**CORONERS COURT**

**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of Irene Charlish |
| **Hearing dates:** | 2 March 2023 |
| **Date of findings:** | 3 March 2023 |
| **Place of findings:** | Lidcombe |
| **Findings of:** | Magistrate Kennedy<br>Deputy State Coroner |
| **Catchwords:** | CORONIAL LAW – Cause and manner of death, involuntary patient, effects of post mortem clozapine levels, mental health treatment in hospital |
| **File number:** | 2017/178985 |
| **Representation:** | Sergeant Chytra, Coronial Advocate Assisting<br>NSLHD – Mr Frazer Counsel instructed by Violet Stojkova,<br>Special Counsel<br>Hicksons Lawyers<br>Dr Tillekeratne – Mr Coffey Counsel, instructed by Brigitte Mather<br>Avant |

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| **Findings:** | ***The identity of the deceased***<br>The deceased person was Irene Charlish<br><br>***Date of death***<br><br>*Between 11 June 2017*<br><br>***Cause of death***<br>Complications of a fall with contributing factors of respiratory failure, respiratory disease, coronary artery disease and acute kidney disease, further complicated by the underlying schizoaffective disorder.<br><br>***Manner of death***<br><br>Misadventure (fall) compounded by underlying natural causes |
| **Recommendations:** | **NIL** |

*The Coroners Act 2009 (NSW) in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

INTRODUCTION

**1.** This is an inquest into the death of Irene Charlish, who was 68 years old when she died on 11 June 2017 at Ryde Hospital in Eastwood.

**2. Introduction**

2.1. The primary functions of this inquest are to determine the following pursuant to the Act:

(a) The identity of the deceased;
(b) The date and place of the person's death;
(c) The manner and cause of the person's death.

2.2. Guided by these five aspects, an inquest investigates the facts and circumstances of a death, places them on the public record and in certain cases will examine changes that could be made to prevent similar deaths in the future. An inquest is not a forum for the laying of blame or the attribution of guilt. Nor is it a vehicle for civil litigation. It is not a trial, but an inquiry.

2.3. In this context it should be recognised that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. Families often wish to grieve and deal with their loss in private. That grieving, and loss does not diminish significantly over time. Unfortunately, the coronial process can compel a family to re-live distressing memories of a death and do so in a public forum.

2.4. In this case, there is no controversy as to Irene's identity, date or place of her death. However, the manner and cause of her death has been unable to be determined. The focus of this inquest was whether the manner and cause of Irene's death can be established on the balance of probabilities.

## 3. Background

3.1 Irene had her first admission to a mental health facility in 1966 at the age of 18 and, from 1973, apart from brief periods in the community, lived in institutions. Irene was a patient of Macquarie Hospital from 1994 and was moved to Lavender House on 16 August 2005. A Mental Health Tribunal Review was held on 12 January 2017 and it was determined that there was no other care of a less restrictive kind that was appropriate and reasonably available than to keep Irene detained as an involuntary patient. This was in keeping with previous reviews that were conducted on a twelve-monthly basis in accordance with legislative requirements.

3.2 Irene was known as an independent and determined lady with a great generosity of spirit. She would attend music and singing group on a Tuesday, knitting group on Wednesday and exercise class on ward on Thursday morning. If there was an outing to the local Chinese restaurant for lunch on a Friday, Irene would attend. Staff at Lavender House described Irene as very talented at knitting and at arts and crafts, particularly at colouring in.

3.3 Staff attended the inquest, and it was clear that she was a much loved character at the home she lived for such a long time at Lavender House. It was a tribute to her that staff wished to be present at the Inquest.

3.4 Irene's family was also present through Ms McFarlen, and participated in the inquest in memory of her Aunt.

## 4. Medical History

4.1 Irene had a longstanding history of schizoaffective disorder which was first diagnosed in 1966 at the age of 18. Her mental illness was reported to have been characterised by somatic, grandiose and persecutory delusions, thought broadcasting, thought insertion, persistent auditory hallucinations and elevated irritable mood alternating with depressive symptoms. It should be said that Irene had more challenges than most in

relation to her mental health. She was never in a place where she could look after herself, and required the care of others for almost the entirety of her life. In saying that, it is clear that she lived a full and busy life using her creativity to bring joy to those around her.

