Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 8/ 19

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Seanpol Martin Padraig O'NEILL*** *with an inquest held at* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth****, on* ***18 – 19 February 2019*** *find that the identity of the deceased person was* ***Seanpol Martin Padraig O'NEILL*** *and that death occurred on* ***23 February 2015*** *at* ***Armadale Kelmscott District Memorial Hospital****, from* ***methadone toxicity*** *in the following circumstances:-*

Counsel Appearing:

Mr D Jones assisted the Coroner

Mr J Berson and Ms L Bultitude-Paull (State Solicitor's Office) appeared on behalf of the East Metropolitan Health Service and Drs D Hacking and J Choo.

Ms B Burke (ANF Legal Services) appeared on behalf of Nurses A Becker, M Fries, R Joseph, M Mafu and L Ross.

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INTRODUCTION

1. Seanpol Martin Padraig O'Neill (the deceased) died on 23 February 2015 at Armadale Kelmscott District Memorial Hospital (the Hospital) as a result of methadone toxicity.

2. At the time of his death, the deceased was an involuntary patient under the *Mental Health Act 1996,* which was then in force. Accordingly, immediately before his death he was a "person held in care" and his death was a "reportable death".[1]

3. In such circumstances, a coronial inquest is mandatory.[2]

4. Where, as here, the death is of a person held in care, I am required to comment on the quality of the supervision, treatment and care the person received while in that care.[3]

5. I held an inquest into the deceased's death on 18 – 19 February 2019. Members of the deceased's family were in attendance during the inquest and three of them (the deceased's mother, one of his sisters and a cousin) gave oral evidence at the inquest.

6. The documentary evidence at the inquest included a report into the deceased's death prepared by the Western Australia Police[4], several expert reports, the deceased's hospital medical notes and letters from the deceased's mother, two of his sisters and his cousin. Altogether, the Brief comprised three volumes.

7. A total of 13 witnesses gave oral evidence at the inquest and addressed aspects of the deceased's medical care and relevant departmental policies.

8. The inquest focused on the deceased's supervision, treatment and care while he was an involuntary patient at the Hospital from 16 – 23 February 2015.

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[1] Sections 3 & 22(1)(a), *Coroners Act 1996*
[2] Section 22(1)(a), *Coroners Act 1996*
[3] Section 25(3) *Coroners Act 1996*
[4] Exhibit 1, Vol. 1, Tab 5, Report - Coronial Investigation Squad

THE DECEASED

Background[5]

9. The deceased was born in Subiaco on 6 July 1984 and had three older sisters. At the time of his death he was 30 years of age and lived next door to his mother in a house she owned in Gosnells.

10. I had the very considerable benefit of reading letters from the deceased's mother, Ms McGeown, his sisters Ms Pittuck and Ms Barrier and his cousin, Ms Donnelly (the letters).[6]

11. What shines through the letters is that the deceased had a very close and loving relationship with his family. He is described with great love as a warm, kind and gentle person with a wonderful sense of humour.

12. The letters also refer to the deceased's determination in overcoming the various challenges he faced as a result of his medical and mental health issues. For example, as a child, the deceased was a keen cyclist who reportedly excelled in the sport and competed at state and national levels.

13. The deceased is also described as a very intelligent person who had a keen interest in computers. He started his own business as a software and application developer and then branched out into cabling and networking services.

14. In 2001, the deceased began a relationship which resulted in the birth of a daughter. Although the deceased's relationship with his partner subsequently broke down, they shared the custody of their daughter.

15. The letters make it clear that his daughter was the deceased's number one priority and that he loved her dearly. Within the constraints placed on him by his medical and mental health conditions, the deceased was clearly a devoted father who took his responsibilities very seriously.

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[5] Exhibit 1, Vol. 1, Tab 11, Report – Dr Hacking, pp4-10
[6] Exhibit 2, Letters from the deceased's relatives

16. According to the letters, the deceased was also a devoted uncle and his nieces and nephews adored him. In common with the rest of the family, they felt (and indeed, continue to feel) his loss keenly.

Medical & Mental Health History[7]

17. At birth, the deceased was diagnosed with congenital oculocutaneous albinism which caused impaired vision and involuntary eye movements.

18. When the deceased was 8 or 9 years of age, he was diagnosed with attention deficit hyperactivity disorder which was treated with dexamphetamine until he was about 12 years of age. Following this, the deceased reportedly suffered anxiety, depression and panic attacks.

19. The deceased was a client of the Shenton Park Child and Adolescent Mental Health Service between 1996 and 2003 and the Inner City Mental Health Service between 2003 and 2004.

20. In 2004 and 2005, the deceased was seen at the Armadale Mental Health Service (AMHS) in relation to anxiety and low mood, but he was discharged from the service in December 2005.

21. At the time of his death, the deceased was a client of the AMHS[8] which consists of:

i. 41 authorised beds under the *Mental Health Act 2014* located in the Hospital;
ii. two adult community mental health clinics, one located on the Hospital campus (Mead Centre), and the other located in Gosnells (Eudoria Street Centre);
iii. an older adult community mental health clinic located on the Hospital campus, and;
iv. a community residential facility also located on the Hospital campus.

[7] Exhibit 1, Vol. 1, Tab 11, Report – Dr Hacking
[8] Exhibit 1, Vol. 3, Tab 33, Statement – Ms Taylor, para 5

22. Nineteen of the 41 authorised beds referred to in paragraph 21(i) above are in an open ward called Moodjar Ward.[9]

23. In 2005, the deceased began consulting Dr Prichard, a respiratory and sleep physician. The deceased was diagnosed with narcolepsy and prescribed dexamphetamine.[10]

24. The deceased had also been diagnosed with achalasia, a rare disease of the lower oesophagus which caused him to be admitted to Sir Charles Gairdner Hospital in 2010.

25. On 3 February 2012, the deceased was admitted to the AMHS high dependency unit (HDU) and was diagnosed with paranoid schizophrenia.

26. From his discharge on 17 April 2012 until his death, he was a client of the Gosnells Community Mental Health Team, based at the Eudoria Street Clinic. His schizophrenia was managed with long acting, regular injections of zuclopenthixol decanoate.

27. The deceased was admitted to the HDU from 25 September 2012 - 3 October 2012 with a relapse of his paranoid schizophrenia.

28. From 11 – 15 March 2013, the deceased was admitted to the Hospital following an overdose of Physeptone tablets (methadone) which he said was accidental.

29. The deceased was admitted to the HDU from 27 – 30 April 2013, with a relapse of his paranoid schizophrenia.

30. On 26 June 2014, the deceased was admitted to the intensive care unit at the Hospital following an overdose of methadone which he again said was accidental. He was subsequently transferred to an open ward under the care of the AMHS and discharged home on 1 July 2014.

31. The deceased is reported to have taken several illicit drugs including marijuana, MDMA (ecstasy) and amphetamines.

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[9] Transcript 18.02.19, p65 (Nurse Joseph)
[10] Exhibit 1, Vol. 1, Tab 28, Report – Dr Prichard

32. A post mortem examination found changes in the deceased's lungs that were suggestive of previous intravenous drug use.

33. At the time of his admission to the Hospital on 16 February 2015, the deceased was prescribed zuclopenthixol, diazepam, amoxicillin, dexamphetamine, Codapane and Physeptone[11] and was receiving the disability support pension.

