CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Andrea Sewell
Hearing dates:	8 and 9 April 2019; 13 May 2019
Date of findings:	4 June 2019
Place of findings:	NSW Coroner Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – psychiatric patient - death as result of a choking episode – was assessment of deceased's swallowing ability adequate, in light of pre-existing neurological condition – whether resuscitation efforts were adequate.
File number:	2015/274162
Representation:	Counsel Assisting the Inquest: P Aitken of Counsel i/b Office of the General Counsel, Department of Justice. Hunter New England Local Health District: L Boyd, Solicitor Advocate i/b NSW Crown Solicitors Office Dr B Ravindram: J Sandford of Counsel i/b Meridian Lawyers Registered Nurses L Batten, S Longworth and F Mudzimurema: M Byrne, Nurses and Midwives Association.

Findings:	**Identity** The person who died is Andrea Sewell. **Date of death** Andrea Sewell died on 17 September 2015. **Place of death** Andrea Sewell died at Royal North Shore Hospital, St Leonards NSW 2065. **Cause of death** The cause of Andrea Sewell's death is hypoxic ischaemic brain injury as a result of cardiac arrest following a choking episode. **Manner of death** Andrea Sewell died as a result of misadventure.

Section 81(1) of the *Coroners Act 2009* (NSW) requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of Andrea Sewell.

The Inquest

1. An inquest is different to other types of hearings. It is neither criminal nor civil in nature. It does not determine whether a person is guilty of an offence and does not make determinations and orders that are binding on parties.

2. A Coroner is required to confirm that a particular death occurred and make findings as to the identity of the person who died, the date and place of death, and the cause and manner of the death. In addition under section 82 of the Act a Coroner may make recommendations that are necessary or desirable in relation to any matter connected with the death, including health and safety.

3. In the case of Andrea Sewell an inquest into the circumstances of her death is mandatory. This is because at the time she died she was an involuntary patient within a psychiatric unit, and as a result she is to be regarded as a person in lawful custody. Pursuant to section 27(1)(b) of the Act, an inquest is required to be held in such circumstances.

Introduction

4. Andrea Sewell was 46 years old when she died in hospital on 17 September 2015. Nineteen days earlier she had been admitted on an involuntary basis to Hunter New England Local Health District's Mental Health Unit in Newcastle. On the evening of 9 September she suffered a choking episode while having supper. By the time hospital staff were able to establish a clear airway Ms Sewell was in a critical condition and was suffering severe hypoxic ischaemic brain damage. After consultation with her family her life support was removed and she died on 17 September.

5. Andrea's mother Meg Sewell and her brother Phillip Sewell attended each day of the inquest. At the close of the evidence, Counsel Assisting read to the court Meg Sewell's loving tribute to her daughter. She described a courageous and talented woman who was a loving and caring daughter. It was evident that Andrea's family loved her very much and feel her loss deeply.

Ms Sewell's life

6. Ms Sewell was born in New Zealand on 24 September 1968, although she spent most of her life in Australia. As an adult she worked in the IT industry. Throughout her life she loved all animals and was an accomplished equestrian rider. She had two children who now live with her former partner.

7. From her early teens Andrea suffered depression and anxiety. She developed a dependence on alcohol and struggled to overcome it, achieving sobriety for a period of time. However it remained a recurring problem, together with bouts of depression.

8. In August 2014 Andrea was diagnosed with a neurological condition known as Osmotic Demyelination Syndrome [ODS]. This rare but serious disorder is associated with alcohol abuse over a long period of time. Patients suffer cranial nerve abnormalities which can create severe difficulties with swallowing, speech production, eye movements, and coordination of limbs. Although some patients make a full recovery others can be left severely disabled for the rest of their lives.

9. In Ms Sewell's case she had severe symptoms of tremor, headache, slurred speech and swallowing difficulties. With determination and courage she worked at her rehabilitation, and achieved significant recovery of her speech, gait and swallowing abilities. Unfortunately however during 2015 her mental health deteriorated. She started to live in motel accommodation and had some brief admissions to Maitland Hospital. The Hospital's records showed the emergence during this time of manic and paranoid thinking.

10. On the evening of 29 August 2015 police were called to a hotel in King Street, Newcastle where Ms Sewell was staying. The manager had become concerned about her comments indicating suicidal intent. Police officers found Ms Sewell to be hallucinating and repeating the words *'I am suicidal'*. She was taken to the Mater Hospital.

