Coroners Act 1996
[Section 26(1)]

Western  *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 41/18

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***Maris KUGIS*** *with an Inquest held at Perth Coroners Court, Court 85, Central Law Courts, 501 Hay Street, Perth, on 22 November 2018 find the identity of the deceased was* ***Maris KUGIS*** *and that death occurred on 10 September 2016 at Sir Charles Gairdner Hospital as the result of Bronchopneumonia in a man with Chronic Obstructive Pulmonary Disease in the following circumstances:-*

Counsel Appearing:

Sergeant L Housiaux assisted the Deputy State Coroner

Ms R Davey (State Solicitors Office) appeared on behalf of the North Metropolitan Health Service

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INTRODUCTION

Maris Kugis (the deceased) had been a long term involuntary inpatient of Graylands Hospital due to his multiple medical and mental health issues.

In September 2016 he was admitted to Sir Charles Gairdner Hospital (SCGH) as a result of his seriously declining health with increasing shortness of breath and persistently low oxygen saturations. He was diagnosed with acute on chronic type 2 respiratory failure due to chronic obstructive airway disease, congestive cardiac failure and malignant pleural effusion. He also required treatment for constipation and renal failure. He was discharged back to Graylands Hospital (Graylands) with a plan for follow up; the probability he would require palliative care in the future, with a target of maintaining oxygen saturations above 80% on room air.

Within hours of his return his oxygen saturation dropped to less than 80% on room air and he was returned to SCGH. Following discussions with the deceased's relevant carers it was determined he should be treated palliatively and he died on the late afternoon of 10 September 2016.

The deceased was 68 years of age.

By the provisions of the *Coroners Act 1996* (WA) (the Act) involuntary patients under the *Mental Health Act 2014* (WA) are 'persons held in care'. This mandates the holding of an

inquest (section 22 (1)(a)) to examine the circumstances of the death, and a coroner conducting that inquest must comment on the quality of the supervision, treatment and care of that person while held in that care. (section 25 (3))

During the course of the inquest the evidence comprised of the written documentation provided in the brief of evidence, Exhibit 1, and the oral testimony of Dr Joseph Lee, Consultant Psychiatrist, who was the deceased's treating psychiatrist at the time of his death.

BACKGROUND

The Deceased

The deceased was born on 9 July 1948 in Germany. He migrated to Australia when still a baby with his parents and older brother. The family originally lived in NSW and then Queensland where the deceased spent most of his life before moving to Perth in April 2011, aged 62.

The deceased self-reported he was a very successful high school student and attended university in Queensland, where he became involved in illicit drugs. This appears to have been the beginning of his descent into mental health issues. He claimed to have owned his own shop while in Brisbane and then to have worked as a taxi driver for a period of time. There are reference in the medical files to the deceased having two adult children, but there is no record of any contact with them and Graylands was unable to find any next of kin when

attempting to locate them. He was likewise estranged from his brother. There is no indication of the deceased having any friends or close associations during his time in Western Australia (WA). He reported he had come to WA in order to escape the mafia in Queensland, however, it was considered this was likely due to his mental health issues.[1]

The Graylands medical file reports the deceased had multiple involuntary admissions to Royal Brisbane Hospital while living in Brisbane. He had been maintained in Queensland on long acting antipsychotic injections since the 1970s. Following his move to WA he very quickly became homeless and was admitted to the Bentley Mill Street Centre as an involuntary patient under the 1996 *Mental Health Act* in July 2011, where he effectively stayed until October 2012 following a brief discharge which resulted in his conveyance to Royal Perth Hospital (RPH) by police.

On 7 October 2011, while at the Mill Street Centre, an order was made by State Administrative Tribunal (SAT) under the *Guardianship and Administration Act 1990* (WA) which made the Public Advocate the deceased's appointed limited guardian. That empowered the Public Advocate to decide where the deceased was to live, with whom he was to live, to make treatment decisions for the deceased, to determine the services to which he should have access and to consent to the use of chemical or physical restraints with respect to the person of

[1] Ex 1, tab 9

the deceased, where necessary, to enable medical investigations to be undertaken or treatment provided. The Public Advocate delegated those responsibilities to a person appointed to act on behalf of the deceased. That order was reviewed and confirmed in January 2012 to remain, and was due for review in January 2017.[2] The Public Trustee appointed a plenary administrator to the estate of the deceased.

The order enabled the deceased's appointed limited guardian to make medical decisions on behalf of the deceased because he was determined to be unable to effectively manage his wellbeing.

