Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: 75/19

I, Sarah Helen Linton, Coroner, having investigated the death of ***Jason James Sutherland MALLETT*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***26 November 2019*** *find that the identity of the deceased person was* ***Jason James Sutherland MALLETT*** *and that death occurred on* ***3 March 2017*** *at* ***Sir Charles Gairdner Hospital*** *as a result of* ***cardiac arrhythmia in a man with coronary arteriosclerosis and myocarditis*** *in the following circumstances:*

Counsel Appearing:

Mr B Nelson assisting the Coroner.
Mr S Pack (State Solicitor's Office) appearing on behalf of the North Metropolitan Health Service.

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INTRODUCTION

1. Jason James Sutherland Mallett was a 46 year old man who died on 3 March 2017 at Sir Charles Gairdner Hospital. His family have requested that I refer to him as Jason.

2. Immediately before his death, Jason was an involuntary patient under the *Mental Health Act 2014* (WA). As a consequence, at the time of his death the deceased was a 'person held in care' for the purposes of the *Coroners Act 1996* (WA). In such circumstances, a coronial inquest is mandatory and I must comment on the quality of the supervision, treatment and care of Jason while he was held in care.[1] I held an inquest at the Perth Coroner's Court on 26 November 2019.

3. Jason was being treated for mental health issues at Sir Charles Gairdner Hospital when he died as a result of a sudden disturbance of his heart's normal beating rhythm (cardiac arrhythmia) on the background of significant pre-existing heart disease. The inquest focussed primarily on Jason's medical treatment during this admission to identify whether his heart disease should have been identified and whether his monitoring was adequate.

HISTORY OF EVENTS LEADING TO DEATH

4. Jason was born on 16 June 1970[2] at St John of God Hospital in Subiaco.[3] He attended Hale School for his primary and secondary education, and was said to have especially enjoyed music.[4] He was described as being kind and intelligent[5] and he enjoyed a close relationship with his family.[6]

5. Jason moved to Adelaide when he was 18 years old to study at Flinders University.[7] He later returned to Perth and continued his studies at Curtin University.[8] Prior to completing his degree, Jason obtained employment as a public servant, where he worked for a couple of years before his mental health issues overtook his life. Jason had other short stints of employment during his twenties as a security guard, but otherwise remained unemployed and lived in rental accommodation owned by his family.[9]

6. Jason had begun using marijuana when he was 15 years of age, and when he was 23 years of age it appears he began to experiment with other illicit drugs. In April 1995, when he was 24 years of age, Jason was admitted as an involuntary patient at Graylands Hospital with a diagnosis of psychotic disorder associated with severe polysubstance abuse, including

[1] Section 22(1)(a) *Coroners Act 1996* (WA).
[2] Exhibit 1, Tab 1.
[3] Exhibit 1, Tab 8 [2].
[4] Exhibit 1, Tab 8 [6].
[5] Exhibit 1, Tab 9, p. 1.
[6] Exhibit 1, Tab 8 [5]
[7] Exhibit 1, Tab 8 [9]; Exhibit 1, Tab 9, p 1.
[8] Exhibit 1, Tab 8 [10].
[9] Exhibit 1, Tab 9, p 1.

amphetamine and marijuana. This first admission lasted for about a month.[10]

7. After discharge from Graylands Hospital Jason became a patient of the Subiaco Mental Health Service (Avro House) for many years. Consultant Psychiatrist Dr John Fletcher from that service became his treating psychiatrist for the next eight years or more leading up to Jason's death. In Dr Fletcher's opinion, Jason's first hospital admission was in fact his first episode of Bipolar Affective or Mood Disorder and probably was correctly labelled a manic episode likely precipitated by drug use.[11]

8. Jason's primary diagnoses in the eight year period he was treated by Dr Fletcher was Bipolar or Mood Affective Disorder, as well as Schizo-affective disorder. His main activities, interests and preoccupations revolved around Security matters, with a special interest in the army and law enforcement agencies, and he wished that he could join them. As noted above, he did manage to obtain some security type jobs, but could not hold them down for long due to the severity of his underlying mental illness, and he received a Disability Support Pension.[12]