Ms Sewell's admission to the Mental Health Centre

11. When Ms Sewell was assessed at the Mater Mental Health Centre she was found to be mentally ill. She was detained on an involuntary basis under the NSW *Mental Health Act 2007.* Her speech exhibited delusional and paranoid themes, and in the opinion of her treating psychiatrist Dr Bipin Ravindram she was in a state of psychosis. She was also expressing thoughts of self harm and suicidal ideation.

12. In the Mental Health ward Andrea continued to be very unwell and in need of intensive monitoring. On 5 September it was decided to move her to the Psychiatric Intensive Care Unit [PICU]. Dr Ravindram's plan was to have Andrea observed at fifteen minute intervals, continue her medication regime, and recover her functioning with the support of the Unit's nursing and occupational therapy teams. Dr Ravindram also wanted to seek the expertise of a neuropsychologist. This was to help him determine if there was any possible relationship between her previous history of ODS, of which he was aware, and her current psychiatric illness. This assessment was booked to take place on 10 September.

13. Dr Ravindram reviewed Andrea again on 7 September and found her to be manic and very agitated. Although he judged her to be very unwell and in need of higher doses of anti psychotic medication, Dr Ravindram thought it

best to adopt a cautious approach. He was aware that anti psychotic drugs pose risks, some relating to a patient's swallowing ability. Possible side effects of such medication include under- or over-production of saliva as well as increased sedation. These may impact adversely on a patient's ability to swallow food.

14. These factors together with Andrea's history of swallowing difficulties with ODS caused Dr Ravindram to direct that she be closely monitored when eating, drinking and walking. Dr Ravindram's plan was that if any abnormalities were observed he would arrange for an assessment by a speech pathologist.

15. Dr Ravindram also directed that Ms Sewell receive a neurological examination. This was performed the following day by Dr Michael Davidson, an intern medical officer. He carried out a cranial nerve examination which involved checking Ms Sewell's facial and oral movements, lips, jaws, tongue, arms, fingers, legs and toes. In his statement Dr Davidson explained that although this examination does not directly assess swallowing ability, detecting abnormalities in certain cranial nerves may suggest such problems. He did not find any such abnormalities. He said that if he had had any concerns in this area he would have organised an urgent speech pathologist review and placed Ms Sewell on nil oral intake of foods.

16. It should be noted that during Ms Sewell's admission in the Mental Health Centre, no difficulties with her eating or swallowing abilities were observed or documented.

The events of 9 September 2015

17. At about 7.30pm that evening Ms Sewell was having supper in the PICU dining area, eating some orange segments and drinking coffee. The nurses on shift were not aware of her previous diagnosis of ODS or of any possible consequential swallowing difficulties. However the court heard that competent clinicians are well aware that mental health conditions can heighten risks associated with eating. In addition to the potential side effects of medications referred to in paragraph 13 above, the impulsivity of some mentally unwell patients can cause them to put too much food at once into the mouth, or fail to remain focused on chewing before swallowing. It is for this reason that the PICU, in common with most mental health units, requires that two staff members be present at patient meal times to monitor patients' eating. This was the case when Ms Sewell was a patient there.

18. Registered Nurse Franscisca Mudzimurema was observing the patients from the nurses' station, which she said had a good line of sight to the dining area. She noticed Ms Sewell sitting rigid in her chair and drooling liquid. RN Mudzimurema immediately alerted nursing colleagues that something was wrong. They used a device known as a '**Yanker' s**ucker to remove excess salivation, then a further device known as a Guedel Airway to try to maintain Ms Sewell's airway by suctioning fluid from her throat.

19. PICU medical staff attended and provisionally diagnosed aspiration/asphyxiation. Dr Aryan Arghandewal directed chest compressions and accompanied Ms Sewell to the co-located Emergency Department of the Calvary Mater Hospital. Here forceps were used to extract a large piece of fruit, together with vomit and other debris. Ms Sewell was then intubated. Tragically she was by now in a critical condition and she was placed on life support. A CT of her brain on 11 September confirmed a hypoxic brain injury.

20. Ms Sewell had been transferred to Royal North Short Hospital on 10 September. After consultation with medical staff, on 17 September her family made the decision to remove her life support, and she died that evening.

The cause of Ms Sewell's death

21. A post mortem examination was not conducted but on the recommendation of forensic pathologists, a Coroner's Certificate recorded the cause of Ms Sewell's death as hypoxic-ischaemic brain injury, with antecedent causes of cardiac arrest and choking. The Certificate noted a significant contributing condition of Osmotic Demyelination. In light of evidence received at the inquest, I have deleted this condition as a significant contributor to Ms Sewell's death, for reasons which appear below.