With those orders in place the deceased was discharged from the Mill Street Centre to supported accommodation in a one bedroom apartment in Northbridge, managed by Foundation Housing, on 2 October 2012. At that time he was described as pleasant and cooperative with no persecutory ideation.[3]

Unfortunately, following his discharge his mental state quickly deteriorated and it was apparent he was medication noncompliant. He abused community carers appointed to assist him with his home care and abused fellow residents. This resulted in frequent disputes and altercations with other residents and those attempting to assist him. The deceased

[2] Personal Communication Ms Gail Warley – Manager – Public Advocates Office to Sgt Housiaux 22.11.2018
[3] t 22.11.18, p9

was again admitted to Graylands on 15 March 2013 as an involuntary patient under the *Mental Health Act*.

The deceased remained a resident of Graylands, in different wards, until his death. His welfare continued to be supervised through the Public Advocate and his finances managed by the Public Trustee, as ordered by the SAT on 25 January 2012.

The deceased's continuing involuntary status under the relevant Mental Health Act was reviewed three monthly by the Mental Health Review Board.[4] The deceased was assessed by the Aged Care Assessment Team (ACAT) in 2013 and it was determined he would never be able to live in the community and was unsuited to aged care living. His assessment for residential care was declined as his mental health issues made him unsuitable for nursing home living.

Medical History

The deceased had serious and long term medical issues which undoubtedly exacerbated his mental health issues.[5] The deceased suffered ankylosing spondylitis of the spine which caused him serious and unremitting chronic pain. He had an orchidectomy in 2003 which resulted in hypogonadism.

In conjunction with his ankylosing spondylitis he suffered osteoporosis with compression fractures in his thoracic and

[4] t 22.11.18, p9 & Ex 1, tab 14/15
[5] t 22.11.18, p7

lumbar spine, severe kyphosis and osteoarthritis, all of which resulted in serious pain managed with opiate analgesia, and for which the deceased had been referred to the pain clinic. The deceased refused to follow the management regime offered by the pain clinic and his treatment for osteoporosis was ceased due to him declining further intervention.

The deceased had bilateral hip replacements in the 1990s and had dislocated both his hips in 2011, but refused any intervention to correct that issue and as a result was wheelchair bound.

The deceased was a smoker, had chronic obstructive pulmonary disease, suffered an umbilical hernia, had cataracts in both his eyes, and in the months prior to his death had hyponatraemia (low sodium) which in hindsight may have been due to an adenocarcinoma, undiagnosed until shortly before his death in September 2016. The deceased had ischaemic heart disease for which he refused investigation or treatment, peripheral vascular disease, and an abnormal Prostate Specific Antigen (PSA) which was awaiting further investigation as well as pressure sores due to his poor mobility.

As a result of his physical medical problems the deceased had a significant medication regime to which were also added his requirements for antipsychotic medication and mood stabilisers. He required oral medication twice daily, as well as

twice weekly and monthly antipsychotic injections and weekly opiate analgesia patches.

In order to cope with the deceased's physical ailments he frequently required transfer from Graylands to SCGH when he would allow medical intervention. In addition, as a result of the deceased frequently absconding from Graylands and being at large in the community, he was frequently seen in the emergency departments of SCGH and Royal Perth Hospital (RPH) either by self-presenting or being taken there by the police because he could no longer survive on the streets.[6] While at large it was clear he doctor shopped for opiate analgesia.[7]

The deceased's more recent medical interventions involved endocrinology outpatients in February 2015 to review his low testosterone and osteoporosis, urology assessment in March 2015 to investigate his rising PSA, vascular surgery and ulcer management clinics for review of his poorly healing ulcer. The deceased was frequently assessed in the pain clinics but refused ongoing treatment.

Mental Health Issues

The deceased's mental health issues fell into two categories. He was diagnosed with chronic schizophrenia in the 1970s and had been treated with antipsychotics since that time. In

[6] t 22.11.18, p10
[7] Ex 1, tab 9

addition, the deceased suffered from personality disorders, but was never suitable for long term therapy necessary to address his personality traits.

The deceased had originally been treated with haloperidol, successfully, but later in life he became medication resistant and haloperidol was found to be less effective. Despite being treated long term with compulsory depot medication, the deceased always struggled against his injections and remained very hostile to any depot antipsychotic. His attitude, in conjunction with his numerous medical conditions, made him extremely difficult to manage in any setting.

In Graylands the deceased remained in constant pain as a result of his physical medical issues which made him very irritable as far as the management of his mental health issues were concerned. He was described as irritable, constantly refusing treatment and struggling against medication he was required to take as an involuntary patient.

The deceased was litigious which, with his persecutory psychotic symptoms, resulted in frequent complaints to the Chief Psychiatrist and the Australian Health Practitioner Regulation Agency (AHPRA) about all those attempting to care for him. He accused the system of attempting to kill him by neglecting his physical health, despite the fact he refused interventions which would improve his circumstances. His psychotic disorder proved to be treatment resistant and

medications which had been effective previously no longer ameliorated his symptoms.