9. In mid-2014 Jason saw another psychiatrist, Dr Haroon Riaz, at a private psychiatric service, for assessment of whether he had adult attention deficit hyperactivity disorder. He was diagnosed with ADHD and was treated with long acting methylphenidate medication on a gradually increasing dose from 2014 to 2016.[13]

10. Dr Riaz took some steps to explore whether there would be any impact on Jason's schizophrenia/bipolar disorder from prescribing stimulant medication, but the decision appears to have been made that it was not inappropriate. Dr Fletcher had indicated that he did not object to Dr Riaz prescribing stimulant medication to Jason, but I was informed that it is not currently a condition dealt with in public mental health services.[14]

11. Jason had frequent manic relapses with psychotic features over the years but very few depressed episodes. His disorder was almost always compounded, and often precipitated, by drug use. Nevertheless, it was generally felt that his mental health was kept under control.[15]

12. Jason appeared generally stable and well in 2016 and he had successfully ceased illicit drug use. However, on 9 September 2016 Jason produced a positive urine drug screening test for marijuana, which required his methylphenidate medication to be ceased, pursuant to the treating regulations. Dr Riaz reviewed Jason on 12 October 2016, at which time he presented as stable and well. He was informed of his positive test for marijuana and the consequences. He did not see Dr Riaz again after this date.[16]

[10] Exhibit 1, Tab 12.
[11] Exhibit 1, Tab 12.
[12] Exhibit 1, Tab 12.
[13] Exhibit 1, Tab 13.
[14] Exhibit 1, Tab 16, p. 4 and p.9.
[15] Exhibit 1, Tab 12.
[16] Exhibit 1, Tab 13.

13. Jason's family, and his mother in particular, had always been very supportive of Jason. Around Christmas 2016 Jason's family noticed a significant change in his behaviour. He was uncharacteristically aggressive, paranoid and rude. It appeared that his mental health was deteriorating and he admitted that he had been using amphetamines and cannabis. He was clearly not himself, as he was a polite and gentle man when well.[17]

14. Jason was briefly admitted to the 'Hospital in the Home' community service on 10 January 2017 for two days but he failed to engage and discharged himself when the Hospital in the Home team visited him at home as it felt like an invasion of his privacy. It was also felt that he did not meet their admission criteria as it is a voluntary service.[18]

15. He remained difficult to manage and showed the typical signs of being in an early relapse. Dr Fletcher's last face to face contact with Jason was on 3 February 2017, when he remained paranoid and self-blaming and admitted being only intermittently compliant with his medications. In later telephone conversations on 9, 14 and 15 February 2017, Jason seemed more hopeful and expressed a belief that the methylamphetamine was working its way out of his system, although he was still using cannabis. Dr Fletcher went on annual leave on 15 February 2017.[19]

16. Jason's family and Dr Fletcher made unsuccessful attempts to get Jason admitted for private mental health treatment around this time.[20]

17. Jason was ultimately admitted as a voluntary patient to the Sir Charles Gairdner Hospital Mental Health Unit on 24 February 2017. He looked dishevelled on arrival and his hygiene was poor. Jason was reviewed by a number of psychiatrists over the next few days and found to be paranoid and evasive and his presentation was virtually identical to previous relapses. He was started on various medications to manage his illicit drug withdrawals and psychotic symptoms. The impression was that Jason was having a manic relapse of his Bipolar Affective Disorder with psychotic features.

18. Jason's family had limited their visits to him as he wanted them to take him home but they knew he was too unwell and didn't want to unsettle him. However, in one visit by a family member, it was observed that he seemed to be grey in the face and legs, like his circulation wasn't functioning fully.[21]

19. Jason had a physical examination on 24 February 2017 and an ECG was requested, which appeared to be normal.[22] I note another ECG was performed later on 2 March 2017, which also did not appear to raise concern.[23]

[17] Exhibit 1, Tab 8 [23] – [39] and Tab 12.
[18] Exhibit 1, Tab 12 and Tab 16 [26] – [28].
[19] Exhibit 1, Tab 12 and Tab 16 [26].
[20] Exhibit 1, Tab 8 [23] – [39] and Tab 12 and Tab 16.
[21] Exhibit 1, Tab 8 [40] – [42].
[22] Exhibit 1, Tab 16 [34].
[23] Exhibit 1, Tab 16 [37].

