Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 13/16

I, Sarah Helen Linton, Coroner, having investigated the death of ***Stephen Kenneth RYAN*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***8 April 2016*** *find that the identity of the deceased person was* ***Stephen Kenneth RYAN*** *and that death occurred on* ***12 August 2013*** *at* ***Bentley Hospital*** *as a result of* ***bronchopneumonia on background of chronic obstructive pulmonary disease*** *in the following circumstances:*

Counsel Appearing:

Mr T Bishop assisting the Coroner.
Ms J Berry (State Solicitor's Office) appearing on behalf of Bentley Health Service.

TABLE OF CONTENTS

INTRODUCTION

1. Stephen Ryan (the deceased) died on 12 August 2013 at Bentley Hospital.

2. At the time of his death, the deceased was subject to an involuntary patient order under the *Mental Health Act 1996* (WA). Accordingly, under the terms of the *Coroners Act 1996* (WA) the deceased was deemed to be a person held in care. In such circumstances, a coronial inquest is mandatory.[1]

3. I held an inquest at the Perth Coroner's Court on 8 April 2016. The documentary evidence comprised of a comprehensive report of the coronial investigation compiled by Sergeant Preston from the Coronial Investigation Squad,[2] who also appeared as a witness at the inquest to speak about the report.

4. No issues of concern were raised at the inquest in relation to the deceased's supervision, treatment and care prior to his death.

THE DECEASED

5. The deceased was born in Young in New South Wales on 27 October 1950, so he was 62 years of age at the time of his death.[3]

6. The deceased had an unremarkable childhood. He was very intelligent and was a very successful school student, winning awards on several occasions. After finishing high school he studied metallurgy at university for one year before leaving to start employment at a bank.[4]

7. Over time as a young adult the deceased's mental health deteriorated, which led to contact with the police. Eventually he acquired an extensive criminal record in New South Wales.[5] When arrested by police after an incident, the deceased would often be taken by police to a mental health unit.[6]

8. The deceased first received treatment at a mental health unit when he was in his mid-twenties and he received regular

[1] Sections 3 and 22(1)(a) *Coroners Act 1996* (WA).
[2] Exhibit 1.
[3] Exhibit 1, Tab 1.
[4] Exhibit 1, Tab 8.
[5] Exhibit 1, Tab 12, p.2.
[6] Exhibit 1, Tab 8.

psychiatric treatment over the rest of his adult life.[7] He had a well-documented history of treatment resistant schizophrenia.[8]

9. When not in hospital, he lived a fairly itinerant lifestyle between Sydney, Coffs Harbour and the town of Yass.[9] His treatment in the community was complicated by this itinerant lifestyle, as well as poor compliance with his prescribed medication.[10]

10. The deceased spent a lot of time as an involuntary patient at the Jordan Centre, which is a psychiatric unit attached to the Coffs Harbour Hospital in New South Wales.[11] His last admission to Coffs Harbour was from 24 September to 22 November 2012.

11. At some stage while the deceased was an involuntary inpatient at the Jordan Centre it became apparent he was no longer able to manage his own affairs and the deceased's sister, was appointed his guardian.[12]

12. Sometime in 2012 it was decided by the deceased's psychiatrist and family that his care should be transferred from the Jordan Centre to another facility. Before he was transferred the deceased absconded from the Jordan Centre. While out in the community he managed to board a flight to Perth, Western Australia.[13]

13. The deceased apparently intended to travel on towards Broome but within a week of arriving in Perth he came to the attention of police four times in five days. He was eventually taken to hospital on 23 December 2012 by police after he was found walking along a busy road attempting to stop drivers to seek assistance. He was initially admitted at Royal Perth Hospital (RPH) and then later transferred to Bentley Health Service on 28 December 2012.[14]

