Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 5/17

I, Barry Paul King, Coroner, having investigated the death of ***Ejub Mehinovic*** *with an inquest held at the* ***Perth Coroner's Court*** *on* ***24 January 2017****, find that the identity of the deceased person was* ***Ejub Mehinovic*** *and that death occurred* ***on or about 23 November 2015*** *at* ***Unit 8, 6 Tuart Place, Morley*** *from* ***coronary artery atherosclerosis*** *in the following circumstances:*

Counsel Appearing:

Ms A Sukoski assisted the Coroner
Mr A L Mason (State Solicitor's Office) appeared on behalf of the North Metropolitan Health Service

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INTRODUCTION

1. On 25 November 2015 the body of Ejub Mehinovic (the deceased) was found in his unit in Morley with no sign of life. He had last been seen alive at about 1.00 pm on 22 November 2015.

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. At the time of his death the deceased was under a community treatment order (CTO) under the *Mental Health Act 1996* (MH Act), so he was an involuntary patient within the meaning of that statute. He was therefore a 'person held in care' under the definition in 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 to inquire into the death of the deceased was, therefore, mandatory.

7. On 24 January 2017 at the Perth Coroners Court, I held an inquest into the deceased's death. 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 Senior Constable Lesley Berecz of

the Coronial Investigation Squad in the Western Australia Police.[1]

8. Oral testimony was provided by:

   a) Dr Felicity Sewell, a psychiatrist at Sir Charles Gairdner Hospital (SCGH) who had treated the deceased;[2] and

   b) Dr Sunny Sorunmu, a senior medical officer at the Inner City Community Mental Health Service (ICMHS) who was the deceased's treating doctor from 2012.[3]

9. Under section 25(3) of the Act, 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.

10. I have found that the supervision, treatment and care of the deceased was reasonable and appropriate in the circumstances.

THE DECEASED

11. The deceased was born on 18 December 1964 in what was then known as Yugoslavia. He immigrated to Australia with his mother and father when he was four years old. He had a younger brother who later died from cancer.[4]

12. The deceased attended primary and secondary school in Collie. He worked on trains and in the local coal industry as well as in other occupations for short periods. He last worked in about 1982. He never married and had no children.[5]

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[1] Exhibit 1, Tabs 1-19 and 22
[2] ts 4 – 9 per Sewell, F
[3] ts 9 – 16 per Sorunmu, S
[4] Exhibit 1,
[5] Tab 19

13. In 1988 the deceased was admitted to Graylands Hospital (Graylands) with paranoid psychosis. He was admitted to Graylands again in January 1989 and in September 1989, the latter occasion followed an incident where he threatened to shoot a petrol pump attendant. He was diagnosed with schizophrenia.[6]

14. In 1991 the deceased was charged and convicted of the offence of murder in relation to the death of his father. The facts appeared to be that the deceased stabbed his father several times with a kitchen knife as his father was assaulting him repeatedly with a metal walking stick.[7] The deceased was sentenced to indefinite imprisonment.

15. In July 2002 and February 2003 the deceased was referred back to Graylands for assessment of his suitability for parole. In each case, his parole was denied by the Prisoners Review Board.

16. On 21 October 2005 the deceased was transferred to the Frankland Centre at Graylands for pre-parole release. Because he had had a poor response to antipsychotic medication until then, he was commenced on the atypical antipsychotic medication clozapine, which is a medication commonly used as a last resort for treatment-resistant schizophrenia. It carries potential side-effects of such severity that patients require careful monitoring.