20. Jason was made an involuntary patient on 27 February 2017 after being reviewed by Consultant Psychiatrist Dr Sewell, as he was increasingly distressed, manic and significantly psychotic and needed to be in the locked part of the Mental Health Unit.[24]

21. Dr Fletcher noted that Jason would have been accepting of being a voluntary patient, as he was a chain-smoker and he would be able to smoke on an open ward by coming and going outside the ward. The change to an involuntary ward was significant as he was no longer able to smoke. Jason had previously threatened on several occasions to burn down the Mental Health Unit at SCGH if he was admitted there, as he would be unable to smoke cigarettes.[25]

22. There is evidence Jason did, as predicted, have difficulty adjusting to the non-smoking rules in the hospital. Despite being given nicotine replacement therapy, he became very distressed at being unable to smoke. Some notes he wrote show that the inability to smoke cigarettes was a pressing concern for him.[26] On 2 March 2017 Jason rang his mother and complained that he couldn't have a cigarette and was going to die there. She called hospital staff immediately after the call as she was concerned. She could hear Jason yelling and screaming in the background during this call.[27]

23. Jason was very agitated and abusive towards staff at this time. He was given medications to calm him, including intramuscular clonazepam, without success. Eventually security were called and Jason was placed in seclusion for two hours at 6.30 pm, which was extended for another hour at 8.30 pm due to his ongoing extreme agitation.[28]

24. At about 9.30 pm Jason was observed in the seclusion room by Dr Altham and nurses. He appeared to remain paranoid and hypervigilant but was willing to take his oral medication. After he took a dose of quetiapine, chloral hydrate and Phenergan, his seclusion was revoked. He was then walked back to his bedroom and encouraged to stay in his room to allow the medications to take effect.[29]

25. Dr Altham directed that Jason be observed every 30 minutes. He was observed at 9.55 pm and he was still awake. He was subsequently observed every half an hour overnight and on each occasion he appeared asleep. It seems he chose to sleep on the floor of his room, and a decision was made not to disturb him.[30]

26. On the last occasions, at 6.00 and 6.30 am, Jason was still sleeping on the floor and was heard breathing loudly and snoring.[31]

[24] Exhibit 1, Tab 12.
[25] Exhibit 1, Tab 12, p. 2.
[26] Exhibit 1, Tab 20.
[27] Exhibit 1, Tab 8 [44] – [47].
[28] Exhibit 1, Tab 15.
[29] Exhibit 1, Tab 10 and Tab 15.
[30] Exhibit 1, Tab 10 and Tab 11.
[31] Exhibit 1, Tab 11 [18].

27. At 6.45 am two nurses entered Jason's room to do the last observations prior to handover. One of the nurses had conducted the 6.00 am and 6.30 am checks. This nurse spoke to Jason to try to wake him and then approached closer. He squeezed Jason's trapezius as a physical stimulation to try to help wake him, but Jason was unresponsive. The nurse then noticed that Jason appeared blue and stiff, so he activated the duress alarm.[32]

28. The two nurses then immediately commenced CPR. They applied the pads for the Automated External Defibrillator, but could see the rhythm showed Jason was in asystole, which is a form of cardiac arrest that does not benefit from a shock via the defibrillator, so they returned to CPR.[33]

29. Dr Altham attended along with other staff and CPR was continued until an ambulance arrived. There was a slight delay for the ambulance to enter the unit and Jason was then transferred by ambulance to the Emergency Department. On examination he was pulseless with no pressure. He was still in asystole. A bedside ultrasound showed no cardiac activity. It was felt that given his non-shockable rhythm and unknown downtime, he likely had a very poor prognosis, so a decision was made to terminate any further resuscitation efforts and his death was confirmed at 7.43 am.[34]

CAUSE AND MANNER OF DEATH

30. The former Chief Forensic Pathologist, Dr Clive Cooke, conducted a post-mortem examination. The examination showed changes of recent medical treatment, including resuscitation attempts. There was enlargement of the heart, with some thickening of the heart muscle. Arteriosclerotic hardening of the arteries was present, with areas of coronary arteriosclerosis.[35]

31. Following further investigations, which showed scarring of the heart muscle, as well as foci of inflammation association with degeneration of heart muscle cells (myocarditis), Dr Cooke concluded that Jason's death was caused by a cardiac arrhythmia in a man with coronary arteriosclerosis and myocarditis.[36] Dr Cooke explained that it appeared from the information available that Jason had died from a sudden disturbance in his heart's normal beating rhythm, arising on the basis of significant pre-existing heart disease.[37]

32. I accept and adopt the opinion of Dr Cooke as to the cause of death. Taking into account also the opinion of Professor Joyce, which I detail below, about the lack of any clear contribution from Jason's medications, I find that death arose by way of natural causes.

