STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Ms Shelley Young
Hearing date:	22-23 November 2021
Date of findings:	23 December 2021
Place of findings:	NSW State Coroner's Court - Lidcombe
Findings of:	Magistrate Carmel Forbes, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death – medical care and treatment of long-term mental health patients-prescribing of anti-psychotic and sedative medication-choking on food
File number:	2017/0297344

Representation:	Ms D Ward SC, Counsel Assisting, instructed by Ms H Aitken, Department of Communities and Justice, Legal. Mr P Rooney instructed by A Reberger, Makinson d'Apice Lawyers representing Northern Sydney Local Health District.
Findings:	Ms Shelley Young died on 29 September 2017 at Manly Hospital, Sydney, New South Wales, as a result of choking on a tangerine.
Non-publication order:	

Introduction

1. Ms Shelly Young was a 65 year old woman who died at Manly Hospital, Sydney on 29 September 2007. She died from choking on a tangerine. She had been identified as a choking risk and as needing to be supervised while she ate. She obtained the tangerine from a fruit bowl that was left out for patients.

2. A coroner's primary role is to investigate and make findings as to the identity of the deceased person, the date and place of the death, and the manner and cause of death. A further role for a coroner is to assess whether there has been an appropriate response to an unexpected death and whether more needs to be done to protect others from a similar death.

Medical background

3. Ms Young had been a resident at Macquarie/Gladesville Hospitals since 1977. An agreed chronology of her care since that time is attached to these findings.

4. Her sister, Barbara McGregor, informed this court that she was originally admitted suffering deep depression and after many rounds of electro convulsive therapy treatment she was diagnosed with schizo-effective disorder.

5. Both her illness and her treatment had long term consequences for Ms Young and her physical, emotional and psychological health. For example, she was at first treated with a variety of first generation antipsychotics which altered her skin pigmentation and left her with chronic kidney disease. She was later treated with a variety of second generation antipsychotics with their own side effects, both

individually and in combination, including: an increased risk of confusion, falls and constipation.

6. Independent expert evidence in relation to her care and treatment was obtained from Associate Professor Wijeratne, Consultant Psychiatrist with a speciality in geriatric psychiatry. He informed the court that there were multiple complications arising from Ms Young's chronic antipsychotic use including: osteopenia or bone thinning, bowel obstruction resulting in surgery in 2004, and cognitive impairment.

7. Ms Young also experienced tardive dyskinesia, a hyperkinetic movement disorder that in Ms Young's case seemed to affect her tongue. In addition, Ms Young had impaired swallowing or dysphagia. Associate Professor Wijeratne stated that dysphagia has been associated with multiple complications of antipsychotic use including impaired function of the musculature of the mouth, pharynx and oesophagus.

8. By 2016 a formal cognitive assessment recorded that Ms Young was demonstrating extremely low range performance in immediate memory, executive function (spatial and abstract reasoning), processing speed and learning. Her cognitive impairments, together with positive symptoms of her schizoaffective disorder (delusions + auditory hallucinations) meant that she was frequently perplexed/confused by events and was distracted easily. Her mood reportedly fluctuated with mild irritability a feature of her condition. She tended to act impulsively.

9. In December 2016 Ms Young was taken from Macquarie Hospital to Ryde Hospital and then to the Royal North Shore Hospital (RNSH)

where she was diagnosed with dehydration on a background of urinary tract infection. Ms Young ultimately remained at RNSH until 13 March 2017 with a final diagnosis of severe delirium.

10. Associate Professor Wijeratne describes delirium as an acute confused state characterised by alteration in sensorium such that the person has difficulty maintaining attention and is disoriented. Common associated features include behavioural changes, mood changes and psychotic symptoms such as delusions and hallucinations. It is not a condition confined to people living with a pre-existing mental illness.

11. During this admission at RNSH, lasting in excess of 3 months, Old Age Psychiatrist, Dr Zoltan Zsadanyi, recommended ceasing Ms Young's prescribed lithium and a reduction in her Clozapine medication. Lithium and Temazepam were ceased, Clozapine was reduced to 275mg per day and Olanzapine was reduced to 10mg at night. Sodium valproate 800mg daily continued.

12. Lithium is an antipsychotic (first generation). Clozapine and Olanzapine are also antipsychotic medications (second generation). Temazepam is a benzodiazepine that acts as a nervous system depressant commonly prescribed to treat stress, anxiety or insomnia. Sodium valproate is an anticonvulsant drug.