The deceased's use of methadone in the community

34. It appears that the deceased was first prescribed methadone in the form of Physeptone tablets (10 mg) on 26 November 2012.[12]

35. According to Dr Fernandez[13] (the deceased's GP), the deceased was on long term opioid analgesia (ie: Physeptone) for chronic pain at the direction of Dr Salmon, a pain specialist.[14]

36. According to the deceased's pharmacy records, he was given one month's supply of Physeptone on a regular basis. His daily dose varied from 30 - 40 mg in 2012, to 70 mg for most of 2014. From 21 January 2015, the deceased's daily dose was 80 mg.[15]

37. The evidence as to whether the deceased took his medication regularly as prescribed is mixed.

38. As noted, in March 2013 and June 2014, the deceased took an overdose of Physeptone.[16] On both occasions the deceased said the overdoses were accidental and denied any suicidal intent.

39. There is evidence that at times Ms McGeown helped with the supervision of the deceased's medication.[17]

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[11] Exhibit 1, Vol. 1, Tab 29, Deceased's pharmacy records
[12] Exhibit 1, Vol. 1, Tab 29, Deceased's pharmacy records
[13] Exhibit 1, Vol. 1, Tab 10, Report – Dr Fernandez
[14] Exhibit 1, Vol. 1, Tab 21, Report – Dr Salmon
[15] Exhibit 1, Vol. 1, Tab 29, Deceased's pharmacy records
[16] Exhibit 1, Vol. 1, Tab 11, Report - Dr Hacking
[17] Transcript 18.02.19, p27 (Dr Hacking)

40. However, at a family conference with Dr Hacking in about January 2015, Ms McGeown reportedly expressed concern that the deceased was not taking his dexamphetamine as prescribed. This concern had also been raised by the mental health workers who had been supporting the deceased.[18]

41. In December 2014, the deceased told Dr Prichard that for a 6-month period in that year, he (the deceased) had not taken his dexamphetamine medication because he was too busy to have the prescription filled.[19]

42. On the other hand, Ms Donnelly (the deceased's cousin) gave evidence that she lived with the deceased for 4 or 5 months. She said he took his medication regime seriously. She was aware that he kept his prescribed methadone tablets in a safe in his bedroom and was careful not to leave them lying about when his daughter was staying.[20]

43. According to the deceased's pharmacy records, between 10 December 2014 and 10 February 2015, he (or someone on his behalf) was dispensed 1,200 dexamphetamine tablets (5 mg) by his local pharmacy.[21] This is a six-month supply based on the deceased's prescribed dose. How so many tablets came to be dispensed to the deceased and exactly what happened to those tablets is outside the scope of this inquest and therefore remains a mystery.

44. When the deceased was admitted to the Hospital on 16 February 2015, he expressed strong concern that his dexamphetamine had been ceased and asked for a second opinion. He also corrected medical staff about the dose and frequency of his methadone medication.[22]

45. On the basis of the available evidence, all that can be said with any certainty is that it is possible that the deceased may not have taken his prescribed medication regularly.

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[18] Transcript 18.02.19, p34 (Dr Hacking)
[19] Exhibit 1, Vol. 1, Tab 28, Report – Dr Prichard
[20] Transcript 18.02.19, p116-118 (Ms Donnelly)
[21] Exhibit 1, Vol. 1, Tab 29, Deceased's pharmacy records
[22] Exhibit 1, Vol. 3, Tab 1, Deceased's medical records & Transcript 18.02.19, p27 (Dr Hacking)

THE DECEASED'S GP VISIT - 16 FEBRUARY 2015[23,]

46. During her evidence, Ms Pittuck (the deceased's sister) confirmed that as a consequence of his oculocutaneous albinism, the deceased was legally blind and had never held a driver's licence. As a result, she and other family members drove the deceased to his medical appointments and assisted with transport generally.[24]

47. In the afternoon of 16 February 2015, Ms Pittuck dropped the deceased at his GP clinic for a doctor's appointment.[25]

48. The deceased saw Dr Luy and told her that his dexamphetamine medication had been stolen.[26] This was a claim that the deceased had made in the past and Dr Luy quite properly refused to provide him with an additional prescription for dexamphetamine.

49. The deceased became angry at Dr Luy's refusal to prescribe additional dexamphetamine and made threats towards her and clinic staff. It appears that the deceased left the clinic but he returned some time later.

50. After returning to the clinic, the deceased refused to leave when asked to do so and began expressing a number of bizarre delusions. He also said he had information (that he referred to as "intel") that his GP would refuse to provide him with additional dexamphetamine.[27]

51. When Dr Luy consulted them, staff at Eudoria Street Centre suggested that the deceased be taken to hospital as an involuntary patient for review.[28] Dr Luy accepted this advice and completed forms under the *Mental Health Act 1996* requiring the deceased to be taken to an approved facility and examined by a psychiatrist.[29]

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[23] Exhibit 1, Vol. 3, Tab 1, ED nursing triage assessment
[24] Transcript 18.02.19, p109 (Ms Pittuck)
[25] Transcript 18.02.19, p110 (Ms Pittuck)
[26] The deceased subsequently told Dr Chowdhury, the psychiatrist who reviewed him on admission to the Hospital, that his dexamphetamine medication had been stolen from "*the Marine base in Darwin where he worked as a Sergeant*", Exhibit 1, Vol. 3, Tab 1, Deceased's medical records.
[27] Exhibit 1, Vol. 3, Tab 1, Involuntary patient order
[28] Exhibit 1, Vol. 1, Tab 11, Report- Dr Hacking
[29] Exhibit 1, Vol. 1, Tab 11, Report- Dr Hacking

52. By the time Ms Pittuck returned to the GP clinic after doing some shopping, Police were in attendance. By coincidence, one of the attending police was a family member and he confirmed that police attendance was related to the deceased.[30]

53. Another police car attended and before the deceased was taken to the Hospital, he gave Ms Pittuck the prescriptions that Dr Luy had given him.[31]

54. These prescriptions were for 240 Physeptone (methadone) tablets (10 mg) and 50 Anetex (diazepam) tablets (5 mg) and Ms Pittuck had them filled at the deceased's usual pharmacy. She subsequently gave the dispensed medication to the deceased's mother and updated her on what had occurred at the clinic.

55. Ms Pittuck confirmed that this medication was still in sealed containers when it was destroyed by Ms McGeown after the deceased's death.[32]

56. At about 5.20 pm on 16 February 2015, the deceased got out of the police vehicle and was taken to the Hospital by ambulance.[33]

57. On arrival at the Hospital's emergency department he was seen by a psychiatric liaison nurse (PLN) who assessed the deceased as delusional but not acutely at risk. As no mental health beds were available, the deceased remained in the Hospital's emergency department with a guard.[34]

THE DECEASED'S ADMISSION 17-21 FEBRUARY 2015[35]

58. At 9.15 am on 17 February 2015, the deceased was reviewed by the Duty Psychiatrist, Dr Chowdhury who found the deceased was thought disordered and had persecutory and grandiose delusions and possible auditory hallucinations.

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[30] Transcript 18.02.19, p111-112 (Ms Pittuck)
[31] Transcript 18.02.19, p113 (Ms Pittuck)
[32] Transcript 18.02.19, p1114, 115-116 (Ms Pittuck)
[33] Exhibit 1, Vol. 2, Tab 23, St John Ambulance patient care record
[34] Exhibit 1, Vol. 3, Tab 1, Deceased's medical records
[35] Exhibit 1, Vol. 3, Tab 1, Deceased's medical notes

59. The deceased was diagnosed with a manic episode of schizoaffective disorder and the plan was to transfer him to the HDU as soon as a bed became available.[36]

60. At 12.00 pm, the deceased was reviewed by Dr Hacking (who was his psychiatrist at the Eudoria Street Clinic) and a PLN and transferred to Moodjar ward on the Leschen unit.