[32] Exhibit 1, Tab 11.
[33] Exhibit 1, Tab 11.
[34] Exhibit 1, Tab 5 and Tab 15.
[35] Exhibit 1, Tab 6.
[36] Exhibit 1, Tab 6, p 1.
[37] Exhibit 1, Tab 6, p. 2.

COMMENTS ON SUPERVISION, TREATMENT & CARE

Management of Jason's Cardiac Risk

33. At the time of his death Jason was 46 years old and had a strong history of being extremely obese, having a raised blood sugar as in Diabetes 2 disorder, and was on medication for both raised cholesterol and lipids, and for hypertension. In combination, this led to a diagnosis of metabolic syndrome. Some of his medications would have contributed to the development of this condition, and it is known that it is more commonly seen in people with mental health problems such as schizophrenia and bipolar mood disorder. It can lead to increased chance of heart attack/stroke amongst other things.[38]

34. Therefore, although he had never had a heart attack or stroke or any other severe cardiovascular adverse event, Jason was at very high risk of having a heart attack, when he was admitted to hospital on the last occasion.[39]

35. The Court requested an expert cardiology review of the circumstances leading up to Jason's death. Cardiologist Dr Johan Janssen provided an expert opinion to the Court. Dr Janssen noted that it had been recognised that Jason had metabolic syndrome a number of years prior to his death, and he had been given lifestyle advice and prescribed medication to reduce his high cholesterol, but generally his cardiovascular risk did not appear to be at the forefront of his treatment plan in the years prior to his death, with the greater focus generally on his psychiatric care. It was not apparent to Dr Janssen from the documentation why more was not done to pursue further management of his cardiovascular risk factors over time.[40]

36. When Jason was admitted to the Mental Health Unit at SCGH, there were two ECG's performed, the second on the day before he died. Dr Janssen reviewed the results and concluded that the ECG's were normal and did not suggest acute coronary syndrome nor prolonged QT times nor myocarditis. Although the post mortem examination later found that he had coronary artery disease, Dr Janssen felt that clinically it was not obvious.[41]

37. Dr Janssen noted that there is evidence that psychological stress, particularly acute stress, is associated with cardiovascular disease. The risk is even greater in patients with coronary artery disease. The combination of stress and coronary artery disease can cause myocardial infarction (a heart attack). The post mortem findings showed that Jason had significant coronary artery disease and myocarditis. In addition, the known circumstances indicate he was under extreme agitation on the night prior to his death. Dr Janssen expressed the opinion these findings, in combination with the doses of psychotropic drugs, benziodiazepines, an intermediate level of marijuana and, his cigarette smoking, put Jason at increased risk of ventricular arrhythmia leading to sudden death.[42] Dr Janssen agreed with Dr Cooke's opinion that Jason most likely suffered an arrhythmic death.

[38] Exhibit 1, Tab 16, *Handy fact sheet 'Metabolic Syndrome'*.
[39] Exhibit 1, Tab 12.
[40] Exhibit 1, Tab 17.
[41] Exhibit 1, Tab 17.
[42] Exhibit 1, Tab 17.

Dr Janssen felt the myocarditis and combination of drugs was probably instrumental.[43]

Toxicology

38. Dr Janssen referred to the combination of drugs that Jason was given as possibly contributing to his cardiac event. This was explored further in the coronial investigation.