17. On 26 May 2006 the deceased was granted parole for five years with conditions relating to treatment and management by Graylands. He needed several months of encouragement for him to develop the social skills necessary to leave the hospital, and he was assisted in finding accommodation.[8]

18. In May 2007 the deceased was placed at Romily House, a hostel in Claremont providing supported accommodation, but made the other residents feel uncomfortable, so he

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[6] Tab 19
[7] *Mehinovic v R* unreported, WASC, Library No 9090, 8 October 1991
[8] Exhibit 1, Tab 19

was moved to independent supported accommodation in Mount Lawley.[9]

19. In April 2008 the deceased was finally discharged from Graylands with follow up at the Community Forensic Mental Health Outpatient Clinic, and he appeared to cope well in the community for the next two years with regular depot clozapine. He moved into a unit in Morley, and his blood pressure, weight and blood test results were regularly monitored at a local medical clinic.[10]

20. In September 2010 the deceased was re-admitted to the Frankland Centre after he appeared confused and disoriented during a home visit. He was transferred to Sir Charles Gairdner Hospital for examination, and when no causes for his abnormality could be found, was eventually diagnosed with a probable clozapine-induced grand mal seizure. He was returned to the Frankland Centre and treated with clozapine and sodium valproate. His mental state gradually improved enough to be discharged home on 9 December 2010.[11]

21. In September 2011 the deceased's parole period ended. He was placed on a CTO under the MH Act and his ongoing care was transferred to the ICMHS where his case manager was Michael Harvey, an experienced clinical nurse, and his senior medical officer was Dr Sorunmu.[12]

22. The team at ICMHS regularly reviewed his mental state, monitored his vital signs and weight, and provided him with ongoing support and psycho-education for his condition. It seems that, after about two or three years of treatment at ICMHS, the CTO was revoked or allowed to expire as the deceased no longer met the requirement for the order.[13]

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[9] Exhibit 1, Tab 19
[10] Exhibit 1, Tabs 19 and 22
[11] Exhibit 1, Tab 19
[12] ts 12 per Sorunmu, S
[13] ts 12 per Sorunmu, S

ADMISSION TO SCGH

23. On 21 September 2015 Mr Harvey referred the deceased to SCGH under the MH Act for examination by a psychiatrist after the deceased's local pharmacist reported that he had not been taking his medication and had become increasingly irritable and verbally aggressive. The deceased had also been issued with a move-on notice by a police officer because he had been verbally aggressive to bank staff.

24. Before referring the deceased to SCGH, Mr Harvey reviewed him and considered that he was having a relapse of his psychosis. He discussed the situation with Dr Sorunmu, who agreed that they could no longer safely provide the deceased treatment in the community due to his non-compliance with medication and the potential risks inherent with that.[14]

25. At SCGH, Dr Sewell examined the deceased and made an involuntary patient order under the MH Act. Dr Sewell admitted the deceased into a secure ward, recommenced him on clozapine and prescribed him olanzapine for the period up to when the clozapine was at therapeutic levels.[15]

26. Throughout his treatment at SCGH the deceased maintained that he did not have schizophrenia, and he was reluctant to continue medication as a voluntary patient. As he was a significant risk to the community if he was not treated, Dr Sewell made a CTO before discharging him on 21 October 2015.[16] Prior to doing so, she contacted the deceased's supervising consultant psychiatrist at ICMHS and obtained an appointment schedule, which she included on the CTO form. The first appointment was for 17 November 2015.[17]

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[14] Exhibit 1, Tabs 18 and 20
[15] Exhibit 1, Tab 19
[16] ts 6 per Sewell, F; Exhibit 1, Tab 1
[17] ts 6 per Sewell, F; Exhibit 1, Tab 1

EVENTS LEADING UP TO DEATH

27. Dr Sorunmu was ill on 17 November 2015, and the policy at ICMHS required that the deceased's appointment had to be changed. The policy was in place because, in the past, patients in similar circumstances had seen substitute doctors and, as Dr Sorunmu put it, some unpleasant events had happened. In this case, Mr Harvey called the deceased and arranged for the appointment to be changed to the afternoon on 23 November 2015.[18]

28. At about 1.00 pm on Sunday 22 November 2015, one of the deceased's neighbours saw him cleaning his car, as he normally did on a Sunday.[19]

29. At about 2.30 am on 23 November 2015 another of the deceased's neighbours was awoken by her dog, which jumped on her bed and kept looking out her bedroom window, which faced the deceased's unit. The neighbour then heard a loud bang and a sound like breaking glass. She opened her front door to see what had happened and noticed that light was coming from the deceased's kitchen window. She did not see anything else.[20]