61. Although Moodjar ward is usually an open ward, at the time of the deceased's transfer it was actually being locked because of the mental state of another patient.

62. A risk assessment scored the deceased as at low risk of suicide and moderate risk of violence.

63. Dr Hacking reviewed the deceased again at 5.20 pm in the company of Dr Choo and a nurse and placed the deceased on an involuntary patient order under the *Mental Health Act 1996*. Dr Hacking found that the deceased was floridly psychotic and had grandiose delusions.[37]

64. The deceased's medications were reviewed by Dr Hacking and his dexamphetamine was ceased. The reason for this was that dexamphetamine can increase the risk of a patient developing psychosis.[38]

65. The deceased was placed on 15 minute observations and the plan remained to transfer the deceased to the HDU when a bed became available.

66. Dr Choo's record of Dr Hacking's order in the deceased's medical notes says "*15/60 please*".

67. At the inquest, nursing and medical staff expressed different views about the purpose of the 15 minute visual observations ordered by Dr Hacking.

68. Dr Hacking (with whom Dr Choo agreed[39]) said the reason for the order was so that the deceased's global mental state could be closely monitored.

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[36] Exhibit 1, Vol. 1, Tab 11, Report – Dr Hacking
[37] Exhibit 1, Vol. 3, Tab 1, Involuntary patient order
[38] Transcript 18.02.19, p24, 35 & 41 (Dr Hacking)
[39] Transcript 18.02.19, p44-45 (Dr Choo)

69. Dr Hacking agreed that one aspect of that assessment was whether the deceased was physically present on the ward, but that was not the only rationale for the order.[40]

70. Only one of the five nurses called at the inquest agreed that the reason for the 15 minute observation order included assessment of the deceased's mental state.[41] Three of the nurses said that they thought the 15 minute observation order had been made solely on the basis of the deceased's absconding risk.[42]

71. This understanding is consistent with the fact that many of the visual observation records (VOR) on which the 15 minute observations of the deceased are recorded are variously headed: "*Abs*", "*Absc*" and "*Absconding*".

72. This difference of view is significant for two reasons. Firstly, the majority of the nurses who gave evidence said they thought their obligation under the order was merely to establish the deceased's physical presence on the ward.

73. Secondly, the majority of the nurses did not consider that the order required them to make any observations of the deceased's vital signs, including at night when he was asleep.[43]

74. Several nurses said that there are a number of reasons why visual observations might be ordered by a doctor, whether at 15 minute intervals or otherwise. Those reasons include monitoring a patient's risk of self-harm, absconding, disinhibition, agitation or aggression.[44]

75. Whilst these risk factors might be regarded as subordinate to a more general requirement to assess global mental state, different considerations and levels of vigilance would seem to apply.

76. Therefore, a greater degree of clarity as to the purpose of the visual observation order at the time that an order is made would seem sensible.

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[40] Transcript 18.02.19, p23 (Dr Hacking)
[41] Transcript 18.02.19, p71 (Nurse Ross)
[42] Transcript 18.02.19, p66 (Nurse Joseph); p95 (Nurse Mafu) & p103 (Nurse Becker)
[43] Transcript 18.02.19, p92 (Nurse Fries); p98 (Nurse Mafu) & p105 (Nurse Becker)
[44] Transcript 18.02.19, p59 (Nurse Joseph)

77. Although Dr Hacking and Dr Choo thought that when visual observations were ordered, global mental state would be assessed as matter of course, the evidence from a number of the nurses suggests that the order was construed more narrowly.

78. I suggest that when visual observations are ordered, the reason for the order should be briefly documented in the patient's medical notes.

79. In this case, the visual observation order was made on 17 February 2015 with the notation "*15/60 please*".[45]

80. The addition of a few extra words explaining the rationale for the order, for example: "*for mental state/absconding risk*" would take a couple of seconds and in my view, would be a sensible improvement to patient management.

81. As was expected given the deceased's prescription medications, a urine test on 17 February 2015 was positive for amphetamines, benzodiazepines and opiates. The test was negative for cannabis which was consistent with the fact that the deceased had denied he was using cannabis.[46]

82. A physical examination which had been ordered was only ever partially completed because of the deceased's agitation.[47] Blood tests that were ordered were never completed. At a family meeting following the deceased's death, one of the deceased's sisters reportedly told Dr Hacking that the deceased disliked blood tests.[48]

83. The deceased was given his first dose of a medication called zuclopenthixol acetate (commonly known as Acuphase) at 6.10 pm on 17 February 2015.[49]

84. The deceased's vital signs (including oxygen saturations, blood pressure, pulse, temperature and level of consciousness) were found recorded at 9.20 pm and found to be normal, although his pulse was slightly elevated.[50]

[45] Exhibit 1, Vol. 3, Tab 1, Deceased's medical notes
[46] Exhibit 1, Vol. 3, Tab 1, Deceased's medical notes
[47] Exhibit 1, Vol. 3, Tab 1, Deceased's medical notes
[48] Exhibit 1, Vol. 3, Tab 1, Deceased's medical notes
[49] Exhibit 1, Vol. 3, Tab 1, Deceased's medical notes
[50] Exhibit 1, Vol. 3, Tab 1, Deceased's medical notes

85. Acuphase is a fast acting antipsychotic medication given by injection that is used to settle acute episodes of psychosis. Acuphase does carry a risk of provoking cardiac arrhythmias[51], and as a precaution, the deceased underwent an electrocardiogram (ECG) on 17 February 2015.[52]

86. The ECG found that the deceased's "*QTc interval*" was within normal limits meaning that he was not at high risk of developing an arrhythmia.[53]

87. At the time of the deceased's death the Hospital did not have a written policy that set out the required observations following the administration of Acuphase.[54]

88. Nevertheless, both Dr Hacking[55] and Dr Choo[56] and three of the nurses who gave evidence at the inquest were clear that at the relevant time,[57] the requirement was that following administration of Acuphase, vital signs should be recorded hourly for six hours.

89. Nurse Joseph was unaware of the Acuphase observation policy in 2015[58], and Nurse Becker couldn't recall whether there was or wasn't a policy in 2015.[59]

90. The deceased was given three doses of Acuphase during his admission, namely on 17, 19 and 21 February 2015. There is no record in the deceased's medical notes that hourly observations for six hours were conducted following each dose of Acuphase.[60]

91. Nurse Ross said she was aware of a separate form for recording observations after administration of Acuphase,[61] but if such a form was used in the deceased's case, it was not produced to the Court.

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[51] Transcript 19.02.19, p127 (Prof. Joyce)
[52] Exhibit 1, Vol. 3, Tab 1, Deceased's medical notes
[53] Exhibit 1, Vol. 3, Tab 1, Deceased's medical notes & Transcript 19.02.19, p137-8 (Prof. Joyce)
[54] Exhibit 1, Vol. 2, Tab 33, Statement – Ms Taylor, para 49(a) & Transcript 19.02.19, p177 (Ms Taylor)
[55] Transcript 18.02.19, p29 & 32 (Dr Hacking)
[56] Transcript 18.02.19, p46 (Dr Choo)
[57] Transcript 18.02.19, p76 (Nurse Ross); p86 (Nurse Fries) & p96 (Nurse Mafu)
[58] Transcript 18.02.19, p65-66 (Nurse Joseph)
[59] Transcript 18.02.19, p104 (Nurse Becker)
[60] Exhibit 1, Vol. 3, Tab 1, Deceased's medical notes
[61] Transcript 18.02.19, p76 & 80 (Nurse Ross)

92. It seems more likely that the eight observations recorded in the deceased's Adult Observation and Results Chart - AKMR140.3 (AORC) were the only observations that were carried out during his admission.