13. The admission at RNSH continued long after the urinary tract infection had resolved. Associate Professor Wijeratne tells the court this is a reflection of the often protracted course of delirium; whilst disease in a peripheral organ may resolve the brain lags in recovery.

The move to RSL Tobruk, Narrabeen

14. During Ms Young's admission at RNSH Ms McGregor obtained a guardianship order from NSW Civil and Administrative Tribunal (NCAT) for a period of 12 months. This was a limited guardianship order giving the guardian custody to the extent necessary to decide where Ms Young lives, what health care Ms Young receives, to make substitute decisions about proposed minor or major medical or dental treatment and to make decisions about services to be provided to Ms Young.

15. Ms McGregor did not want Ms Young to return to Macquarie Hospital once she left RNSH.

16. In early 2017 a Mental Health Aged Care Partnership Initiative (MHACPI) agreement was reached between the Northern Sydney Local Health District and an aged care provider, as part of state-wide Pathways to Community Living Initiative (PCLI) program. This program opened a 10 bed facility in the local area for eligible Stage 1 PCLI Consumers (ie people over 65 years who have been in a mental health facility for longer than 365 days). Ms Young was fortunately able to secure a room as part of the initiative at RSL Tobruk. So whilst she was discharged from RNSH to Macquarie Hospital on 13 March 2017 in July 2017 Ms Young left Macquarie Hospital and moved to her new home in Narrabeen.

17. According to Ms McGregor, Ms Young was thrilled to be in her new home at Tobruk. She was overjoyed at having her own, nicely decorated personal space with patio garden and privacy, and enjoying the amenities, food and caring environment.

18. The records from RSL Tobruk record Ms Young participating in bus trips, craft exercises, community meals and regular visits from her family.

19. For the first few weeks Ms Young's treating team continued the medication regime that was in place at the time of her discharge from Macquarie Hospital. Her treating team was: Dr Kathy Zeleny (General Practitioner), Jacqueline Salmon (Registered Nurse and Ms Young's caseworker through the Mental Health and Ageing Community Placement Initiative) and Dr Megan Alle (Psychogeriatrician also with the Mental Health and Ageing Community Placement Initiative).

20. Unfortunately, Ms Young's health deteriorated. On 10 August 2017 Dr Alle decided to increase Ms Young's Olanzapine from 10 mg daily to 20 mg daily for a 3 day trial. Ms McGregor was informed.

21. On Monday 14 August 2017 Jacqueline Salmon reviewed Ms Young and spoke to Dr Alle. A decision was made to continue the additional Olanzapine until Ms Young's next psychiatry review, due on Thursday 17 August. Ms McGregor was not informed of this decision.

22. When Ms McGregor visited Ms Young on 16 August 2017, Ms Young was sleepy and according to the Tobruk notes, Ms McGregor apparently declined the additional 10mg Olanzapine medication, due at noon.

23. The next day, Friday 18 August 2017, Dr Alle went to see Ms Young. Ms McGregor and Jacqueline Salmon were also there. Ms McGregor apparently asked for the additional medications to be stopped. Dr Alle thought that Ms Young was showing significant improvement due to

the extra 10mg Olanzapine and apparently outlined a plan to reduce it to 10 mg and then 5 mg and observe Ms Young's mental state and level of sedation.

24. Deterioration in the already difficult working relationship between Ms McGregor and the team from the Mental Health Aged Care Partnership Initiative followed, leading to further proceedings in NCAT. These proceedings were adjourned on the condition that the current practice and treatment, as advised and in consultation with the guardian, remained in place in the meantime. Ms Young died before the proceedings returned to the Tribunal.

25. Ms Young's GP meantime made steps to obtain a second opinion but before that could happen, Ms Young was taken to Manly Hospital by ambulance on 20 September 2017.

Admission to Manly Hospital

26. Ms Young was seen in the emergency department on 20 September 2017 and was ultimately admitted to Medical Ward 1 with a provisional diagnosis of delirium, potentially due to cellulitis or a urinary tract infection. Because she required treatment for her physical illness but also needed ongoing psychiatric care, Ms Young was referred to the consultation liaison psychiatry team, a service catering for the mental health assessment and treatment of patients admitted to the medical and surgical wards of the hospital. Ms Young regularly saw Dr Anna Bolliger, Staff Specialist Psychiatrist during her admission and Dr Bolliger also had several discussions with Dr Alle (Ms Young's community psychiatrist), with Ms McGregor and with the

admitting physician and treating team managing Ms Young's other medical care on Medical Ward 1.