39. Prior to his death Jason was given a number of different medications, including a number of sedating medications to try to calm him. To determine whether these medications contributed to the death, the Court obtained an expert opinion from Professor David Joyce, a Clinical Pharmacologist and Consultant Physician. Professor Joyce reviewed the documentation that showed Jason's medications prior to hospital admission, as well as the medications administered to him in hospital. Professor Joyce also reviewed the post-mortem toxicology results.[44]

40. Professor Joyce noted that Jason's general observations in the period from 24 February to 2 March were unremarkable, his blood pressure control was satisfactory and the control of his diabetes was satisfactory.[45]

41. Psychotropic drugs were given regularly during the hospital admission, as well as some other medications. Professor Joyce found that overall, the post-mortem toxicology results showed blood concentrations of the drugs that seem to have been within the ranges anticipated from the dosage regimens. Therefore, any consideration of their toxicity and possible contribution to the death had to focus on what risk conventional therapy with multiple drugs might pose to a man with coronary heart disease and unrecognised myocarditis and fibrosis. Having considered the matter in depth, Professor Joyce found that overall, the evidence did not give a very strong reason to implicate the psychotropic drugs in Jason's death, although a contribution could not be completely dismissed.[46]

42. In conclusion, Professor Joyce indicated that he had not found evidence to support anything more suspicious than a drug involvement, and he felt it appropriate that drug toxicity be omitted from mention among the causes of death, which is consistent with Dr Cooke's expert opinion.[47]

Management of Jason's Psychiatric Care

43. Dr Fletcher was not involved in Jason's treatment immediately prior to his death, but he was given information about his last admission and canvassed this in his report to the Court. Dr Fletcher acknowledged that Jason had metabolic syndrome and was probably at high risk of having a heart attack when he was admitted to hospital on the last occasion.[48] Dr Fletcher noted

[43] Exhibit 1, Tab 17.
[44] Exhibit 1, Tab 18.
[45] Exhibit 1, Tab 18.
[46] Exhibit 1, Tab 18.
[47] Exhibit 1, Tab 18.
[48] Exhibit 1, Tab 12.

that Jason had a "very stressful but necessary psychiatric admission and seclusion"[49] due to his highly aroused state that had led to both verbal and potentially physical aggression to other patients and staff. In Dr Fletcher's opinion, the period of seclusion was "for very clear and justifiable … clinical reasons."[50]

44. Dr Adam Brett is a Consultant Psychiatrist who often provides expert opinions on coronial matters. Dr Brett reviewed Jason's medical care at the request of the Court and gave an expert opinion on his psychiatric care whilst in hospital prior to his death. Dr Brett provided a written report and gave evidence at the inquest.

45. Dr Brett observed that Jason had serious mental health issues and associated medical issues that were difficult to manage. He noted that mental health problems are often associated with an increased risk of physical health issues, so Jason's case was not uncommon in that regard. Similarly to Dr Fletcher and Dr Janssen, Dr Brett noted that metabolic syndrome is a common problem with modern antipsychotic medication and Jason's obesity would have put more strain on his cardiovascular system, together with his significant history of smoking.[51]

46. Overall, Dr Brett considered the medical care was very good, within the constraints of current delivery of mental health care in this State, and the clinicians worked as well as they could to address his multiple problems.[52]

47. Dr Brett did express some reservations about whether there was any good evidence to support the diagnosis of ADHD, but also indicated that he did not believe that this diagnosis had an impact on Jason's death.[53] In that regard, Dr Brett observed that it is not good practice for an individual with multiple mental health issues to be managed by different services, and queried why people with ADHD cannot be managed in the public mental health service.[54]

48. Taking this one step further, Dr Brett suggested that Jason's problems were complex and would have ideally been managed by one coordinating service, in a model similar to Headspace, to provide a more holistic approach to his patient care. In Jason's case, this would have meant that his mental health, substance abuse, medical monitoring, case management, peer and carer support could all occur under the same roof.[55] Dr Brett indicated that the lack of a coordinated approach to complex mental health care for adults has been highlighted as a significant problem in recent reports. He believes there needs to be a simple and consumer friendly service where people's overall needs can be addressed in one place. Dr Brett suggested that a service such as this may have helped in Jason's overall care.[56]

[49] Exhibit 1, Tab 12, p. 5.
[50] Exhibit 1, Tab 12, p. 5.
[51] Exhibit 16, p. 10.
[52] Exhibit 1, Tab 16, p. 9.
[53] Exhibit 1, Tab 16, p. 9.
[54] T 15 – 16.
[55] T 15; Exhibit 1, Tab 16, pp. 9 – 10.
[56] Exhibit 1, Tab 16, p. 10.

