CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Chella Leijten
Hearing dates:	7 February 2020
Date of findings:	7 February 2020
Place of findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – involuntary patient, *Mental Health Act 2007*, natural cause death
File number:	2018/91149
Representation:	Mr S Kelly, Coronial Advocate Assisting the Coroner
Findings:	Chella Leijten died on 21 March 2018 at Greenwich Hospital, Greenwich NSW 2065. The cause of Ms Leijten's death was metastatic lung carcinoma. Ms Leijten died as a result of natural disease process. At the time of her death a determination had previously been made in accordance with the provisions of the *Mental Health Act 2007* that Ms Leijten was a mentally ill person and was to be detained in a mental health facility as an involuntary patient.

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1. Introduction

1.1 Ms Chella Leijten was 57 years old at the time of her death. She had a lengthy medical history with multiple physical and mental health issues. Throughout her adult life Ms Leijten had numerous repeated and a lengthy admissions to mental health facilities as an involuntary patient. In March 2017 Ms Leijten was diagnosed with a terminal condition and subsequently placed on a palliative care pathway with a poor prognosis.

1.2 In the early hours of the morning on 21 March 2018, whilst Ms Leijten was admitted as an involuntary patient in a palliative care facility, Ms Leijten was found to be unresponsive and subsequently pronounced deceased.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. Inquests of this kind are usually held in situations where a person has been detained in a correctional centre, either on remand or whilst serving a custodial sentence. However, lawful custody is also taken to include circumstances where a person is involuntarily admitted to, and detained in, a mental health facility. In such cases there is an expectation within the community that the death of a person so detained will be properly and independently investigated.

2.3 A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately.

3. Ms Leijten's personal history

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future.

3.2 Sadly, little is known about Ms Leijten's personal history as she spent much of her adult life in medical facilities to address her many physical and mental health issues. However, Ms Leijten was known to be a fiercely independent woman. She had a close relationship with her father and regularly visited him where he lived on the Central Coast. Ms Leijten also had a brother but did not maintain frequent contact with him.

3.3 Ms Leijten developed friendships with a number of her fellow patients during her lengthy admission periods to hospitals, and enjoyed going on daytime outings. Ms Leijten was known to also enjoy

crocheting in the evenings, and would often crochet rugs which were donated for sale at a fete to raise funds for the hospital where she was admitted.

4. Ms Leijten's medical history

4.1 In her late teens Ms Leijten was diagnosed with schizoaffective disorder. During her adult life she was frequently involuntarily admitted to a number of mental health facilities, including a lengthy admission to Gladesville Hospital as an involuntary patient between 1983 and 2002. Following her discharge Ms Leijten moved into Department of Housing accommodation and came under the care of the Assertive Outreach Team (**AOT**) from Lower North Shore Community Mental Health.

4.2 Between about 2002 until 2014 Ms Leijten was able to adequately care for herself, with the support of care coordination from the AOT. However, following the death of Ms Leijten's father in 2014, her mental health deteriorated, eventually resulting in a lengthy admission to Royal North Shore Hospital (**RNSH**) for acute treatment between October 2015 and May 2016 following a relapse in her schizoaffective disorder. This was followed by a further admission to Macquarie Hospital for psychiatric rehabilitation.

4.3 In late 2016 Ms Leijten began to show progressive weight loss. However she expressed reluctance in allowing the AOT to assist in following this issue up. Later in March 2017 Ms Leijten was reviewed by the AOT medical team. Blood tests were arranged which revealed a tumour marker. Further investigations confirmed metastatic non-small cell lung cancer. At the time it was noted that Ms Leijten's prognosis was poor, with a life expectancy typically measured in months without treatment.

4.4 Initially, Ms Leijten was willing to receive social support provided by the AOT. However by October 2017 Ms Leijten expressed reluctance to continue with her existing medication regime, due to the side effects of some of her medication, which appeared to cause respiratory distress secondary to her lung cancer.