27. Various pro re nata (PRN) medications were administered to Ms Young across the course of this admission, in addition to the routine medications she was taking at the time of her admission.

28. In addition, at the time of admission Manly Hospital received and included within their records, various documents from RSL Tobruk which in turn included some material that had been provided by Macquarie Hospital. This material included reference to Ms Young being at risk of choking because of, amongst other things, her lack of teeth, a swallowing/chewing disorder, reduced mastication and impulsivity.

29. A swallow assessment conducted on 18 September 2017 whilst Ms Young was at RSL Tobruk, led to recommendations noted in the records available to Manly Hospital, that Ms Young be fully supervised at all time during meals and a soft moist food diet be trialled.

30. Ms Young was supervised with her meals whilst a patient on Medical Ward 1 and arrangements were made for Ms Young to be further assessed via a formal speech review. The speech review did not, however, occur.

31. Ms Young was ultimately transferred to the Specialist Mental Health Ward for Older Persons at Manly Hospital on 28 September 2017. She was placed on Level 2 observations, requiring observation every 15 minutes.

32. On 29 September 2017 Ms Young spent some time with Ms McGregor.

33. On the same day Nurse Unit Manager (NUM) Muriithi contacted the registrar on the treating team and requested a medical review because she was concerned Ms Young might still be experiencing delirium. Ms Young was reported to be agitated, walking around the ward and knocking on windows. Ms Young was assessed by a Junior Medical Officer who recorded the impression of resolving delirium on a background of manic relapse of schizoaffective disorder.

34. At some time around 1pm Ms Young was given 1 mg Haloperidol (an antipsychotic) with some effect.

35. According to the nursing observation charts Ms Young was observed in the corridor at 1300 and 1315 and was back in her room at 1330 and 1345. The observation at 1400 had Ms Young in her room and courtyard, perhaps she was walking between the two. At 1415 Ms Young was seen in the corridor.

36. At 1430 NUM Muriithi carried out a walk-thru of the ward and discovered Ms Young in her room, slumped in a chair. She was unresponsive. According to NUM Muriithi, when she discovered Ms Young, she was seated peacefully and the witness' first impression was that Ms Young had experienced a cardiac arrest.

37. NUM Muriithi called for help, a call for the rapid response team was made and CPR attempts continued until about 1535 that afternoon.

38. During resuscitation and on direct laryngoscopy 4-5 pieces of tangerine were seen in Ms Young's airway and removed. Resuscitation was unsuccessful.

39. At the request of Ms McGregor a limited autopsy was conducted, limited to external examination and toxicology. The forensic pathologist concluded that the cause of death was choking.

40. The forensic pathologist informed this court that it is not uncommon for first responders not to be able to see obstructing food boluses in the airways, food could be too deep into airways and also the tongue can obstruct their vision. She said that the possibility that the tangerine originated from the stomach (in the course of CPR) cannot be completely excluded however, based upon the medical records that tangerine pieces were removed, that there was the absence of upper teeth and limited lower teeth, past choking episodes, documented choking risks, documented delirium and confusion, eating without supervision and not eating soft foods, she determined the cause of death as in keeping with choking

41. On balance, for the reasons set out by the forensic pathologist I am satisfied that the cause of Ms Young's death was choking.

The prescribing of anti-psychotic and sedative medication at Manly Hospital

42. Both Associate Professor Wijeratne and Dr Sullivan are independent expert psychiatrists that reviewed Ms Young's care and treatment on behalf of the NSLHD. They both emphasised that in an ideal world the doctors prescribing for Ms Young in 2017 would know about the circumstances around the original prescribing of Clozapine.

Ideally there would be information about:

a) the decision to introduce Clozapine and the initial dose;

b) Ms Young's response to Clozapine in light of her apparently treatment resistant schizophrenia or schizo affective disorder (ie what benefit did Ms Young actually derive from the medication that could be weighed against the risk of side-affects such as anticholinergic activity); and

c) the decision to continue Clozapine prescribing even after Ms Young's 2004 bowel obstruction.

43. The prescribers in 2017 had some information about the more recent prescribing of Clozapine available from the Macquarie Hospital and RNS material but not readily available from the historical records at Macquarie Hospital.

44. The records show that Clozapine had been prescribed since at least 2004 at Macquarie Hospital, it was continued during the 2016-2017 three month admission at RNSH and continued through the March 2017 – July 2017 admission at Macquarie Hospital.