In mid-2013 the deceased was transferred to the extended care team in an attempt to address his social issues, but required treatment on the secure ward to ameliorate long term restrictions. The deceased was allowed 8 hours unescorted ground access a day, but absconded frequently despite being in his wheelchair. He was able to use public transport and when able, obtained prescription medication from various general practitioners not aware of his circumstances.

On any occasion the deceased was made a voluntary patient in an attempt to allow him more freedom, it was unsuccessful as he refused medication and again absconded until needing assistance again. When absconding he would present to the police complaining about the staff in Graylands. The deceased would frequently self-present to an emergency department after a period of absconding in a dehabilitated state and need to be returned to hospital as an involuntary patient.[8]

2016

In December 2015 the deceased was transferred from the extended care team to Carson Ward and in January 2016 came under the care of Dr Lee, consultant Psychiatrist.

[8] Ex 1, tab 13

The deceased accused the staff on Carson Ward of giving him electroconvulsive treatment while he was asleep and his mood fluctuated. He was not cooperative with care and continued to struggle against his antipsychotic injections. He threatened staff frequently and would verbally abuse those attempting to interact with him. He refused to attend medical appointments for his physical ailments or take medications as prescribed. Attempts to correct his low sodium levels with fluid restriction were resisted in the form of threatening to report staff for neglect. Staff found it difficult to assess the deceased due to his delusions and a difficulty in determining which symptoms were grounded in reality and which were delusional.

Attempts were made to treat the deceased with respect to his psychiatric conditions from those in the psychiatric team, clinical psychologists with respect to his personality disorders, physiotherapy, occupational therapy, and dietetics for his physical conditions, and numerous nursing staff. He was also seen for medical reviews by the Graylands GP in reach service.

The deceased's situation continued to be reviewed three monthly by the Mental Health Review Board who consistently ordered the deceased remain as an involuntary patient in an authorised facility. The deceased would attend the board on occasion to accuse staff of mistreatment, or would not attend at all.

In March 2016 Dr Leah Power from the pain medicine clinic at SCGH discharged the deceased from the clinic because he had refused any of the treatments it was believed would assist him. The deceased complained of increasing pain and used opiates regularly resulting in buprenorphine patches being added to his medication regime in May 2016. The deceased's pain levels due to his osteoporosis were extreme and although he accepted medication, including OxyContin, he refused to attend any specialist appointments.

Between 20 May and 3 June 2016 the deceased absconded while on an unescorted ground access and when he eventually returned via Armadale Hospital and the police he was clearly unwell. Investigations revealed low sodium levels and in conjunction with SCGH attempts were made to restrict his fluid intake and undertake further investigations. He was transferred to SCGH on 24 June 2016 due to further deterioration and his fluid intake was again restricted until his sodium level improved by 27 June 2016. He was returned to Graylands but with decreased mobility and continuing complaints of pain.

On readmission to SCGH due to falling oxygen saturations he was diagnosed with likely aspiration pneumonia and pressure sores and provided with antibiotics, and again diagnosed with low sodium before returning to Graylands. His antipsychotic olanzapine was changed to palperidone, but both his mental and physical condition continued to deteriorate. During

admissions to SCGH the deceased and his guardian declined treatment for cardiac or pain/spinal investigations despite confirmed compression fractures.[9]

On admission to SCGH on 18 August 2016 for low sodium levels the deceased was diagnosed with syndrome inappropriate antidiuretic hormones (SIADH) and he was again treated by fluid restriction. He allowed some investigations to be completed once treated with a long acting opiate on return to Graylands, and it was assessed his chronic obstructive pulmonary disease was progressing. His management was refined, but he continued to experience low oxygen saturations and was returned to SCGH. At this stage attempts were made by social workers to find any of the deceased's family and he was also provided with daily visits from a social worker.

September 2016

Investigation at SCGH located a large right sided plural effusion and fluid sent for cytology indicated an adenocarcinoma. He was diagnosed with acute on chronic type 2 respiratory failure due to chronic obstructive airway disease, congestive cardiac failure and malignant pleural effusion. He also required treatment for constipation and renal failure.

The deceased was discharged back to Graylands on 8 September 2016 with a plan for the consideration of

[9] Ex 1, tab 17

palliative care and admission to a hospital if his oxygen saturations fell below 80%.

That day the deceased was returned to SCGH hours after being discharged with the above plan. His oxygen saturation had dropped and he had increasing respiratory distress. Following discussions between the deceased and his guardian on 9 September 2016 it was agreed the deceased would receive palliative care and essential medication was ceased. Not for cardiopulmonary resuscitation had been implemented since 5 September 2016 pending the discussion between medical staff, the deceased and his guardian.[10]

The deceased was palliated and kept comfortable following which he deteriorated very quickly and died on 10 September 2016 in SCGH.

