STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Annalies Malm
Hearing dates:	3 February 2015
Date of findings:	3 February 2015
Place of findings:	State Coroner's Court, Glebe.
Findings of:	Magistrate Sharon Freund, Deputy State Coroner
File numbers:	2012/147410
Findings:	I find that Annalies Malm died on the 8th of May 2012 at 12 Bunyala Place Mt Colah the cause of her death being a terminal epileptic seizure. The manner of her death was natural causes.
Representation:	Ms E. Mulligan as Sergeant Assisting the Coroner; Ms K. Bourke for Family and Community Services;

FINDINGS

Annalies Malm was 45 years old when she passed away. She is survived by her parents Diane and Roy and her three siblings, Louise, Gavin and Edwina.

As a baby, Annalies was diagnosed with cerebral palsy. Her medical records indicate that she suffered from a severe intellectual disability, epilepsy (including regular seizures) and other associated medical conditions. Annalies was non-verbal and required help with standing, showering and eating.

I note that the Post Mortem conducted by Dr Van Vuuren revealed that Annalies at the time of her death had “marked aspiration pneumonia in the right lung” she stated in her report that pneumonia can be a consequence of regular seizures.

From the age of 14, Annalies resided in full-time disability care facilities. In 2011, Annalies became a resident of a group home at 12 Banyula Place Mount Colah (“**the Bunyula Group Home**”).

On the 7 of May 2012, Annalies was accidently administered the incorrect medication by disability support worker Nicole Jackson. Ms Jackson immediately contacted the poisons hotline who advised her to contact a Doctor. The evidence indicates that Ms Jackson contacted General Practitioner Nicole Morrison who attended Banyula Place at about 6.30pm and examined Annalies. Dr Jackson, also contacted neurologist Dr Roy Beran to discuss the medication error. The Doctors concluded there was no immediate

health implications arising from the medication error and that Annalies should be closely monitored. Doctors advised the staff at Banyula Place that if breathing difficulties occurred, Annalies should be taken to hospital.

During the night Annalies was restless, red in the face and screaming however this behaviour was not uncommon. Annalies went to sleep about 4.30am on the 8 of May. About 6.10am that morning carers found Annalies deceased.

The role of a Coroner as set out in s. 81 of the Coroners Act 2009 ("the Act") is to make findings as to:

1. the identity of the deceased;
2. the date and place of a person's death;
3. the physical or medical cause of death; and
4. the manner of death, in other words, the circumstances surrounding the death.

A coroner, pursuant to s.82 of the Act, also has the power to make recommendations, concerning any public health or safety issues arising out of the death in question.

As Annalies was in full time care provided by the then Department of Aging and Disability (now Family and Community Services) her death was reported to his Court pursuant to section 24 of the Act. As a result a full and comprehensive investigation was carried out into her death and statements were obtained from the relevant carers and treating medical professionals. Not all were called to give evidence at the inquest as I was satisfied in relation to the evidence they gave however their evidence formed part of the brief of evidence which tendered and formed exhibit 1 in the proceedings.

After considering exhibit 1, namely the brief of evidence, I formed the view that the issues to be determined in this inquest were:

A. Did the medication error cause or contribute to Annalies' death? and

B. Are there any care and treatment issues, in particular in relation to the administration of medication to residents at the Banyula Group Home?

I will deal with each of these issues in turn.

Did the medication error cause or contribute to Annalies' death?

An expert report was obtained from Dr William Allender, Forensic Toxicologist. In his report dated 12 February 2014, Dr Allender found inter alia that:

1. the blood concentration of lamotrigine is well outside the therapeutic range but goes on to state this reading could be caused by interaction with a concurrent dose of valporic acid which results in an elevated blood level of lamotrigine. Both lamotrigine and valporic acid were drugs prescribed to Annalies to control her epilepsy; and
2. all medications administered accidently to Annalies the day prior to her death were found to be within or lower than the therapeutic range;
3. the elevated blood level of lamotrigine together with a compromised respiratory condition could have contributed to Annalies' death however a terminal seizure cannot be ruled out.

Accordingly I am satisfied, on the balance of probabilities, that the medication error the day before Annalies' death did NOT cause NOR did it contribute to Annalies' death.

Are there any care and treatment issues, in particular in relation to the administration of medication to residents at the Banyula Group Home?

Despite the fact that I am satisfied that the mistake in medication did not contribute to Annalies' death, a number of witnesses were called to give evidence regarding the systems at the Banyula Group Home, how the medication error occurred, and what occurred to try and ensure that Annalies had no adverse reaction to the medication error.

Those witnesses comprised of Nicole Jackson (who incorrectly gave Annalies the medication), Jolanta Stepnik and Lily Guo. All three witnesses worked and continue to work at the Banyula Group Home. I found them to be honest and forthright. The support workers genuinely cared for Annalies and the other residents in the home and were all deeply affected by Annalies' passing. Working in disability support is no doubt a challenging profession and these women impressed me as a professional caring team who carried out their duties with pride and diligence.

The error with respect to Annalies' medication was picked up quickly and appropriate steps were taken to manage the error by the staff at the home. They followed the advice of the medical professionals which was to monitor Annalies closely which they clearly did. It is unfortunate that she passed away so shortly after the medication error.

I also accept the evidence of Annalies' treating GP, Dr Nicole Morrison who attended on Annalies after the medication error. Dr Morrison's statement dated 12 June 2012 indicated that she spoke with Annalies' treating neurologist over the phone about the error and they were both of the view that "no acute treatment was required at this time".

Accordingly, I am satisfied on balance that the care and treatment received by Annalies from Dr Morrison was reasonable in the circumstances.

Accordingly, I now turn to the findings I am required to make pursuant to section 81 of the Coroners Act 2009.

I find that Annalies Malm died on the 8th of May 2012 at 12 Bunyala Place Mt Colah the cause of her death being a terminal epileptic seizure. The manner of her death was natural causes.

3 February 2015

Magistrate Sharon Freund
Deputy State Coroner