30. The deceased's car was still in his driveway the next afternoon, which was unusual.[21]

31. The deceased did not attend the appointment on 23 November 2015, which the treating team thought may have been a result of him being unco-operative following the change of the appointment. They were used to him being very rigid as a result of an obsessional personality trait. Because of that expectation, the team did not take any action in relation to the deceased's failure to attend until the team meeting the next morning.[22]

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[18] ts 14 per Sorunmu, S
[19] Exhibit 1, Tab 11
[20] Exhibit 1, Tab 10
[21] Exhibit 1, Tab 11
[22] ts 14 – 15 per Sorunmu, S

32. Following that meeting, Mr Harvey went to the deceased's unit but the deceased did not come to the door, so Mr Harvey and a senior social worker attended at about 1.00 pm on the following day. They noticed that the deceased's car was in the carport and they saw a light in the kitchen despite the time of day. They walked to the rear of the unit, looked through the kitchen window and saw the deceased lying on the floor. The doors and windows were locked. Mr Harvey called 000.[23]

33. Police and ambulance officers attended and forced entry into the unit. The deceased was clearly dead and in a state of decomposition.[24]

34. The unit was clean and organised with no sign of a struggle or any other indication of another person being involved in the deceased's death.[25]

CAUSE OF DEATH AND HOW DEATH OCCURRED

35. On 2 December 2015 forensic pathologist Dr J McCreath and forensic pathology registrar (now forensic pathologist) Dr V Kueppers conducted a post mortem examination of the deceased's body and found early decompositional changes, patchy mild coronary atherosclerosis, focal pallor in the heart muscle and focally patent foramen ovale. There was a small superficial skin split on the forehead, possibly from a collapse-type injury.[26]

36. Microscopic examination showed a more severe degree of coronary atherosclerosis than initially thought. Toxicological analysis showed clozapine at a therapeutic level and no other common drugs.[27]

37. On 6 April 2016 Dr McCreath and Dr Kueppers formed the opinion that the cause of death was consistent with

[23] Exhibit 1, Tabs 7, 13 and 20
[24] Exhibit 1, Tab 8
[25] Exhibit 1, Tab 8
[26] Exhibit 1, Tab 4
[27] Exhibit 1, Tab 5

coronary artery atherosclerosis. They noted that the deceased most likely died from a sudden fatal cardiac arrhythmia on a background of coronary artery atherosclerosis with some scarring in the heart muscle.[28]

38. On the basis of the information available to me, I am satisfied that the deceased had coronary artery atherosclerosis, which caused his death.

39. I find that death occurred as a result of natural causes.

COMMENTS ON THE TREATMENT, SUPERVISION AND CARE OF THE DECEASED

40. The deceased had a long history of significant mental illness for which he received a considerable amount of ongoing treatment and care. I am satisfied that the care he received in relation to that aspect of his health was of a high standard.

41. In terms of his physical health care, he had been regularly monitored for side-effects of clozapine and was not known to suffer cardiac issues. His weight, blood pressure and cholesterol levels did not indicate that he needed further investigations for cardiovascular disease.[29]

42. It is clear that, apart from when the deceased stopped taking his medication in September 2015, the supervision in relation to his mental health care was regular and effective. When he had stopped taking his medication, Mr Harvey and Dr Sorunmu took the appropriate step of referring the deceased for examination, and Dr Sewell's decision to put the deceased on a CTO was clearly justified.

43. I am satisfied that the standard of supervision, treatment and care of the deceased while he was an involuntary

[28] Exhibit 1, Tab 5
[29] Exhibit 1, Tab 22

patient was reasonable and appropriate in all of the circumstances.

CONCLUSION

44. The deceased suffered from treatment-resistant paranoid schizophrenia. Through careful management by dedicated clinicians and significant community support, he was eventually able to cope reasonably well in the community.

45. Unfortunately the deceased died at a relatively young age, but the cardiac event that caused his death was not predictable.

B P King
Coroner
29 June 2017