POST MORTEM REPORT

The post mortem examination of the deceased occurred on 15 September 2016 at the PathWest Laboratory of Medicine WA and was conducted by Dr D Moss, Forensic Pathologist.

The examination revealed severe infection in both the deceased's lungs on the background of his obstructive pulmonary disease. There was a tumour in the tail of the pancreas, but definite metastatic disease was not apparent. There was fluid in both chest cavities and the abdomen, with

[10] Ex 1, tab 19

hardening and narrowing of the blood vessels over the surface of the heart. The large bowel was dilated and further investigations were undertaken.

Microscopic examination of the lungs confirmed severe emphysematous change as well as confirming severe bronchopneumonia. Histology of the pancreatic tumour showed moderately differentiated adenocarcinoma, while sections from the pulmonary hilar lymph nodes showed acute lymphadenitis, but no evidence of metastatic disease. Microbiology and virology of the lungs did not show specific pathogenic organisms and toxicology showed multiple prescribed medications in keeping with the deceased's medical history.[11]

On 6 April 2017 Dr Moss concluded the cause of death for the deceased was bronchopneumonia in a man with chronic obstructive pulmonary disease.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a long term involuntary patient at Graylands at the time of his death which occurred at SCGH due to his physical medical conditions on 10 September 2016.

The deceased had been diagnosed with chronic schizophrenia in the 1970s and continued to suffer schizophrenia on his arrival to Western Australia in 2011. While his schizophrenia

[11] Ex 1, tab 6

was theoretically treatable with antipsychotic medication, his significant personality disorders interfered with the appropriate management of his schizophrenia. Over time the deceased became less responsive to treatment and management for his mental health issues which correspondently interfered with appropriate treatment for his serious physical medical conditions.

The deceased's physical disabilities caused him serious and unrelenting pain which exacerbated his mental health issues.

The combination of the deceased's mental health issues and his serious and progressing physical difficulties made the deceased an extremely difficult management prospect for any clinicians.

The deceased eventually succumbed to his physical medical diagnoses and died on 10 September 2016, although there is no doubt the deceased's physical conditions were exacerbated by his mental health issues.

MANNER AND CAUSE OF DEATH

I am satisfied the deceased died as the result of bronchopneumonia in a man with chronic obstructive pulmonary disease.

I find death occurred by way of Natural Causes.

COMMENTS ON THE DECEASED'S SUPERVISION, TREATMENT AND CARE

I am satisfied that due to the deceased's combined physical and mental health issues he was an extremely difficult patient for clinicians dealing with both his mental health and physical issues.

He had been an inpatient at Graylands Hospital constantly since 2013 as a result of his inability to survive successfully in the community. Earlier attempts to make him a voluntary patient and so allow him some dignity and freedom of movement had always resulted in a serious decline in his mental health, and so prevented any intervention in his clinical medical complaints. Management of his physical illnesses was frequently complicated by his mental health issues and his resistance to compliance with recommended treatment, medication, or planned follow ups prevented optimal management.

From the beginning of 2016 the deceased's deterioration was rapid and, following his period of absconding in May 2016, he was frequently admitted to SCGH as his main clinical facility. Following his return to Graylands he was diagnosed with low sodium levels and it was established that he had SIADH. He also presented with respiratory compromise diagnosed as aspiration pneumonia and chronic obstructive pulmonary disease with acute ischaemic cardiac events.

During an admission in early September 2016 to SCGH he was diagnosed with malignant metastatic adenocarcinoma in a pleural effusion.

At post mortem examination it was established the adenocarcinoma originated in the pancreas and pancreatic cancer is well known to present late with a poor prognosis. It is likely, in hindsight, the low sodium levels seen since his return to care in May 2016 related to the pancreatic cancer.

It is clear the deceased's treatment was reasonable in all the circumstances of his chronic psychiatric illness and his severe clinical conditions. The fact he was so pain driven and resistant to intervention hindered clinicians in the ability to treat him optimally for all his medical issues.

Review by Dr Adam Brett, Consultant Psychiatrist, of the deceased's management while in Graylands confirmed the deceased had a well-established diagnosis of paranoid schizophrenia, complicated by cluster B personality disorder and poor compliance with management and treatment. Dr Brett agreed the deceased was chronically unwell, both mentally and medically and that the treatment options available to his treating clinicians were limited due to the deceased's poor compliance with management of both his mental and medical issues.[12]

[12] Ex 1, tab 10

Dr Brett confirmed his opinion the deceased's care while an involuntary patient was very good in very difficult circumstances. The deceased was provided with as much clinical medical input as he would tolerate and his situation at all times was well documented.

I am satisfied the supervision, treatment and care of the deceased while an involuntary patient under the care of Graylands Hospital was reasonable and appropriate.

E F Vicker
Deputy State Coroner
4 April 2019