45. The RNSH admission provided an opportunity for Ms Young to receive a second opinion about medication management from a geriatric psychiatrist.

46. Dr Zsadanyi noted in the records "What is most critical at this stage is that Ms Young's medication be reduced as soon as possible with a view to remove any psychotropic medication that might be causing her delirium. At the time of my attending Ward 7F today, she was prescribed the following olanzapine 10 mg nocte, temazepam 5mg nocte, clozapine 275mg nocte, clozapine 150 mg mane, Na valproate 400mg b d, lithium 250mg b d, haloperidol 2.5-5mg IM or orally PRN, olanzapine 2.5-5mg 6 hourly/prn… Noting the above polypharmacy and Ms Young's clinical presentation, strongly indicative of a chronic delirium, it is doubtful that her mental illness is the reasons for her continuing to remain unwell…It is now time to reduce and discontinue whatever medication possible, as soon as possible due to the likelihood that Ms Young has very limited reserve after this prolonged episode of delirium, due to her long h/o mental illness and her past episodes of delirium."[1]

47. Dr Zsadanyi then recommended a step down and eventual cessation of Lithium and a step down in prescribing of Clozapine to an end point of 300mg per day. Ultimately by the time Ms Young moved to her home at RSL Tobruk this had further reduced to 225mg per day.

48. Dr Zsadanyi went onto say "The aim is to continue reducing medication doses and trying to cease what medication we can".[2]

49. This is consistent with Ms McGregor's concerns around excessive sedation and polypharmacy.

[1] Ex 1 Tab 31 p 1707

[2] Ex 1 Tab 31 p 1708

50. Dr Zsadanyi's concern was also echoed by the expert evidence of Associate Professor Wijeratne and Dr Sullivan in relation to the desirability of minimising the number and the amount of anti-psychotic medications where possible. This is particularly the case in elderly patients where, as Associate Professor Wijeratne explained, patients like Ms Young with a history of chronic schizophrenia or schizoaffective disorder are at greater risk of developing a number of co-morbidities resulting in lower life expectancy, increasing risk of developing cognitive impairment and greater sensitivity to drug side effects. He believes that although Ms Young was 65 years old at the time of her death, she was physiologically somewhat older as a result of her chronic mental illness.

51. Dr Alle also gave evidence that as a geriatric psychiatristshe usually aims to reduce medication where possibly because of the complexity that is involved in managing older patients with co-morbid medical conditions.

52. Dr Alle informed this court that:

a) Prior to Ms Young moving from Macquarie Hospital to RSL Tobruk there were handover discussions between Dr Alle and representatives from the treating team at Macquarie.

b) Ms Young was one of the first of two patients to take part in the new PCL initiative as it operated in the Northern Sydney Local Health District. There were 10 beds available in total on a 40 bed locked ward.

c) Even before her first assessment of her new patient, Dr Alle had a broad plan. She wanted Ms Young to stabilise in her new home and would largely continue the current treatment regime in the interim but with an eye to reviewing the medication in due course to determine if, consistent with her general practice, medication could be reduced to the lowest possible level. She wanted to assess mental state, monitor closely and adjust medication if necessary. Associate Professor Wijeratne thought this an entirely reasonable plan, adding that he would expect this would extend to further cognitive review using the 2016 review as a baseline from which to measure any further cognitive decline.

d) Ms Young was experiencing minimal side effects from her medication at the time of Dr Alle's early review and assessment.

e) Dr Alle anticipated some difficulties in Ms Young's adjustment to her new home. Dr Alle said after 20 years in a psychiatric institution (in fact Ms Young had lived in a psychiatric institution for much longer than that) she expected Ms Young would display changes in a different environment and she anticipated changes in Ms Young's mental state that meant she might become unsettled for a time.

f) Hopefully Ms Young would develop a therapeutic relationship with her treating team and carers at RSL Tobruk with time.

g) Ms Young was on a locked ward with other aged care residents. She had her own room and took her meals with other residents. She was able to participate in some activities

such as bus trips and dancing and craft as part of diversional therapy. However the carers were more attuned to the needs of residents living with dementia (as might be expected in a nursing home environment) rather than Ms Young's specific and additional needs arising from having lived with chronic mental illness and the side effects of treatment for her chronic mental illness. Associate Professor Wijeratne emphasised that residential aged care facilities are increasingly under stress in terms of adequate staffing levels and this is even more the case when caring for residents who are both elderly and have a long term mental illness that ought be carefully managed.