PSYCHIATRIC ADMISSION AND TREATMENT AT BENTLEY HOSPITAL

14. The deceased's psychiatric care was managed by Consultant Psychiatrist Dr David Stevens. Dr Stevens noted that the deceased's psychiatric illness caused him to experience chronic paranoid and grandiose delusions. He was quick to anger if he perceived things were not going his way and would often make physical threats in this context. The deceased was treated with

[7] Exhibit 1, Tab 8.
[8] Exhibit 1, Tab 12.
[9] Exhibit 1, Tab 12.
[10] Exhibit 1, Tab 12.
[11] Exhibit 1, Tab 8.
[12] Exhibit 1, Tab 8.
[13] Exhibit 1, Tab 8.
[14] Exhibit 1, Tabs 8, 11 and 12.

anti-psychotic medication, including Palliperidone as a four weekly injection, Risperidone tablets, Quetiapine and Olanzapine. He was also prescribed Sodium Valproate as a mood stabiliser. The psychiatric medication was only partly effective in treating his symptoms. This was, in part, due to the fact that whilst in hospital the deceased often refused to take his medication as prescribed, as he did not acknowledge he had a psychiatric illness and was in need of care.[15]

15. In addition to his continuing psychiatric illness, the deceased was also physically unwell during his admission. The deceased had been a heavy cigarette smoker throughout his adult life, which had led to the development of chronic obstructive pulmonary disease (COPD).[16] His condition was severe throughout his admission at Bentley Hospital, due to his continued smoking and frequent refusal to take medication such as prescribed antibiotics or inhaled steroids. Unfortunately, the deceased had an unrealistic view about the best way to treat his chronic lung condition, stating that in his opinion the best treatment was to smoke more cigarettes.[17]

16. On four occasions the deceased's condition deteriorated to the extent that he had to be admitted under the Respiratory Team at RPH for treatment of type II respiratory failure. His admissions were complicated by his aggression, agitation and refusal to comply with treatment prescribed by Respiratory Physicians. During at least one of these admissions the deceased required two point restrains and a security guard to be present due to aggressive mood.[18]

17. These admissions to the RPH respiratory unit caused distress to both the deceased and his family. The deceased's family expressed their wish that, where possible, they preferred the deceased receive his treatment for his respiratory illness at Bentley Hospital, where he was relatively settled. This request was made with the knowledge that Bentley Hospital could not provide expert respiratory care or treatment, but with a focus on his overall health and wellbeing.[19]

18. Due to the deceased's frail physical state, it was the opinion of his doctors that the deceased was not well enough to travel back to New South Wales from Western Australia as he might not survive the flight.[20] His life expectancy was also not considered to

[15] Exhibit 1, Tab 12, p.2 – 3.
[16] Exhibit 1, Tab 8 and Tab 12, p.2.
[17] Exhibit 1, Tab 12, pp. – 3..
[18] Exhibit 1, Tab 12, p.2.
[19] Exhibit 1, Tab 12, p.2.
[20] Exhibit 1, Tab 6, p.5.

be long.[21] His sister's appointment as his legal guardian in New South Wales was replicated in Western Australia by the State Administrative Tribunal on 4 July 2013. Following the appointment, a family meeting was held on 25 July 2013 with the deceased's sister, as his legal guardian, and his mother. The deceased's sister made it clear that her priority for the deceased's care was to keep him comfortable. In the event of a significant physical health deterioration, active resuscitation should not be attempted.[22]

19. The deceased remained an inpatient at Bentley Health Service from the time he was admitted on 28 December 2012 until his death (apart from his four admissions to RPH respiratory unit). At all times he was treated as an involuntary patient under the *Mental Health Act 1996* (WA). His involuntary status was based on his chronic psychotic symptoms (grandiose delusions), his poor insight and judgment and the risk he posed to himself in a less restrictive setting.[23]

