH when his medical health was significantly deteriorating in his last days was the best approach in the circumstances to assist him at the end stage of his life.[32]

35. I agree with the view of the Public Advocate that the care, supervision and treatment provided to the deceased by the staff at Graylands Hospital and SCGH was appropriate and of a high standard. The deceased presented many challenges as a patient and the staff at Graylands Hospital appropriately involved other professionals in his care so that there was someone available to advocate on his behalf when he was unable to do so for himself. He had lived a surprisingly long and healthy life, given the events in 1957, and when he developed a terminal illness at an advanced age there was little that could be done for him other than to treat his symptoms and provide comfort care at the end.

[31] T 8; Exhibit 1, Tab 10, 3.
[32] Exhibit 1, Tab 11.

CONCLUSION

36. In 1957, the deceased committed a series of serious acts of violence, which ended the lives of three innocent people and also caused him serious brain injury. This led to him serving time as a prisoner before later being transferred to a psychiatric hospital for treatment for his increasingly obvious mental disorders.

37. Despite some periods of time in the community, the deceased spent most of his adult life as a long-term psychiatric inpatient, the last ten years or so as an involuntary patient at Graylands Hospital.

38. Despite his significant mental health issues, the deceased enjoyed surprisingly good physical health for many years, but eventually his physical health also declined. At the age of 81 years, he suffered a stroke and was also diagnosed with lung cancer. He was given medical treatment and care from that time with the expectation that the lung cancer and effects of his stroke would eventually lead to his death, as they did.

39. The cause and manner of his death in June 2014 were expected and could not have been prevented.

S H Linton
Coroner
8 October 2015