h) Dr Alle stopped the prescribing of Lorazepam PRN, Haloperidol PRN and Olanzapine PRN as prescribed at Macquarie Hospital although she later reintroduced PRN Olanzapine 5mg.

i) Dr Alle later increased the level of Ms Young's routine Olanzapine dose. This happened on 10 August 2017 after observing a marked deterioration in Ms Young's condition since Dr Alle's last examination which led Dr Alle to conclude Ms Young was experiencing a depressive psychotic relapse of her schizoaffective disorder. Dr Alle does not consider delirium was a factor in this deterioration. Ms Young was alert and recognised Dr Alle at the time of assessment. Her speech was clear. She was not so disorganised as to suggest delirium.

j) Olanzapine prescribing increased by 10 mg to 20 mg in total each day. Whilst Dr Alle considered an increase in Clozapine she settled upon an increase in Olanzapine because Ms Young had been given PRN Olanzapine 2-3 per week during the latter part of the Macquarie Hospital admission. Dr Alle determined

it was probably better to give a significantly higher dose of Olanzapine (10mg instead of say a more incremental increase) as a known anti-psychotic for a short period of time rather than 'fiddle with PRN'. This was initially a three day trial to monitor Ms Young's response and she hoped to bring Ms Young back to baseline very quickly.

k) A decision was then made on 14 August 2017 that the additional prescribing needed to continue pending further medical review. This decision was not made known to Ms McGregor.

l) Further medical review occurred on 17 August 2017. Ms McGregor was concerned that it had been difficult to rouse Ms Young the day before and wanted the additional Olanzapine withheld. Dr Alle however concluded that there was significant improvement in Ms Young's presentation due to the extra Olanzapine. Nonetheless consistent with the ideal of reducing where possible, Dr Alle reduced the additional Olanzapine from 10 mg to 5 mg (a total of 15mg per day).

m) This continued until 28 August 2017 at which time Dr Alle formed the impression that Ms Young was again suffering a psychotic relapse and so again prescribed Olanzapine at the rate of 10mg midday and 10mg at night (a total of 20mg per day).

At some point (it is not clear if this was 28 August or 4 September) Dr Alle decided to "trial Lyrica 75mg nocte" (at night). She explained that as an anticonvulsant, she thought it may have a role to play in stabilising Ms Young's mental state,

Ms McGregor didn't want Ms Young to be prescribed lithium, she was trying to find agents other than antipsychotics and so she decided to try another mood stabiliser.

53. This prescribing puzzled both Associate Professor Wijeratne and Dr Sullivan. Associate Professor Wijeratne said that Lyrica is not a mood stabiliser and it would have been more judicious at this point to optimise the dose of sodium valproate Ms Young was already prescribed. Dr Sullivan said there was no specific evidence supporting using Lyrica at this time although some antiepileptic drugs are prescribed with some efficacy in some cases.

54. Lyrica was trialled but later withheld as from 14 September 2017 because Ms Young appeared over-sedated at this point. Afile note of that date recorded "Impression: over-sedated, still hypomanic….withhold Lyrica for 1 week and observe mental state – can be reinstituted if sleep disturbance or severe escalation in mood." A file note of 21 September 2017 recorded "Lyrica suspended last week…due to unsteadiness of gait, concerns re fall and concerns of oversedation." Dr Alle says she withheld Lyrica because it didn't seem to help Ms Young's mental state and she decided it was better not to give her anything else.

Even though later suspended, the use of Lyrica is important because it apparently carried over to prescribing at Manly Hospital. It was apparently charted, although not given, in the ED (pregabalin charted but then marked "W" for withheld on the ED medication chart) but was introduced at some time during the Medical Ward admission. So much is clear by a progress note recording that Lyrica was withheld by the medical team over the weekend of 23-24 September because of concerns about sedation. It seems Lyrica was withheld from this point on.

55. Turning to a consideration of prescribing during the Manly Hospital admission, the records demonstrate there were periods of over sedation during the Manly Hospital admission e.g. leading to ICU consult on 21 September 2017 and leading to a reduction in medication over the weekend of 23-24 September 2017.

56. Ms Young was transferred to Manly Hospital on 20 September 2017. Associate Professor Wijeratne was critical of the use of benzodiazepine (diazepam) during this admission. It appears that this was in fact largely confined to Ms Young's time in the emergency department (the medical records don't clearly explain whether this was a single dose or a dose on more than one occasion). Both experts agreed with the advice from the psychiatry registrar to the emergency doctors to "avoid benzodiazepines".[3]

57. Dr Bolliger, Community Psychiatrist, did not prescribe the use of benzodiazepines during the admission that followed emergency department attendance and diazepam use was not further repeated.