4.2 A report produced by Dr Uzoma Onyema the consultant psychiatrist at Lavender House, outlines that Irene had multiple comorbidities including colon adenocarcinoma, asthma, obesity, right hip replacement, iron deficiency anaemia, hypocalcaemia, osteoarthritis, vitamin d deficiency, chronic renal impairment and type 2 diabetes. Irene's complex comorbidities continued to present challenges even in her placement at Macquarie Hospital. She was maintained on a combination of medication including 450mg of clozapine at night. Irene had previously undergone a right hemi-colectomy in 2013 after being diagnosed with colon adenocarcinoma. In May of 2017 she was assessed to have a reoccurrence of her cancer as suggested by elevated cancer markers. Irene's symptoms were resistant to treatment and trials of different medications in different combinations. The intensity of her symptoms fluctuated with varying levels of distress and agitation.

4.3 Irene required nursing care and assistance with her activities of daily living, prompting around meals and medication. A care plan was in place for Irene that was designed to manage Irene's high falls risk by ensuring she used her walker when she was mobilising and that she was always wearing appropriate footwear. According to staff, Irene was able to walk independently so long as she had her walking frame with her.

## 5. Admission to Ryde Hospital

5.1 On Tuesday 6 June 2017, Irene was seen by nursing staff sitting in the foyer in her usual chair doing her knitting. Progress notes show that Irene remained in her chair in the foyer until at least 11am when the last notation was made before her fall.

5.2 About 12.15pm that day, Nurse Unit Manager Patricia Zaferis was sitting in her office when she heard Irene cry out. When Nurse Zaferis entered the bathroom, she saw Irene on the floor with her walking frame on the opposite side to the doorway. Ward Doctor Verere Bateren was called to examine Irene as she was in obvious pain. An ambulance was called and Dr Bateren's suspected that Irene had fallen and struck her left chest on a table before landing on the floor. Irene was distressed and had abnormally fast breathing. She was assisted to a wheelchair and given 1.5mg of Diazepam at 1.15pm. Nurse Kim stayed with Irene and observed that she was oriented to time, place and person. She and Nurse Kim talked about knitting until the Ambulance arrived approximately half an hour later.

5.3 Irene was admitted to Ryde Hospital at 2.50pm on 6 June 2017 and was under the care of Dr Niranjan Tillekeratne. A CT scan of Irene's chest was taken at 5.08pm and showed a small left basal pneumothorax and a possible undisplaced cortical buckle fracture of the left seventh rib anteriorly. No consolidation or contusion was evident to suggest

infection or internal bleeding. A follow up CT scan taken the next day showed the same small left basal pneumothorax and possible undisplaced cortical buckle fracture. Irene was complaining of acute pain over her left seventh rib anteriorly.

5.4 Despite the best efforts of the medical and nursing staff at Ryde Hospital, Irene refused treatment on several occasions and would at times become aggressive preventing staff from providing care. Nursing staff had difficulties in getting Irene to drink fluids and take her medication and there were concerns about her becoming dehydrated. Attempts to administer fluids to Irene through an intravenous cannula were frustrated by her refusal to allow nursing staff to insert or adjust the cannula when needed.

5.5 It should be noted here how frightening and distressing this situation was for Irene. She was hurt, not in her usual environment nor with her usual support group. This is not to detract from the care and attention that she was being given, but is regularly a difficult situation for both patients and staff where the patient such as Irene has complex mental health issues. It should be also noted that Irene's mental health diagnosis was working against her, in that she was not capable of making good choices in her own best interests, which was not fault of her own but rather the schizo affective disorder.