4.5 Ms Leijten's deteriorating condition resulted in a further admission to RNSH. Whilst there Ms Leijten continued to refuse to take her medication resulting in a decline in her mental health, and eventual admission to a mental health ward. On 9 November 2017 Ms Leijten was transferred to Greenwich Hospital and admitted as a palliative care patient. At the time, permission was sought from Ms Leijten's cousin (who resided in The Netherlands) for the transfer to occur. It was noted that Ms Leijten's metastatic non-small cell lung cancer was widely spread and not for active treatment.

4.6 Following a period of stabilisation Ms Leijten was later discharged on 21 November 2017 back to her home in Lane Cove with an oral palliative care medication regime. It was noted that during her admission Ms Leijten had consistently expressed a desire to be discharged home. Following discharge the AOT continued to visit Ms Leijten daily in order to support compliance with her medication regime. At times it was noted that Ms Leijten would be non-compliant with her medication, and in particular refuse medication for pain relief.

4.7 On 1 December 2017 the AOT, together with outpatient palliative care nursing service providers, attended Ms Leijten's home in Lane Cove. She was found to be extremely distressed, erratic and dehydrated. It was evident that Ms Leijten had not been able to care for herself, and that she had been non-compliant with her medication. It was noted that Ms Leijten was disorientated and

psychotic, with delusional thoughts. Ms Leijten was subsequently admitted to RNSH due to concerns about the deterioration in Ms Leijten's mental health and her self-neglect at home.

4.8 Ms Leijten was initially admitted to the palliative care ward at RNSH. However symptoms of her chronic schizophrenia meant that her care was challenging and that she required stabilisation. As a result she was transferred to the mental health inpatient unit for management. During the subsequent three month admission, Ms Leijten's mental health condition appeared to stabilise, although she had residual symptoms of verbal aggression, psychosis and poor insight. Ms Leijten reported that she wanted to leave hospital, giving rise to a risk of absconding. It was also noted that Ms Leijten presented as a risk of misadventure, given her physical frailty and what was deemed to be her unrealistic expectation that she could care for herself at home. Accordingly Ms Leijten was assessed as being unable to care for herself in the community if discharged home.

4.9 On 20 February 2018 Ms Leijten was subsequently referred to the Lavender Unit at Macquarie Hospital for ongoing support in a subacute mental health unit. At the time it was observed that Ms Leijten's prognosis was guarded and that escalation of her physical care needs would occur at some point. On admission Ms Leijten was noted to be very emaciated and frail as a consequence of her terminal metastatic lung cancer. It was also noted that Ms Leijten demonstrated disorganised thoughts and behaviour. She was noted to be irritable and observed to wander around the unit, although was generally pleasant and compliant when approached by staff.

4.10 As Ms Leijten was a long-term involuntary patient, the Mental Health Review Tribunal conducted a review on 8 March 2018 in accordance with section 37 of the *Mental Health Act 2007* (which requires subsequent six-monthly review of an involuntary patient). After receiving written and oral evidence, and noting Ms Leijten's long-term history of schizoaffective disorder, the Tribunal found that Ms Leijten presented as unwell with ongoing symptoms, delusion, and psychotic features complicated by a decline in her physical health. Accordingly the Tribunal determined that Ms Leijten was a mentally ill person and that no other care of a less restrictive kind was appropriate and reasonably available to her and that she must continue to be detained in a mental health facility for further observation or treatment as an involuntary patient subject to ongoing review by the Tribunal. Finally it was determined that unless Ms Leijten was discharged as an involuntary patient she was next to be reviewed by the Tribunal on or before 17 June 2018.

4.11 As a consequence of her terminal metastatic lung cancer, Ms Leijten's health gradually deteriorated. Oxygen therapy delivered via nasal prongs was required to address Ms Leijten's breathlessness, however Ms Leijten repeatedly removed the nasal prongs, and refused her pain medication. As her health deteriorated, Ms Leijten's mobility reduced and she became easily exhausted, experiencing increasingly frequent episodes of respiratory distress. Ms Leijten was also unable to eat or drink enough to ensure adequate nutrition.