58. Midazolam (another benzodiazepine) may have been used on one further occasion after Ms Young was admitted to Medical Ward 1. This was 21 September 2017 when a MET call was made and an ICU team attended because Ms Young was so heavily sedated there was concern about her ability to maintain her own airways. The progress note suggests that the rapid response was called for decreased GCS (Glasgow Comma Scale) with the patient significantly obtunded and minimally responsive but by the time the MET arrived Ms Young was

[3] Ex 1 Tab 29 p 638

agitated, shouting, swearing and punching staff. Amongst other things Ms Young was given 2mg haloperidol IV.[4]

59. Dr Bolliger was not involved in this prescribing of haloperidol but was asked in oral evidence about other potential options. She said one option would have been to increase Clozapine (that is, rather than introduce a new medication) but at this time Dr Bolliger understands Ms Young was refusing oral meds and was in any event at the maximum dose. Haloperidol can be given intravenously which was an advantage over oral meds.

60. Dr Bolliger then prescribed PRN Haloperidol on 22 September 2017 with the initial dose later decreasing across the day in light of Dr Bolliger's later assessment. That is, Dr Bolliger was monitoring Ms Young's response to the PRN medication.

61. Haloperidol was added as a regular medication on 25 September 2017 at 2mg per day. Thus a third anti-psychotic was added to Ms Young's list of medications even as she was struggling with delirium. Dr Bolliger conceded in her statement of 5 September 2021 she could have reduced the regular dose of Olanzapine from 20mg to 10 mg daily when she introduced the regular Haloperidol. In her oral evidence Dr Bolliger expanded upon her answer and said at the time she spoke with Dr Alle about whether there was more they could do to help resolve Ms Young's difficult behaviour which Dr Bolliger attributed to mania. Dr Bolliger placed emphasis on the fact Ms Young's behaviour on the ward put both herself and staff at some risk: Ms Young was refusing to take her meds and was hitting staff. So, Dr Bolliger decided to keep olanzapine at 20mg while introducing

[4] Ex 1 tab 14 p 150

haloperidol with the plan this would be reviewed the following Monday 1 October 2017, on the Specialist Mental Health Ward for Older Persons. Sadly, Ms Young passed away on Friday 29 September 2017.

62. Dr Bolliger maintains that Ms Young's behaviour was so difficult to manage that she was putting herself at risk (and staff) and she does not see, even with the benefit of hindsight, there should have been a reduction in medication on Ward 1.

63. Associate Professor Wijeratne disagrees. Acknowledging this opinion is expressed with the benefit of hindsight, he maintains that the number of antipsychotic medications and relative dosing could have been reduced. He said that observing for anticholinergic effect is quite problematic and he considered it better to take an empirical approach to reduce or withdraw higher anticholinergic medications, acknowledging it's a difficult thing to do.

64. Dr Sullivan had a slightly different emphasis. He said it was important to address the anticholinergic burden but that the benefit of reducing or withdrawing such medications had to be offset against the underlying treatment resistant disorder.

65. Clearly, the focus of prescribing should have been upon reducing the number and amount of anti-psychotic and other medications with sedative effect as soon as clinically possible. The experts took a slightly different view on when this might have become possible in Ms Young's case. This highlights that minds can legitimately disagree on the treatment of a patient with a complex presentation such as Ms Young.

66. Similarly, there was a difference in emphasis between the experts as to the appropriateness of prescribing Clozapine and Olanzapine together (noting that this commenced long before Ms Young even arrived at RSL Tobruk). Associate Professor Wijeratne noted there was limited evidence for the use of two antipsychotics and that the RANZCP Guidelines recommended one antipsychotic only.

67. Dr Sullivan agreed but emphasised that the use of two antipsychotics was common in practice to which Associate Professor Wijeratne agreed.

68. Dr Alle explained in oral evidence "I've spent a lot of my career developing personalised management plans because they [her patients] fall outside the guidelines."

69. I accept that Dr Alle was looking to eventually reduce medication for Ms Young and was not simply following 'common practice' in prescribing more than one antipsychotic at a time. (I note here that the second opinion from the geriatric psychiatrist in 2017 recommending a reduction in the number and amount of medication acknowledged that more than one anti-psychotic would need to continue, at least for a time).