93. I note that generally speaking, all of the observations that were made during the deceased's admission were within normal limits.[62]

94. The last entry in the AORC with respect to the deceased's vital signs, including his respiration rate, was apparently made at 6.00 pm on 22 February 2015. All of the deceased's vital signs were, at that time, within normal limits.

95. From 18 – 22 February 2015, the deceased's agitation and delusional behaviour persisted. In contrast, over the same period his level of sedation appeared to vary. At times the deceased was noted to be sleeping during the day and at other times to appear drowsy or very drowsy. On other occasions, he was said not to appear sedated.[63]

96. In her Police statement, Ms McGeown says that she told nursing staff on 20 February 2015 that she was worried about the deceased's level of sedation and that his medication or its dosage needed to be changed otherwise she thought he would die.[64]

97. In a letter to the Court dated 24 August 2018, Ms McGeown says that on 19 February 2015 and again on 21 February 2015, she raised her concerns about the deceased's level of sedation and the medication he was being prescribed with hospital staff.[65]

98. During her evidence at the inquest, Ms McGeown reiterated the fact that she had brought her concerns about the deceased's level of sedation to the attention of staff on the ward.[66]

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[62] Exhibit 1, Vol. 3, Tab 1, Deceased's medical notes
[63] Exhibit 1, Vol. 3, Tab 1, Deceased's medical notes
[64] Exhibit 1, Vol. 1, Tab 7, Statement – Ms McGeown
[65] Letter from Ms McGeown dated 24 Aug 18, paras 29, 36 & 48
[66] Transcript 19.02.19, p212 (Ms McGeown)

99. These concerns, if raised in the manner suggested, were not documented in the deceased's medical notes.

100. There is an entry in the medical notes at 7.20 pm on 20 February 2015 which records a visit to the Hospital by Ms McGeown in the following terms: "*Visited by Mo.* (mother) *who spent brief time with nursing. D/x* (discussed) *concerns regarding circumstances for discharge. Would like a Fa.* (Family) *Meeting when Seanpol is better*".[67]

101. Dr Hacking said that no concerns about the deceased's possible over-sedation were ever raised with him. He said that if the deceased's family had raised such concerns with him, he would have discussed them with the clinical team.[68] Dr Choo said she had no concerns that the deceased was over-sedated during his admission.[69]

102. The deceased's step-father visited him in Hospital on 22 February 2015 and later told Ms McGeown that the deceased "*was happy, laughing, cracking jokes and singing*" during the visit. The deceased's step-father reportedly had no concerns about the deceased's health on that day.[70]

103. As an aside, I note that the deceased's step-father noticed that the deceased had "*a fair bit of money on him, in his wallet, which was lying on the bedside counter*".[71]

104. Ms McGeown said that this money (which she said in her Police statement was close to $1,000) was missing after the deceased's death.[72] Ms McGeown also raised this matter with me during her oral evidence.[73]

105. Although this issue is outside the scope of this inquest, I would observe that recovering whatever money may have been in the deceased's wallet on 22 February 2015 would now be virtually impossible, given the time that has elapsed since his death.

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[67] Exhibit 1, Vol. 3, Tab 1, Deceased's medical notes
[68] Transcript 18.02.19, p33 (Dr Hacking)
[69] Transcript 18.02.19, p49-50 (Dr Choo)
[70] Letter from Ms McGeown dated 24 Aug 18, paras 53 & 54
[71] Letter from Ms McGeown dated 24 Aug 18, para 54
[72] Letter from Ms McGeown (24 Aug 18), para 66 & Exhibit 1, Vol. 1, Tab 7, Statement – Ms McGeown, paras 91-93
[73] Transcript 19.02.19, p212-3 & 216 (Ms McGeown)

22 FEBRUARY 2015[74]

106. According to his medical notes, the deceased appeared "*sedated*" at the start of the afternoon shift on 22 February 2015, and was stumbling slightly when walking.

107. The deceased complained of feeling agitated and irritable and so, in accordance with his agitation and arousal chart, he was given olanzapine (10mg) at 3.00 pm and clonazepam (2mg) at 3.30 pm.

108. The deceased was noted to be pacing the ward at 8.30 pm but resting in bed by 9.00 pm and asleep by 10.15 pm. According to the VOR, he was recorded as "*asleep*" every 15 minutes thereafter until midnight on 22 February 2015.

23 FEBRUARY 2015[75]

109. The VOR records the deceased as "*asleep*" (presumably in bed) from 12.15 am on 23 February 2015 onwards. The last entry in the VOR was apparently made at 7.45 am on 23 February 2015 when the deceased is noted to be "*sleeping*".

110. At 7.55 am on 23 February 2015, Nurse Becker entered the deceased's room to wake him for breakfast. The deceased did not respond when called and she realised that he was not breathing and was cold to the touch.

111. Nurse Becker used a duress alarm to alert staff to the medical emergency.[76]

112. In response to that alarm, Nurse Joseph attended the deceased's room with the emergency trolley. Nurse Joseph found the deceased was not breathing, had no pulse and that the deceased's body was "*cold and stiff*".[77]

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[74] Exhibit 1, Vol. 3, Tab 1, Deceased's medical notes
[75] Exhibit 1, Vol. 3, Tab 1, Deceased's medical notes
[76] Exhibit 1, Vol. 2, Tab 35, Statement – Nurse Becker & Transcript 18.02.19, p103 (Nurse Becker)
[77] Exhibit 1, Vol. 1, Tab 16, Statement – Nurse Joseph

113. The medical emergency team was alerted and Dr Hamilton, an intensive care unit registrar, arrived at the deceased's room at 8.02 am.

114. Following discussions between the medical emergency team, the nurse manager and Dr Hamilton, it was decided that CPR would not be commenced given signs of death were "*very clearly long standing*". Dr Hamilton's notation in the deceased's medical notes was: "*no signs of life, patient cold, rigor mortis evident*".[78]

TOXICOLOGICAL FINDINGS

115. The deceased was prescribed a number of medications on his admission to the Hospital. Attached as annex "A" is a table summarising those medications.