49. Noting Dr Janssen's comments about the lack of focus on Jason's cardiovascular issues, I can see how a coordinated service might have benefited Jason, allowing a more holistic approach to his mental and physical health care.

50. In summary, Dr Brett concluded that Jason had a serious mental disorder whose management was difficult. His care whilst in his final hospitalisation was appropriate, given the issues, but more may have been done to reduce his risk factors in the years before his death if a more coordinated system was able to be offered.[57] Nevertheless, Dr Brett was complimentary of the consistency and level of care that Dr Fletcher provided to Jason, which he noted was quite unusual in mental health and of obvious benefit to Jason.[58]

Access to Smoking Areas or Nicotine Replacement Therapy

51. All WA Hospitals have gone completely smoke free but as a voluntary patient, Jason would have had the option of leaving the hospital premises to smoke on the street, although this would obviously not be encouraged by hospital staff. Once he became an involuntary patient, that option was no longer available. The evidence indicates the inability to smoke cigarettes while an involuntary patient detrimentally affected Jason's mental health and appears to have led to his increased agitation that eventually resulted in him being sedated and moved to seclusion.

52. Dr Mark McAndrew was Head of Clinical Service at SCGH Mental Health Service at the time of Jason's death and is now the Acting Medical Co-Director for Community Mental Health in the North Metro Health Service. Dr McAndrew did not have any direct involvement in Jason's care, but he reviewed his medical records and was able to speak to the care provided to Jason at the hospital.

53. Jason was provided with nicotine replacement therapy but it appears he did not find that a sufficient substitute. Dr McAndrew gave evidence that for most patients this is not the case, and the complete smoking ban (which began at Sir Charles Gairdner Hospital in 2015) has caused less problems than anticipated, and the number of clinical incidents actually reduced. Dr McAndrew advised that the Mental Health Unit have taken a very proactive approach to nicotine replacement, which has proven to be very effective in curbing nicotine withdrawal, although he accepted that for a chain smoker like Jason, the removal of the ritual surrounding smoking a cigarette could have affected him more than others. Nevertheless, on the whole, they have had "more compliments than complaints in respect of that policy."[59]

54. Given it does not appear to be a significant problem for the majority of patients, and noting there are obvious reasons why the WA Health Department as a whole has brought in the blanket non-smoking rule in WA public hospitals, I do not take this issue any further.

[57] Exhibit 1, Tab 16, p. 12.
[58] T 16.
[59] T 28.

Physical Monitoring and Pulse Oximetry

55. The North Metropolitan Health Service has a Seclusion policy, which was complied with in Jason's case. However, Dr Brett noted the policy does not include physical monitoring recommendations. Instead, it requires the nursing staff to observe the patient through a window and mentally note the respiratory rate.[60]

56. Dr Brett referred to prescribing guidelines that make recommendations for the physical monitoring of patients following rapid tranquilisation, which he felt could apply following the intramuscular administration of medication to Jason. Dr Brett accepted that Jason's agitation may have made the usual recommended monitoring of vital signs inappropriate, but suggested the use of continuous pulse oximetry to measure oxygen saturation would have been desirable. Whether that would have impacted on the outcome was difficult to say, but Dr Brett considered it would have been a helpful safety measure to adopt if it was available and he was willing to comply with it.[61]

57. Dr Brett explained that a pulse oximeter is a machine which is placed on a patient's finger and it measures the saturation of oxygen in the blood. It is non-invasive and there are wireless versions available, so they are not uncomfortable to wear, although people can take them off and they can fall off when people are asleep, so they do have some practical difficulties. Nevertheless, Dr Brett is aware that pulse oximetry is used more frequently now in intensive psychiatric care and inpatient settings.[62]

58. Dr McAndrew expressed the opinion that the team who managed Jason's care under difficult circumstances performed their task quite well. Dr McAndrew queried whether the term 'rapid tranquilisation' appropriately applied to Jason as in his view that is a term more related to what occurs in emergency departments, whereas this was more in the vein of sedation. However, Dr McAndrew accepted that issue of proper monitoring arose in this case, and he accepted in his evidence that Dr Brett's suggestion of the use of a pulse oximeter was an issue worthy of consideration for the future.[63]