70. Dr Bolliger was in part guided by what Dr Alle suggested and also by her own observations of Ms Young and the need to manage the underlying mental illness as well as the co-existing delirium.

71. I find that while different decisions could have been made the decisions actually made were not outside the bounds of appropriate treatment.

The adequacy of steps taken to assess Ms Young's ability to swallow and supervise meals during the admission to Manly Hospital

72. By the 1990s Ms Young had lost all but two of her teeth.

73. Ms McGregor reports that in 2009 Ms Young was taken to Ryde Hospital from Macquarie Hospital with a piece of apple lodged in her throat.

74. On 16 March 2016 an "alert" was entered in the LHD EMR recording Ms Young "choked on food".

75. The discharge summary from Macquarie Hospital on 18 July 2017 as provided to RSL Tobruk identifies Ms Young's choking risk. This also noted that Ms Young had returned to a full diet at the request of Ms McGregor, despite the identified choking risk.

76. Further problems were observed at RSL Tobruk. On 17 September 2017 Ms Young choked on her food at lunch prompting a speech pathology assessment the next day.

77. Ms Young then choked on a small piece of biscuit at Tobruk on 19 September 2017.

78. There were several contributing causes: lack of teeth, tardive dyskinesia (abnormal tongue movement likely due to the use of first generation anti psychotics in particular), dysphagia (impaired swallowing associated with multiple complications of anti-psychotic use including impaired function of the musculature of the mouth,

pharynx and oesophagus), and behaviourally, Ms Young's tendency at times to eat and talk at the same time.

79. Manly Hospital were on notice of these problems with choking. The records provided by RSL Tobruk included the speech pathology assessment of 18 September 2017 which said, amongst other things, "Other directives" Swallow AX 18/09/17 Ms Young presents with mild predominately oral phase dysphagia on b/g of missing dentition and cognitive issues associated with a mental health background. Due to limited food trials today unable to ascertain extent of dysphagia and impact missing dentition has on her mastication ability, however given recent change in behaviour ?infection and recent choking episode, she is to commence a soft moist diet with hard meats cut finely and thin fluids in isolation. Softer meat alternatives such as flake fish are appropriate. Please ensure she is FULLY SUPERVISED at all times during meals and please ensure staff are reminding her not to speak while eating. Sister Ms McGregor called and updated on recommendations and outcome of ax. Recommendations: 1 soft moist diet with all meats cut finely. Softer alternative provided if available (flake fish and mix with sauce or soft processed ham) ALL FOOD CUT FINELY 2. Ideally avoid all hard, dry, particulate, stringy, gristly or mixed consistency foods. No bread or toast please until further ax can be conducted. 3. Extra sauce to help keep moist and to add flavour, 4. Thin fluids ideally in is olation 6. No dual consistencies 7. Medications as tolerated 8. FULL set up assistance 9. FULL supervision with intake 10. To be 90 degrees upright with neck fixation during and 30 mins post all intake 11. Rigorous oral care post intake 12. Small mouthfuls at a slow pace encouraged (requires prompting) 13. r/v 1/52 to check tolerance and adherence to regime. Please contact SP immediately if signs of aspiration (coughing,

choking, throat clearing, wet voice) observed on current regime, if chest declines or she is unable to swallow.[5]

80. Ms Young had been transferred to Manly Hospital by the time her follow up speech pathology review was due at RSL Tobruk.

81. Dr Alle specifically raised this issue with Dr Bolliger who discussed it with NUM on Medical Ward 1, Genevieve McKinnon. NUM McKinnon recalled a discussion around Ms Young impulsively gulping food or water, something she had observed for herself. She further told the Court that Ms Young's swallowing risk was also an alert in the Powerchart system which was the hospital electronic medical records system.

82. NUM McKinnon further noted that Ms Young was getting meals under the 'blue mat/red mat' system. Because Ms Young was classified as being 'red mat' that meant staff were alerted to the fact that the meals were not to be delivered to Ms Young in person but rather only a nurse could take a meal into her. In addition, Ms Young was being 'specialled' 1 to 1 during her time on Medical Ward 1.

83. The treating doctors on Medical Ward 1 were alerted to the risk. An entry in the EMR for Saturday 23 September 2017 referred to a medical review by Dr Sanela Redzepagic saying nurses observed Ms Young to eat well – no coughing or difficulty with food but that she should have a formal speech pathology review on Monday (25 September 2017). No speech pathology review followed.