116. After the deceased's death his blood and urine were examined by a toxicologist. That analysis found a number of medications in the deceased's system including methadone at levels which were within the known fatal range.[79]

117. As a result of that finding, a report was obtained from Professor David A Joyce, a physician and clinical pharmacologist.[80]

118. Professor Joyce did not consider that the medications prescribed to the deceased during his admission were counter-therapeutic either in terms of the medications selected or their prescribed dosage.[81]

119. Professor Joyce made the following observations on the levels of each of the medications found in the deceased's system:[82]

i. *zuclopenthixol (Acuphase):* the level detected was higher than expected given the total dose of 350 mg over the previous 5 days but was well below any

[78] Exhibit 1, Vol.3, Tab 1, Deceased's medical notes
[79] Exhibit 1, Vol. 1, Tab 26, ChemCentre toxicology report
[80] Exhibit 1, Vol. 1, Tab 27, Report – Prof. Joyce
[81] Transcript 19.02.19, p144 (Prof. Joyce)
[82] Exhibit 1, Vol. 1, Tab 27, Report – Prof. Joyce & Transcript 19.02.19, p131-133 (Prof. Joyce)

concentration linked to fatal toxicity, when it is the only drug present;

ii. *quetiapine:* the level detected was within the level expected given the recorded dosages and serious adverse effects of this drug would not be expected if it was the only drug present;

iii. *olanzapine:* this drug was only detected in the urine and its absence from the blood would normally indicate that it was not exerting material adverse effects if it was the only drug present;

iv. *diazepam and desmethyldiazepam:* are sedating drugs in the benzodiazepine family with desmethyldiazepam being formed in the body from diazepam. The levels of both drugs was relatively low and would be expected to cause therapeutic sedation. Serious adverse effects of these drugs would not be expected if they were the only drugs present;

v. *clonazepam:* is a sedating drug in the benzodiazepine family and was not detected in the blood but was found in the urine. Adverse effects on breathing would not be expected if it was the only drug present; and

vi. *methadone:* is a potent opioid drug. The levels of methadone were 0.67 mg/L in the deceased's blood and 4.2 mg/L in his liver. Professor Joyce described these levels as being: "*at the top end of the concentration range expected*" in a man taking 70 mg of Physeptone daily.

THE LEVEL OF METHADONE - EXPLANATIONS[83]

120. Professor Joyce suggested two possible explanations for the deceased's level of methadone.

121. One possibility was that there was some interference with the deceased's ability to clear methadone from his system through, for example, drug interaction. However, as Professor Joyce pointed out in his report, none of the medications prescribed to the deceased were "*noteworthy competitors*" of methadone clearance.

[83] Exhibit 1, Tab 27, Report – Prof. Joyce

122. The second possibility was that the deceased had taken an excessive dose of methadone, perhaps by hoarding Physeptone tablets during his hospital admission. However, there is no evidence that Physeptone tablets were found in the deceased's hospital room during the Police investigation that followed his death.[84]

123. In addition, three nurses who were involved in the deceased's care confirmed that their standard practice was to ensure that all oral medication was swallowed after it was administered.[85]

124. At the time of the deceased's death, the policy for the administration of medications did not include a specific requirement that a staff member giving oral medication had to witness that it had been consumed,[86] but this was considered to be standard nursing practice.[87]

125. The current policy relating to the administration of medication now contains the statement: "*Oral medications must be witnessed as having been consumed by the patient*".[88] However, I note that no guidance is given to staff as to how this should be achieved.

126. I accept that there is a danger with making policies so detailed and specific that they become impenetrable, but in my view, the current policy could be usefully enhanced if some specific guidance on this point were added.

127. No beds were available on the HDU during the deceased's admission and so he remained on an open ward. Other than the fact that he was subject to 15 minute observations, the deceased's movements around the Hospital were unrestricted and he was permitted to have visitors.

128. Nevertheless, there is no evidence that anyone from outside the Hospital brought medication to the deceased during his admission.

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[84] Exhibit 1, Vol. 1, Tab 6, Report – Constable A Pagels
[85] Transcript 18.02.19, p64 (Nurse Joseph), p78 (Nurse Ross) & p88 (Nurse Fries)
[86] Exhibit 1, Vol. 2, Tab 33.12, Policy: Medication Management Clinical Practice Standard
[87] Transcript 19.02.19, p199, (Ms Taylor)
[88] Exhibit 1, Vol. 2, Tab 33.22, Policy: Medication Management, p48

129. Nurse Fries said that when a patient had visitors, then depending on the patient, a personal or room search might be conducted to ensure that contraband had not been brought on to the ward.[89]

130. The Hospital's policy with respect to patient property on mental health wards was first issued in February 2010. That policy provides that it is the responsibility of the admitting nurse to ensure that the patient's own medication is collected and bagged on admission.[90]

131. Where there is concern that a patient may have items in their possession that could be considered a danger to themselves or others, the policy provides that the patient may be searched.[91] I am also aware that under the *Mental Health Act 2014*, staff now have additional search and seizure powers.[92]

132. There is no evidence that any medication was seized from the deceased when he was admitted, nor that any medication was found during his admission. This is despite the fact the deceased's room was the subject of random checks.[93] It is theoretically possible that the deceased had Physeptone tablets in his possession on admission that were not detected, or that Physeptone tablets were given to him by a person or persons unknown during his admission.

133. However, on the basis of the evidence, these possibilities are merely speculative.

134. What is clear, is that if the deceased had access to additional Physeptone tablets they did not come from the ones dispensed to Ms Pittuck on 16 February 2015.

135. Given the evidence of the nurses who administered medication to the deceased, it seems unlikely that he could have hoarded the Physeptone tablets that were administered to him while he was in hospital.

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[89] Transcript 18.02.19, p89-90 (Nurse Fries)
[90] Exhibit 1, Vol. 2, Tab 33.24, Policy: Patient Property in Mental Health Wards, page 3
[91] Exhibit 1, Vol. 2, Tab 33.24, Policy: Patient Property in Mental Health Wards, page 5
[92] Division 2 of Part 11 of the *Mental Health Act 2014*
[93] Transcript 18.02.19, p89 (Nurse Fries)

136. I have been unable to come to a conclusion about whether or not the deceased obtained additional Physeptone tablets during his admission.

137. On the basis of the evidence before me it seems more likely that the deceased was not sufficiently habituated to a 70 mg dose of Physeptone because he had not been regularly taking that amount in the community.

CAUSE AND MANNER OF DEATH[94]

138. The forensic pathologist who conducted a post mortem of the deceased's body on 25 February 2015 expressed the opinion that the cause of death could not be ascertained.[95]

139. Subsequent microscopic examination of the deceased's kidneys showed changes consistent with high blood pressure whilst changes in his lungs were suggestive of intravenous drug use.[96]

140. Neurological examination of the deceased's brain was unremarkable.[97]

141. After reviewing the results of these further tests, the forensic pathologist issued a supplementary report on 18 September 2015 expressing the opinion that the cause of death was methadone toxicity.[98]

142. I accept and adopt that conclusion.

143. In his report, Professor Joyce considered the potential causes of sudden death with methadone in combination with psychotropic drugs.

144. Professor Joyce concluded that cardiac arrhythmia and respiratory depression were the potentially lethal adverse effects from the drugs being taken by the deceased.[99]

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[94] Exhibit 1, Vol. 1, Tab 27, Report – Prof. Joyce
[95] Exhibit 1, Vol. 1, Tab 24.2, Post mortem report
[96] Exhibit 1, Vol. 1, Tab 24.2, Post mortem report
[97] Exhibit 1, Vol. 1, Tab 25, Neuropathology report
[98] Exhibit 1, Vol. 1, Tab 24.1, Supplementary post mortem report
[99] Transcript 19.02.19, p136 (Prof. Joyce)

145. Professor Joyce noted that the deceased's ECG on 17 February 2015 was normal and the post mortem observations of the deceased's heart did not suggest any increased risk of heart issues.[100] Professor Joyce concluded that cardiac arrhythmia remained a possible cause of death, but that there was no specific support for that conclusion.[101]

146. Professor Joyce noted that methadone causes sedation and respiratory depression. Tolerance to methadone, which develops with habitual use can be protective.