22. I turn now to address the issues at inquest.

Was Ms Sewell's swallowing ability adequately assessed and monitored?

23. A central focus of the inquest was whether Ms Sewell's known history of ODS, as well as the prescribing of anti psychotic medications, increased her risk for choking; and if so, whether this risk was adequately appreciated by her clinicians and reflected in her treatment.

24. The inquest was assisted on this issue with the expert opinions of the following specialists:

- Associate Professor Denis Crimmins, consultant neurologist
- Dr John O'Neill, consultant neurologist
- Dr Matthew Large, Director of Psychiatry at Prince of Wales Hospital, Sydney.

<u>The evidence of A/P Crimmins and Dr O'Neill</u>

25. At the inquest A/P Crimmins and Dr O'Neill gave concurrent evidence. A/P Crimmins generally adhered to opinions he had provided in his expert report, that:

- due to her history of ODS and swallowing difficulties, Ms Sewell retained a residual risk for swallowing difficulties, and on admission ought to have been identified as at high risk for development of an aspiration problem.

- A patient in her position needed to have a cranial nerve assessment at the time of admission, to document any abnormalities which would predispose her

to swallowing difficulties. A/P Crimmins noted that Ms Sewell's cranial nerve examination occurred late in her admission, and that it did not include a swallowing assessment.

- Due to her history of swallowing difficulties a speech pathology assessment was needed prior to introducing or increasing medication which could have the effect of exacerbating swallowing problems.

26. At the inquest Dr O'Neill conceded that Ms Sewell's history meant her threshold for swallowing difficulties might be lower than for a person without such a history. Nevertheless in his view she had been symptomatically cleared of such difficulties by December 2014, and did not exhibit any such symptoms while in the PICU. In his opinion there was thus no oversight in not arranging for a speech pathology assessment. Nor was there anything to criticise in Dr Ravindram's prescribing of anti psychotic medication. Dr Ravindram had shown his awareness of the associated risks and responded by prescribing conservative doses.

27. It is important to note that despite his opinion that a speech pathology review was necessary, A/P Crimmins declined to be critical of Dr Ravindram for not ensuring that it take place. He acknowledged that psychiatric institutions do not normally have ready access to neurological review and speech pathologist expertise. In addition, identifying neurological disease in patients such as Ms Sewell who have severe ongoing psychiatric problems can be very difficult. For these reasons he considered that Dr Ravindram had done the best job he could under the circumstances, and that his conduct could not be regarded as unreasonable.

<u>The evidence of Dr Matthew Large</u>

28. There was support for the position ultimately taken by A/P Crimmins in the evidence of Dr Matthew Large. Dr Large has been a psychiatrist since 1994, and has extensive experience in the practice of psychiatry in intensive care and acute settings. He provided an expert report and oral evidence at the inquest, offering a psychiatric perspective on the decision not to conduct a speech pathology review.

29. In Dr Large's opinion obtaining a speech and swallowing assessment for Ms Sewell would not have been unreasonable. However there could be no basis for criticism for not doing so, in circumstances where no eating or drinking difficulties had been observed. In Dr Large's view, without such observed difficulties most psychiatrists would not have ordered speech and swallowing testing. Specialist psychiatric wards are not resourced to provide such services, unlike neurology wards where the prevalence of paralysis symptoms means they are routinely required.

30. Dr Large also provided useful evidence as to the possible causes of Ms Sewell's choking episode. He concurred with Dr O'Neill that given the absence of observed swallowing difficulties Ms Sewell's inability to swallow her food that evening was unlikely to have been the consequence either of

her ODS or the side effects of her anti psychotic medication. It was more likely to have resulted from the type of impulsivity behaviour described above at paragraph 17.

Conclusions regarding adequacy of assessment

31. Given the opinions of Dr Large, Dr O'Neill and A/P Crimmins as to Dr Ravindram's treatment decisions, there is no foundation for finding that his care of Ms Sewell fell short in any way, including in not directing a speech pathology assessment.

32. Further given the opinions of Dr O'Neill and Dr Large, the evidence cannot clearly demonstrate that Ms Sewell's choking episode was due to a swallowing difficulty consequent upon her pre-existing ODS. Various possible underlying causes were proffered, including impulsivity behaviour, residual symptoms of ODS, and the side effects of anti psychotic medication. I have mentioned that the Coroner's Certificate issued in relation to Ms Sewell's death identified ODS as a significant contributing condition. In light of the expert evidence heard at the inquest I do not name ODS in my findings.