[5] EX 1, vol 2, tab 30, page 938-939

84. The London Protocol Report, dated 11 December 2017, observed "despite the alerts to choking risk, and extensive documentation in the consumers' EMR file regarding speech assessment findings and recommendations of a soft diet, there was no nursing notes on the medical ward apart from two references to diabetic diet that was initiated on 21 September 2017"[6].

85. The handover from Medical Ward 1 to the Specialist Mental Health Ward for Older Persons, including details of the increased risk of choking, was patently inadequate.

86. The London Protocol Report stated as follows "Nursing/clinical handover from medical to older persons mental health unit did not include speech/diet alerts nor history of two prior choking incidents on the 18/09/17 and 19/09/17 nor care planning to ensure risk mitigation. The older persons mental health unit inpatient admission checklist has a prompt for diet but not for speech assessment. An RN did make a referral for speech assessment on 29/09/17 at the same time as referring five other patients however this was no recorded in the consumer's EMR file."

87. This omission at handover meant that no arrangements were in place on the Older Persons Mental Health Unit to monitor Ms Young at mealtimes or when eating.

88. This was particularly important as Ms Young was in all probability still experiencing delirium at the time of her transfer to the second ward. Symptoms of delirium can fluctuate over time, including fluctuating across any given day and so observations of delirium resolving are not

[6] Ex 1 Vol 1 tab 21

reliable in isolation. Associate Professor Wijeratne emphasised that delirium can be quite prolonged and was previously prolonged for Ms Young during the RNSH admission.

89. Furthermore, NUM Muriithi on the day that Ms Young died, requested a medical review because she was concerned that Ms Young was still experiencing some delirium.[7] Upon review Ms Young was reported to be disoriented, emotionally labile and exhibiting some psychiatric phenomenology. Continuing supervision of eating was all the more important in that circumstance

90. There was a fruit bowl on the Specialist Mental Health Ward.

91. The inappropriateness of that fruit bowl, as arose in the case of Ms Young, was that fruit was available to those who should have been supervised whilst eating but who lacked the capacity to remember to wait until supervised before helping themselves to a piece of fruit.

Conclusion

92. Christine Frew, Service Director of Northern Beaches Community Mental Health Service provided a statement setting out the changes that took place in response to Ms Young's sad death[8]. The main changes were:

- The fruit bowl was moved away from the common area and staff were informed of the need for a choking risk assessment prior to providing fruit. If a choking risk was identified staff needed to observe the patient whilst eating. Further, in January 2019 a Dysphagia Fact Sheet

[7] Ex 1 Tab 15 p 152

[8] Ex 1 Tab pp 224-227

was prepared to explain signs of dysphagia and what a speech pathologist can do.

- The admission task list for Specialist Mental Health Service for Older Persons (SMHSOP) was amended to include referral to speech pathology and dietician referral. Staffs on the ward were alerted to the need to review patient alerts.

- A resuscitation team meeting was held given deficiencies in the maintenance of equipment on the resuscitation trolley. A resuscitation trolley in service training was held.

- The orientation program for interns, residents and registrars was revised to include a tour of the hospital given delay in locating the SMHSOP on the day Ms Young died. A map of the hospital was included with the resuscitation equipment sued by the rapid response team.

- Related procedures were amended in response.

93. Manly Hospital no longer exists, having been decommissioned in 2019.

94. Northern Beaches Hospital now operates the OPMHS Inpatient unit for the Northern Beaches community. The Northern Beaches Hospital is operated by Healthscope under a public private partnership arrangement with the NSW Government/Northern Sydney Local Health District. The Northern Beaches Hospital maintains its own local policies and procedures.

95. This is not a case about the Northern Beaches Hospital but it is important that the significant lessons learnt after Ms Young's death, particularly systemic failures around handover between the medical ward and the OPMHW, should not be forgotten. I recommend a copy of these findings be provided to the new Hospital.

96. It is always important for hospitals to keep in mind the experiences families have while their loved ones are admitted into their care. Ms McGregor says Ms Young had a strong spirit and great stamina and that she will not be forgotten. She wished she could have done more for her sister by having a better understanding of the mechanisms and systems which govern the general medical care of someone who has long standing mental health and physical organic problems and how to regain redress for such a fragile person.

Findings pursuant to section 81(1) of the *Coroners Act 2009*

97. Shelley Young died on 29 September 2017 at Manly Hospital, Sydney, New South Wales as a result of choking on a tangerine.

Carmel Forbes

Deputy State Coroner

NSW State Coroner's Court, Lidcombe

Date: 23 December 2021