147. On the other hand, there are two respiratory conditions that can occur in people who are obese which can enhance the risk of respiratory depression.[102]

148. The first of these conditions is sleep apnoea syndrome (SAS), where the patient doesn't breathe for periods of time whilst asleep and levels of carbon dioxide rise episodically. Sedation makes this condition worse.[103]

149. Dr Prichard said that a sleep study performed on the deceased in 2004/5 did not show any evidence that the deceased had SAS, but that the deceased may have developed this condition as he gained weight.[104]

150. At the time of his admission, the deceased weighed 125 kg and had a Body Mass Index of 39, putting him in the obese category.[105] At one point, the deceased weighed 137 kg.[106]

151. Professor Joyce was asked about the significance of the evidence that the deceased was heard snoring loudly at about 3.00 am on 23 February 2015. Professor Joyce said this was an indication that the deceased may developed SAS at that time, but noted that many snorers do not have SAS.[107]

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[100] Transcript 19.02.19, p137 (Prof. Joyce)
[101] Transcript 19.02.19, p138 (Prof. Joyce)
[102] Transcript 19.02.19, p138-139 (Prof. Joyce)
[103] Transcript 19.02.19, p139 (Prof. Joyce)
[104] Transcript 19.02.19, p158 & 160 (Dr Prichard)
[105] Exhibit 1, Vol. 3, Tab 1, Deceased's medical records
[106] Transcript 19.02.19, p214 (Ms McGeown)
[107] Transcript 19.02.19, p143 (Prof. Joyce)

152. The second condition referred to by Professor Joyce was obesity hypoventilation syndrome (OHS). Over time, obese patients with OHS become accustomed to abnormally high levels of carbon dioxide and low levels of oxygen in their blood.[108]

153. Patients with OHS are known to be sensitive to sedatives that have any capacity to supress breathing. A vicious cycle can develop where carbon dioxide levels rise and breathing is further supressed, leading to death due to lack of ventilation.[109]

154. Dr Prichard did not consider it likely that the deceased had OHS because he had no signs of right heart failure commonly associated with this condition. Dr Prichard also noted that OHS could be ruled out if serum bicarbonate levels were within normal range.[110]

155. The deceased's medical notes contain tests results for a blood test on 15 December 2014 where the deceased's bicarbonate and carbon dioxide levels were within the normal range.[111] Dr Prichard felt that these results could be extrapolated forward to the date of the deceased's death, so as to exclude the likelihood of OHS.[112]

156. In addressing why the deceased appears to have become lethally over-sedated, Professor Joyce considered the sedating effect of the other medications taken by the deceased, mainly diazepam and clonazepam but to a lesser extent quetiapine and olanzapine as well.[113]

157. Professor Joyce thought it surprising that doses of these medications sufficient to control the deceased's agitation would lethally increase the effect of the deceased's methadone, but noted that this had occurred in similar cases so that the risk was a real one.[114]

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[108] Transcript 19.02.19, p140 (Prof. Joyce)
[109] Exhibit 1, Vol. 1, Tab 27, Report – Prof. Joyce
[110] Exhibit 1, Vol. 1, Tab 28, Report – Dr Prichard
[111] Exhibit 1, Vol. 3, Tab 1, Deceased's medical notes
[112] Transcript 19.02.19, p163, (Dr Prichard)
[113] Exhibit 1, Vol. 1, Tab 27, Report – Prof. Joyce
[114] Exhibit 1, Vol. 1, Tab 27, Report – Prof. Joyce

158. Professor Joyce also suggested the possibility that the deceased was not regularly taking his prescribed dose of methadone in the community and had therefore not developed sufficient tolerance, as an explanation for his over-sedation.[115]

159. There was also a possibility that the deceased had an unusually slow elimination rate for methadone but Professor Joyce could see no particular reason why this should be the case.[116]

160. The final explanation put forward by Professor Joyce relates to the significance of the deceased's daytime sleepiness, which was recorded during his admission and whether the deceased did in fact have narcolepsy.[117]

161. Dr Prichard confirmed that the deceased was correctly diagnosed with narcolepsy on the basis of his symptoms, blood test results, family history and his positive response to dexamphetamine and REM suppressant medication.[118]

162. On the basis of the evidence of Professor Joyce and Dr Prichard, it is possible that the deceased may have developed sleep apnoea syndrome which, coupled with the medications he was given whilst in hospital including methadone, may have caused his death.

163. However, on the basis of the available evidence, this conclusion remains speculative.

QUALITY OF SUPERVISION, TREATMENT AND CARE

164. In assessing the quality of the treatment and care provided to the deceased during his admission at the Hospital, I have considered the findings of the clinical investigation that was conducted following the deceased's death. The report of that investigation (the Report) was attached to the

[115] Exhibit 1, Vol. 1, Tab 27, Report – Prof. Joyce
[116] Exhibit 1, Vol. 1, Tab 27, Report – Prof. Joyce
[117] Exhibit 1, Vol. 1, Tab 27, Report – Prof. Joyce
[118] Exhibit 1, Vol. 1, Tab 28, Report – Dr Prichard & Transcript 19.02.19, p153 (Dr Prichard)

statement of the Ms Taylor, the service director for the AMHS.[119]

165. In my view, there are two broad areas where the care and treatment provided to the deceased could have been improved.

Monitoring of the deceased's vital signs

166. The checks made of the deceased's vital signs (pulse, temperature, blood pressure, breathing rate) were recorded in his AORC.[120]

167. Between admission to the ward and death, the deceased's vital signs appear to have been checked on only eight occasions. No observations at all were recorded on 18 February 2015.[121]

168. With the benefit of hindsight, more regular checks of the deceased's vital signs may have provided an opportunity to identify any deterioration in the deceased's condition.

169. Given the deceased's physical co-morbidities (namely his obesity and narcolepsy), and the fact that he was being administered a number of medications with a known sedating effect, more regular monitoring would have been prudent.

170. Having made that observation, I acknowledge the dilemma identified by Professor Joyce, namely that more frequent monitoring of a patient who is sedated because of agitation, usually requires disturbing the patient - which compromises the benefits of sedation.[122]

171. As Professor Joyce points out, the appropriate level of monitoring will vary depending with the patient's clinical presentation.[123]

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[119] Exhibit 1, Vol. 2, Tab 33.3, Clinical incident management form & Transcript 19.02.19, p172 (Ms Taylor)
[120] Exhibit 1, Vol. 3, Tab 1, Deceased's medical records
[121] Exhibit 1, Vol. 3, Tab 1, Deceased's medical records
[122] Exhibit 1, Vol. 1, Tab 27, Report Prof. Joyce & Transcript 19.02.19, p150 (Prof, Joyce)
[123] Transcript 19.02.19, p150 (Prof. Joyce)

172. A "one size fits all approach" would obviously be inappropriate. As always, the emphasis must be on the clinical judgement of staff. Education about potential risks and signs to look out for will also clearly be of benefit.

173. Ms Taylor advised that since the deceased's death, clinical staff now receive compulsory annual training about the cumulative effects of sedating medications and the importance of effectively monitoring sedated patients. Particular reference is made to the importance of identifying and responding to clinical deterioration.[124]

174. Ms Taylor said that 80% of clinical staff have attended this training.[125]

175. Only one of the five nurses who gave evidence at the inquest appeared to be aware of the new training.[126] This situation warrants follow-up action by the Hospital.

176. The Report also recommended more frequent monitoring of oxygen saturations in sedated patients. A pulse oximeter was purchased by the Hospital in April 2016 to facilitate this recommendation. [127]

177. This is a positive development, but I accept that there may often be difficulties in making meaningful observations with respect to agitated patients.