33. The inquest also considered whether, in the exercise of its functions under section 82 of the Act, the court ought to recommend that existing psychiatric guidelines for referring patients for speech pathology be broadened, so as include patients with a pre-existing brain stem injury or a history of swallowing difficulties.

34. At the close of evidence Counsel Assisting the inquest submitted that it was not necessary or desirable to make such a recommendation. I accept the submission of Counsel Assisting. As has been noted, the evidence does not establish to the necessary standard that Ms Sewell's choking episode was due to a swallowing difficulty consequent upon her brain stem injury of ODS. In my view therefore the circumstances of her death do not provide the foundation for making this recommendation. I note further the evidence of both neurologists, that choking episodes resulting in death are in their experience an extremely rare event.

Adequacy of the initial response to Ms Sewell's choking episode

35. At the inquest the court heard evidence about the appropriateness of the response within PICU to Ms Sewell's choking episode.

36. The court heard that suctioning equipment such as that used by PICU staff was unlikely to have been effective in removing the large segment of fruit that was blocking Ms Sewell's airway. However I accept the submission of Counsel Assisting, that there is no basis for criticism of the conduct of the PICU staff in this regard. The court heard evidence that it is not expected that staff within a psychiatric unit be proficient in using the equipment that is available for such emergencies within an ED unit. This includes the special type of forceps that were ultimately used to remove the blockage in Ms Sewell's airway. Nor are PICU staff expected to be able to perform intubation

of patients. The priority, as explained at the inquest by Emergency specialist Dr Michael Downes, is to transport the patient to ED as quickly as possible.

37. Since Ms Sewell's death, the Hunter New England Local Health District and the Calvary Mater Hospital have made positive changes for situations such as this where there is a medical emergency within the Mental Health Centre. A Rapid Response team is now available 24 hours a day to provide expert intervention for a psychiatric patient who is deteriorating or in cardiac arrest. The team is to respond within 1-2 minutes of a call being activated. It will attend the Mental Health Centre with the necessary equipment and expertise to perform resuscitation and to provide oxygen and continuous monitoring.

38. A further issue that was explored was whether there had been a miscommunication from PICU staff about the nature of Ms Sewell's emergency. However, although PICU staff had apparently informed the ED team that a patient with cardiac arrest was being brought through, the court heard that the ED team was nevertheless sufficiently informed to be ready for the possibility of airway obstruction.

Is there a need for recommendations?

39. I have addressed at paragraph 31 above the reasons for my conclusion that no criticism attaches to Dr Ravindram and his colleagues in PICU for their management of Ms Sewell. Nor is there a foundation for making recommendations regarding the Mental Health Centre's speech pathology referral guidelines.

40. I am further satisfied, on the basis of the evidence heard at inquest, that there were no shortcomings in the way the PICU staff attempted to manage Ms Sewell's choking episode. I accept there are inevitable limitations on the capacity of psychiatric clinicians to deal with such an emergency, and that the priority is to ensure there are proper arrangements in place to get emergency help as soon as possible. The hospital has taken appropriate steps to improve these arrangements.

41. Regarding the monitoring of patients' eating and drinking in the Mental Health Centre, the court heard that it is now a requirement that the two monitoring nursing staff be in the dining area alongside the patients, and not in the nurses' station as they were on the night Ms Sewell died (noting nevertheless the evidence heard at inquest that the nurses' station has a good line of sight to the dining area).

42. The changes mentioned above are positive steps, and obviate the need to make recommendations in these areas.

Conclusion

43. On behalf of us all at the Coroner's Court, I offer Ms Sewell's family our sincere sympathy for the loss of their daughter and sister.

44. I am grateful for the excellent assistance I received from Counsel Assisting and instructing lawyer Ms De Castro Lopo, and from those representing the interested parties.

Findings required by s81(1) of the *Coroners Act 2009*

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Date and place of death
Andrea Sewell died on 17 September 2015, at Royal North Shore Hospital, St Leonards NSW 2065.

Cause and manner of death
The cause of Andrea Sewell's death is hypoxic ischaemic brain injury as a result of cardiac arrest following a choking episode. She died as a result of misadventure.

I close this inquest.

E Ryan

Deputy State Coroner, Lidcombe
4 June 2019