5. What happened on 20 and 21 March 2018?

5.1 Ultimately, in consultation with a community palliative care nurse, Ms Leijten's treating team decided that comfort care measures should be initiated and that this could be best managed in a palliative care unit. As a result, Ms Leijten was transferred to Greenwich Hospital Palliative Care Unit on 20 March 2018.

5.2 On admission, Ms Leijten was noted to be in need of additional nursing assistance due to her agitation and high falls risk. As part of her palliative care management a not for resuscitation order and a not for transfer to an acute hospital order were put in place.

5.3 At about 5:00pm a medical review was conducted and it was noted that Ms Leijten's condition had deteriorated, with worsening dyspnoea and anorexia over the previous weeks. It was also noted that Ms Leijten was in respiratory distress, using accessory muscles to breathe, and that she appeared cachectic with evidence of reduced air entry in her left lung consistent with her known malignancy. It was determined that Ms Leijten required additional nursing care and that her prognosis was estimated to be in hours to days at the time.

5.4 During the evening of 20 March 2018 Ms Leijten was initially noted to be settled. However later through the night Leijten was observed yelling, rolling side to side in her bed, and taking off her bed gown. She was given some medication to address her agitation which had limited effect.

5.5 However by about 1:55am on 21 March 2018 Ms Leijten was observed to be settled and appeared to be sleeping on her side. During a routine nursing round at about 3:45am Ms Leijten was subsequently found to be not breathing and unresponsive. In accordance with the care directive in place, resuscitation attempts were not initiated, and Ms Leijten was subsequently pronounced deceased.

6. What was the cause of Ms Leijten's death?

6.1 Ms Leijten was later taken to the Department of Forensic Medicine where a limited post-mortem examination was performed by Dr Rebecca Irvine, forensic pathologist, on 26 March 2018. Postmortem whole-body imaging revealed disseminated tumour, including enlarged lymph nodes in the neck, axillae and left supraclavicular regions, solidifications in the left lung with rightward shift of the mediastinum, and a suspicious lesion within the upper lobe of the right lung. In addition it was noted that there were probable liver metastases, and ascites was present. Finally it was noted by Dr Irvine that there was no significant external injury, and no obvious signs of mistreatment or neglect.

6.2 Dr Irvine later prepared an autopsy report dated 7 June 2018 in which she opined that the cause of death was metastatic lung carcinoma.

7. Conclusions

7.1 Having regard to the available medical evidence provided by the clinicians involved in Ms Leijten's care, and the findings from the postmortem examination, it is evident that Ms Leijten died as a result of natural disease process. It is clear that following the diagnosis of Ms Leijten's terminal illness in March 2017 she was provided with appropriate medical and pharmacological treatment, but that her overall prognosis was poor. As Ms Leijten's condition gradually deteriorated she was deemed to be not for active treatment and appropriate measures were put in place to provide palliative care.

7.2 The evidence establishes that Ms Leijten was provided with an adequate and appropriate level of psychiatric and medical care during her hospital admissions, and in particular whilst admitted as an involuntary patient. There is no evidence to suggest that any aspect of Ms Leijten's medical and psychiatric care contributed in any way to her death.

8. Findings

8.1 Before turning to the findings that I am required to make, I would like to acknowledge and express my thanks to Mr Stephen Kelly, Coronial Advocate, for his assistance both before, and during, the inquest. I also thank Senior Constable Anthony Charlton for his role in the police investigation and for compiling the initial brief of evidence.

8.2 The findings I make under section 81(1) of the Act are:

Identity
The person who died was Chella Leijten.

Date of death
Ms Leijten died on 21 March 2018

Place of death
Ms Leijten died at Greenwich Hospital, Greenwich NSW 2065.

Cause of death
The cause of Ms Leijten's death was metastatic lung carcinoma.

Manner of death
Ms Leijten died as a result of natural disease process. At the time of her death a determination had previously been made in accordance with the provisions of the *Mental Health Act 2007* that Ms Leijten was a mentally ill person and was to be detained in a mental health facility as an involuntary patient.

8.3 On behalf of the Coroner's Court of NSW, I offer my deepest sympathies and most respectful condolences to Ms Leijten's family for their loss.

8.4 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
7 February 2020
Coroner's Court of New South Wales