178. In 2016, a policy relating to the prescribing of medications and the monitoring of patients with schizophrenia was introduced. The policy recognises that the adverse effects of antipsychotic medication, such as sedation, can be cumulative.

179. The policy requires clinicians to assess patients for signs of over-sedation or respiratory distress before medications like benzodiazepines are given.[128]

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[124] Transcript 19.02.19, p189 (Ms Taylor)
[125] Transcript 19.02.19, p190 (Ms Taylor)
[126] Transcript 18.02.19, p61-62 (Nurse Joseph)
[127] Transcript 19.02.19, p206 (Ms Taylor)
[128] Exhibit 1, Vol. 2, Tab 33.13, Policy: Antipsychotic Guidelines: Managing Polyharmacy

180. Further, the policy requires clinicians to take account of medications given on an "as needed basis", for example where (as in the deceased's case) the patient is the subject of an agitation and arousal chart.[129]

181. At the time of the deceased's admission, the Hospital did not have written policies with respect to:

i. the monitoring of patients after administration of Acuphase;[130] or
ii. the automatic review of a patient's physical and psychiatric presentation when additional medication for agitation or arousal was being given on an "as needed" basis.

182. A policy dealing with the prescription of Acuphase (the Policy) was introduced after the deceased's death.[131]

183. The Policy provides that Acuphase can only be prescribed with the approval of the treating or on-call consultant and its use an automatic review of the patient's currently prescribed medications.

184. This review must include any medications being administered on an "as needed" basis under an existing agitation and arousal chart.

185. The prescriber must also consider any sedating medications the patient may be prescribed and the Policy makes specific reference to anti-psychotics, benzodiazepines and opioid medications.[132]

186. The Policy sets out the observation regime which must be followed once Acuphase is administered. In the 48 hours post-administration, a total of 19 vital sign observations must be made.[133]

[129] Exhibit 1, Vol. 2, Tab 33.13, Policy: Antipsychotic Guidelines: Managing Polyharmacy, p4
[130] Transcript 19.02.19, p177 (Ms Taylor)
[131] Exhibit 1, Vol. 2, Tab 33.16, Policy: Zucopenthixol Acetate Guidelines
[132] Exhibit 1, Vol. 2, Tab 33.16, Policy: Zucopenthixol acetate Guidelines, p2
[133] Exhibit 1, Vol. 2, Tab 33.16, Policy: Zucopenthixol Acetate Guidelines, p3-4

187. The Policy provides that these observations must be made on the patient's AORC.[134] This requirement was reinforced in an email to clinical staff dated 11 February 2015.[135]

188. Nevertheless, according to Nurse Fries[136] and Nurse Becker[137], although most nurses record the required Acuphase observations on the patient's AORC in accordance with the Policy, some nurses record those observations on the back of the Acuphase prescription form in the table which sets out the prescribed observation regime.

189. I have no way of quantifying how widespread the practice of recording Acuphase observations in places other than the AORC actually is, but it is clearly undesirable if this is occurring at all.

190. All vital observations of whatever kind should be recorded in the AORC for the obvious reason that any clinically significant changes or trends can be readily identified.[138]

191. I suggest that the Acuphase form[139] be amended so that it is no longer possible to record vital sign observations on the form itself. Further, I suggest that the requirement in the Policy that vital sign observations must be entered on the patient's AORC should be highlighted on the Acuphase form.

Risk of absconding – 15 minute checks

192. A further area of improvement relates to entries in the deceased's VOR for the period 22 - 23 February 2015.[140]

193. Dr Hacking's placed the deceased on 15 minute observations at 5.20 pm on 17 February 2015. As a minimum, nursing staff were required to record visual

[134] Exhibit 1, Vol. 2, Tab 33.16, Policy: Zucopenthixol Acetate Guidelines, p4
[135] Exhibit 3
[136] Transcript 18.02.19, p92 (Nurse Fries)
[137] Transcript 18.02.19, p105 (Nurse Becker)
[138] Transcript 18.02.19, p93 (Nurse Fries)
[139] Exhibit 1, Vol. 2, Tab 33.17, Zucopenthixol Acetate chart
[140] Exhibit 1, Vol. 3, Tab 1, Deceased's medical records

sightings of the deceased at 15 minute intervals from that time, in accordance with Dr Hacking's order.[141]

194. The VOR records the deceased as "*asleep*" between 10.15 pm on 22 February 2015 and 7.30 am on 23 February 2015.

195. The final entry in the VOR for 23 February 2015, apparently made at 7.45 am, records the deceased was "*sleeping*".[142]

196. In addition to those observations, there was evidence that at about 10.30 pm on 22 February 2015, the deceased approached the Nurse's station on the ward asking for a soft drink and that at around 12.45 am, he asked for an extra blanket.

197. The deceased's room light was noted to be on between 2.45 am and 3.00 am but that by 3.00 am, he was heard snoring loudly and the room light was off.[143]

198. Three nurses made entries in the VOR in the six hours prior to the deceased being found dead at 7.55 am on 23 February 2015.[144] These nurses all said that, in accordance with their usual practice at the time, they observed the deceased by shining a torch through a glass panel in the door of his room.[145]

199. The nurses said they generally didn't enter the patient's room when conducting these checks so as to avoid the risk of disturbing the patient's sleep pattern.[146]

200. At the time of the deceased's death, there was no expectation that nurses would check for signs of life when observing sedated patients at night who were apparently asleep.[147]

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[141] In fact, these observations were made from 6.50 pm on 16 February 2015
[142] Exhibit 1, Vol. 3, Tab 1, Deceased's medical records
[143] Transcript 18.02.19, p83-84 (Nurse Fries)
[144] Nurses Becker, Fries & Mafu
[145] Transcript 18.02.19, p83 (Nurse Fries), p95 (Nurse Mafu) & pp 105, 107 (Nurse Becker)
[146] Transcript 18.02.19, p83 (Nurse Fries), p95 (Nurse Mafu) & pp 105, 107 (Nurse Becker)
[147] Exhibit 1, Vol. 2, Tab 32.2, Letter Ms Taylor (31 Mar 2017) & Transcript 19.02.19, p208 (Ms Taylor)

201. Accordingly, none of the three nurses thought they were required to observe the deceased for signs of life whilst he appeared to be asleep and none of them did.[148]

202. By way of contrast, Nurse Ross (who made entries in the VOR from 9.00 am to 1.30 pm on 22 February 2015) said that in 2015, her practice was to look for signs of life when observing patients at night.[149]

203. On the basis of the evidence, it appears that the deceased was alive at around 3.00 am on 23 February 2015. Given the fact that he was cold to the touch and rigor mortis was established when he was found at 7.55 am, he must have been dead for some hours prior to that time.

204. It follows that at the very least, the entries in the VOR on 23 February 2015 at 6.45 am, 7.00 am, 7.15 am and 7.30 am that the deceased was "*Asleep*" and at 7.45 am that the deceased was "*Sleeping*", cannot be correct.

205. The Report noted that although Dr Hacking had ordered the deceased be placed on 15 minute observations, his order did not specify that physiological observations should be also taken.[150]

206. While I accept that this is a valid observation, the notations "*asleep*" or "*sleeping*" in a document recording physical sightings of a patient ought to imply more than merely the fact that the person's body is physically present.