20. While at Bentley Hospital the deceased was managed sometimes on a secure ward and sometimes on an open ward, depending upon his symptoms and level of risk. While on the open ward he required 1:1 nursing care (a nurse in attendance at all time) due to his prior history of absconding from hospital. From 11 June 2012 until his death the deceased was cared for on the secure ward as he had become increasingly aggressive towards staff members and resistive to nursing intervention.[24]

EVENTS ON 12 AUGUST 2013

21. On the evening of 12 August 2013 the deceased stated that he was "not too good today." He had been noted to have difficulty walking and his breathing was shallow and laboured. Following a long shower he was assisted by staff to dress himself. He was given some oxygen to assist his breathing, as it was still laboured. While hospital staff was still in his room he quickly became non-responsive. He was attended to by nursing staff and the duty medical officer, however in keeping with the wishes of his sister and legal guardian, active cardiopulmonary resuscitation measure were not commenced.[25] He died at 8.00 pm.[26]

[21] Exhibit 1, Tab 8 and Tab 12, p.2.
[22] Exhibit 1, Tab 12, p.3.
[23] Exhibit 1, Tab 12, p.2 and Tab 15.
[24] Exhibit 1, Tab 12, p.3.
[25] Exhibit 1, Tab 6 and Tab 12, p.3.
[26] Exhibit 1, Tab 3.

CAUSE AND MANNER OF DEATH

22. A post mortem examination was conducted on 14 August 2013 by a Forensic Pathologist, Dr Judith McCreath. The examination showed emphysema in the lungs, probable pneumonia, enlargement of the heart, moderate narrowing of the vessels supplying blood to the heart, congestion of the liver and nodular hyperplasia of the adrenal glands. Microscopic examination showed changes in the lung consistent with chronic obstructive pulmonary disease and patchy pneumonia. Lung cancer was also identified.[27]

23. Toxicological analysis showed the presence of frusemide and no alcohol or common basic drugs were detected.[28]

24. At the conclusion of all investigations Dr McCreath formed the opinion the cause of death was bronchopneumonia on a background of chronic obstructive pulmonary disease.[29]

25. I accept and adopt the conclusion of Dr McCreath as to the cause of death.

26. It follows that I find that the manner of death was natural causes.

QUALITY OF SUPERVISION, TREATMENT AND CARE

27. Under s 25(3) of the *Coroners Act 1996* (WA), 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.

28. Sergeant Preston, who compiled the materials obtained during the coronial investigation, noted that no concerns were raised during the investigation in relation to the deceased's treatment and care whilst at Bentley Hospital.

29. The deceased's sister had last seen the deceased five days prior to his death. She was happy with the way he was being treated and believed he was well looked after. She had no specific concerns about any aspect of the deceased's medical care and supervision.[30]

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[27] Exhibit 1, Tab 4.
[28] Exhibit 1, Tab 4 and Tab 5.
[29] Exhibit 1, Tab 4.
[30] Exhibit 1, Tab 16.

30. I am satisfied that the deceased was given a high standard of care whilst at Bentley Hospital. His death was anticipated, due to the ongoing progression of his lung disease. Efforts were made to keep the deceased as comfortable as possible during his final decline, while still managing his psychiatric symptoms and the risk that they created at times for the safety of him and others.

CONCLUSION

31. The deceased was a 62 year old man with a long history of significant mental illness and a more recent history of chronic obstructive pulmonary disease, brought on by cigarette smoking.

32. For most of his life he lived in New South Wales and his health care was managed in that State. However, the deceased unexpectedly made his way to Perth 18 months prior to his death, and his care was managed at RPH and Bentley Hospital for the last year and a half of his life.

33. His death on 12 August 2013, as a result of complications of his lung disease, was expected and was managed consistently with the wishes of his legal guardian and family. No issues of concern were raised at this inquest in relation to his care or supervision. Sadly, the deceased's death was simply the inevitable result of a lifetime of cigarette smoking and the compounding issue of his psychiatric illness making it difficult for him to make the best choices for his own health.

S H Linton
Coroner
13 April 2016