59. Dr McAndrew advised that pulse oximetry is not currently used in the North Metropolitan Health Service Mental Health Units. Dr McAndrew had made some enquiries and was able to advise that there are some simple cordless options available that readily read the pulse, but the preferred telemetric options that record back to the nursing station are more expensive and might be more difficult to fund. Dr McAndrew also expressed a concern that for some patients who are psychiatric and perhaps paranoid, might be concerned that they were being recorded by the device in a negative way.[64]

60. Dr McAndrew suggested that in-service staff education on the dangers of events such as this was also appropriate, with an emphasis on the fact that

[60] T 22; Exhibit 1, Tab 16, p.11 and Tab 16B.
[61] T 12.
[62] T 13.
[63] T 20 – 21, 33 - 34.
[64] T 20 - 21.

the need to allow a disturbed or agitated person to rest "shouldn't override the need for careful monitoring of their medical status."[65] It is a balancing exercise, and Dr McAndrew accepted pulse oximetry could be a tool to explore as part of that balancing approach, in appropriate cases.

61. This is by no means the first case of its kind that has come before a coroner. As a recent example, I presided over a similar inquest in March 2018 into the death of a man at Graylands Hospital who had a long history of schizophrenia and died shortly after being released from seclusion and sedation from a cardiac event while sleeping in a chair in the common lounge area of the ward.[66] The post mortem examination found undiagnosed coronary atherosclerosis although the ECGs done while he was in hospital did not reveal any dysfunction. As in this case, it was noted in the case of Mr Grieve that this type of death was not uncommon in a psychiatric setting in times of stress.[67]

62. I accept the recommendation of Dr Brett that, ideally, more should be done to create a holistic health care model for adult psychiatric patients, that will enable better management of their physical health care needs in conjunction with their psychiatric needs. Dr Brett indicated that this model is being considered by the current Stokes' Review, so I do not propose to make a recommendation to that effect, although I certainly throw my support behind it.

63. In the short term, I consider the suggestion of Dr Brett for implementation of pulse oximetry in the psychiatric setting, where a patient is cooperative to its use, would certainly assist staff to monitor patients who have recently been agitated and then sedated. Dr McAndrew had very helpfully made some enquiries into the possibility of its use, and appeared to consider it to be appropriate for consideration of implementation for patients in this setting. Accordingly, I make a recommendation to that effect.

RECOMMENDATION

I recommend that the WA Department of Health give consideration to utilising pulse oximetry in mental health patients who have been agitated and required significant sedation, for a suitable period of observation, to ensure that any monitoring is capable of identifying where a patient is exhibiting a decrease in oxygen saturation that may indicate they are experiencing a cardiac event.

[65] T 34.
[66] *Inquest into the death of David Grieve*, delivered 6 September 2018, Coroner Linton.
[67] *Inquest into the death of David Grieve*, delivered 6 September 2018, Coroner Linton, [61].

CONCLUSION

64. Jason was a man who had a long history of mental health issues that had been successfully managed for many years with the strong support of his family and a very dedicated psychiatrist. Nevertheless, on occasion his mental health would deteriorate to the extent that he required hospital admission.

65. In February 2017, Jason became seriously unwell and was hospitalised in the Mental Health Unit at SCGH. At the time, Jason had no previously documented history of chest pain or any medical events that would suggest he had serious coronary disease. However, he did have metabolic syndrome, which was known to put him at high risk of a cardiac event, and this is not uncommon for patients with his psychiatric issues and medication regime.

66. While in hospital, Jason became very upset as he was unable smoke cigarettes and eventually had to be put in seclusion and then sedated to calm him down. After he came out of seclusion, he went to bed and was monitored by nursing staff every half an hour. He appeared to be well until the last check, just before the nursing handover, when he was found unresponsive and could not be resuscitated. Jason's medical care was generally of a high standard, but I have made a recommendation for additional measures to be added to allow better monitoring of similar patients in the future, in the hope that such an event might be identified sooner, with the hope that a better outcome could occur.

S H Linton
Coroner
20 December 2019