207. That is so because the terms "*asleep*" and "*sleeping*" can only be sensibly used with respect to a patient who is alive.

208. Since the deceased's death, a new policy called: "*Observations: Safe and Supportive*" has been introduced. The policy sets out the role of nursing staff when recording patient observations. The policy specifically requires that if a patient is asleep, staff must check for signs of life and record respiration rates.[151]

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[148] Transcript 18.02.19, p90 (Nurse Fries), p98 (Nurse Mafu) & p105 (Nurse Becker)
[149] Transcript 18.02.19, p74-75 (Nurse Ross)
[150] Exhibit 1, Vol. 2, Tab 33.3, Clinical incident management form
[151] Exhibit 1, Vol. 2, Tab 33.19, Policy – Observations: Safe and Supportive

209. Examples of the safe and supportive observation (SASO) forms implemented by the policy were attached to Ms Taylor's statement.[152] There are different versions depending on the frequency of the observations.

210. The SASO form contains a statement that staff are to check for signs of life when a patient is asleep (e.g. respirations, rise and fall of chest, snoring, movement).[153]

211. However, the requirement to record respiration rates does not appear on the face of the SASO form, and at least one nurse was under the impression that the new policy only required respiration rates to be checked.[154]

212. While I accept that the SASO form and the policy behind it are positive changes, I am concerned that the SASO form doesn't set out the requirement that nurses are required to record respiration rates of patients who are asleep. Further, the SASO form does not contain a column where those observations can be recorded.[155]

213. In my view, further enhancements along these lines would help to reinforce the important obligations placed on nurses who make observations about sleeping patients, especially those who are sedated.

214. In her evidence, Ms Taylor accepted that the SASO form could and should be amended. Pleasingly, Ms Taylor said that she would make the necessary changes whether I made a recommendation to that effect or not.[156]

215. With the exception of the issues I have referred to relating to observations of the deceased's vital signs and the observations with respect to his risk of absconding, I am satisfied that the supervision, treatment and care provided to the deceased was adequate.

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[152] Exhibit 1, Vol. 2, Tab 33.9, Form –safe and supportive observation chart
[153] Exhibit 1, Vol. 2, Tab 33.9, Form –safe and supportive observation chart
[154] Transcript 18.02.19, p68 (Nurse Joseph)
[155] Transcript 19.02.19, p186-187 (Ms Taylor)
[156] Transcript 19.02.19, p187-188 (Ms Taylor)

RECOMMENDATIONS

216. In light of the observations I have made, I make the following recommendations:

Recommendation No.1

The Hospital's safe and supportive observation charts (AKMR147.2 - AKMR147.5) (the charts) should be amended to make it clear that as required by the policy "*Observations: Safe and Supportive*", when a patient appears to be asleep, respiration rates must be recorded on the relevant chart and further, a column should be included on the charts for that purpose.

Recommendation No.2

When visual observations are ordered by medical staff or where the frequency of those observations is increased by nursing staff, the reason for the order (or the change in frequency observations) should be documented in the patient's progress notes (MR55A) and on the patient's safe and supportive observation chart (AKMR147.2 - AKMR147.5). A notation that merely indicates the frequency at which observations are to be made should not be regarded as sufficient.

Recommendation No.3

The Armadale Kelmscott Memorial Hospital's zuclopenthixol acetate chart (AKMR170.7) should be amended to make it clear that the vital signs observations prescribed by the *Zuclopenthixol Acetate (Clopixol Acuphase) Guidelines* must be recorded on the patient's adult observation and response chart (AKMR140.3), and nowhere else.

CONCLUSION

217. The deceased was a 30 year old man who died on 23 February 2015 from methadone toxicity. Although the matter is not without doubt, it seems likely that the deceased died from respiratory depression.

218. I have been unable to determine how the methadone found in the deceased's blood reached levels which appear to have lethally sedated him.

219. I consider the most likely explanation is that deceased was not habituated to that level of methadone because he was not regularly taking his prescribed daily dose of Physeptone, namely 80 mg, in the months before his death.

220. Despite these observations, on the basis of the evidence before me, I have been unable to make a conclusion about the manner and cause of the death in this case.

221. It follows that I must make an open finding with respect to the deceased's death.

222. Quite obviously, the deceased's death has affected his family very deeply. As a result of his death, the AMHS made changes to several of its policies and forms.

223. I have made three recommendations which I hope will further clarify the important responsibilities of clinical staff. I hope that the changes already made, as well as the ones I have recommended, will provide the deceased's family with some solace for their terrible loss.

M A G Jenkin
Coroner
8 March 2019

Annex A:

Table of medications dispensed to the deceased during his admission 17 – 22 February 2015

Date	Time	Medication	Dose
17 February 2015	07:25	Clonazepam	1mg
	09:00	Diazepam	5mg
	09:00	Quetiapine	25mg
	12:20	**Methadone**	**40mg**
	12:20	Dexamphetamine	30mg
	12:20	Aripiprazole	5mg
	10:45	Amoxycillin	500mg
	15:30	Paracetemol	1 mg
	16:45	Clonazepam	2mg
	18:10	Zuclopenthixol Acuphase	150mg IM
	18:55	Amoxycillin	500mg
	18:55	**Methadone**	**30mg**
	20:00	Diazepam	10mg
18 February	00:10	Clonazepam	2mg
	08:00	Aripirazole	5mg
	08:00	Amoxycillin	500mg
	08:00	**Methadone**	**40mg**
	08:00	Diazepam	10mg
	14:00	Amoxycillin	500mg
	18:40	**Methadone**	**30mg**
	20:00	Diazepam	10mg
19 February	08:00	Aripiprazole	5mg
	08:00	Amoxycillin	500mg
	08:00	**Methadone**	**40mg**
	08:00	Diazepam	10mg
	14:00	Amoxycillin	500mg
	16:10	Zuclopenthixol Acuphase	100mg IM
	17:30	**Methadone**	**30mg**
	19:10	Quetiapine	50mg
	20:00	Amoxycillin	500mg
	20:00	Diazepam	10mg
20 February	03:40	Clonazepam	0.5mg
	08:00	Aripiprazole	5mg
	08:00	**Methadone**	**40mg**
	08:00	Diazepam	10mg
	10:00	Amoxycillin	500mg
	12:30	Quetiapine	100mg
	14:00	Amoxycillin	500mg
	18:00	**Methadone**	**30mg**
	20:00	Diazepam	10mg
	20:00	Amoxycillin	500mg
21 February	01:25	Clonazepam	2mg
	08:00	Aripiprazole	5mg
	08:00	**Methadone**	**40mg**
	08:00	Amoxycillin	500mg
	10:00	Diazepam	10mg
	10:55	Mylanta	20ml
	14:00	Amoxycillin	500mg
	16:05	Zuclopenthixol Acuphase	100mg
	18:00	**Methadone**	**30mg**
	20:00	Diazepam	10mg
	20:00	Quetiapine	100mg
22 February	01:55	Mylanta	20ml
	02:25	Clonazepam	2mg
	07:00	Paracetamol	1g
	08:00	Aripirazole	5mg
	08:00	**Methadone**	**40mg**
	08:00	Diazepam	10mg
	08:00	Amoxycillin	500mg
	10:16	Mylanta	20mg
	14:00	Amoxycillin	500mg
	15:00	Olanzapine	10mg
	15:30	Clonazepam	2mg
	18:00	**Methadone**	**30mg**
	20:00	Diazepam	10mg
	20:00	Amoxycillin	500mg