5.6 Irene received a combination of medications whilst in hospital to manage her complex comorbidities as well as analgesia as medical officers tried to manage her pain levels. The medications that Irene received included 400mg of clozapine at night, 700mg of sodium valproate a mood stabilizer, 20mg of pravastatin at night for high cholesterol, 5mg daily of perindopril for high blood pressure, 250mg twice daily of metformin for diabetes, 20mg of rabeprazole twice daily for heartburn, 1000 units of vitamin D in the morning and various aperients for constipation. Paracetamol and Targin were provided in varying amounts to help with pain relief.

5.7 On 9 June 2018 medical records note that Irene was refusing almost all nursing care and procedures and an intravenous cannula had not been able to be re-inserted due to Irene's aggression. About 2.10pm the same day, Irene's blood tests showed that she had worsening renal functions and hypercalcemia. A 1mg dose of midazolam was prescribed by Dr Tillerkeratne which was administered at about 3.15pm. By 9.13pm Irene was more settled; a new cannula was able to be inserted and she took all her medications.

5.8 Around 4.56am on 11 June the last routine nursing observations were performed before Irene's death. Her vital signs were all within acceptable limits although her temperature was slightly high. Intravenous fluids were being administered through an intravenous cannula in her left hand.

5.9 At 5.30am on 11 June 2017 Irene was found unresponsive by a nurse and a medical emergency team call was made and CPR was commenced. Despite their ongoing efforts, medical staff were unable to revive Irene and she was declared deceased at 6.15am.

## 6. Post-mortem Report

6.1 A limited autopsy was conducted by forensic pathologist Dr Jennifer Pokorny on 16 June 2017. The examination was limited to a post-mortem CT scan and toxicological analysis and Dr Pokorny prepared a limited autopsy report for the Coroner that was finalised on 31 August 2017. The toxicological examination detected clozapine in the blood at 1.8mg/L; within the range considered potentially toxic or lethal.

## 7. Expert reviews

7.1 Irene was one of the most vulnerable people living in our community. She had her liberty taken away from her as a result of mental illness. For that reason this Court has a responsibility to carefully scrutinise her care and treatment to ensure right was done by her. Investigations therefore took place prior to inquest to ensure an independent review was undertaken of her care and treatment.

7.2 An expert opinion regarding the level of clozapine in Irene's blood was sought from Associate Professor Naren Gunja, an expert in the fields of clinical toxicology, forensic toxicology and emergency medicine with specialised knowledge of drugs, toxins and chemicals, including their effects in humans. Associate Professor Gunja explained that clozapine is well known to undergo post-mortem redistribution. He noted that Irene was on regular clozapine for many years and although her dose may have fluctuated over time, she appears to have been on 400mg at night for the previous six months. Associate Professor Gunja concluded that it was likely that the apparent elevated post-mortem clozapine level was due to redistribution during the post-mortem interval and not due to overdose or supratherapeutic ingestion. The higher post-mortem level can be accounted for by the fact that Irene was on regular clozapine for many years. The amount that Irene was prescribed appears to have been well within the expected range.

7.3 Associate Professor Gunja concluded that while it was possible that the clozapine was a contributory factor to death, it was it unlikely that clozapine itself was the cause of Irene's death. Dr Gunja expressed an opinion in his report that a possible contribution to Irene's death was over-narcotisation from opioid and midazolam administration as she was on a significant regime of opioid medication including oxycodone. He also posited that cardiac arrhythmia was also a possibility.

7.4 A further expert opinion was subsequently obtained from Professor Brendon Yee who specialises in respiratory medicine. Professor Yee reviewed the treatment provided to Irene at Ryde Hospital from a respiratory perspective and found that her management seemed appropriate with analgesia prescribed as per the pain team. Serial chest x-rays were reassuring regarding surveillance of Irene's small pneumothorax and for excluding secondary complications such as haemorrhage or pneumonia. Professor Yee explained that whilst respiratory depression from a combination of opioids, renal impairment, hyperoxia and midazolam was a possibility, it would be a speculative conclusion in the absence of arterial or capillary blood gas analysis. He would also have expected respiratory depression to have occurred in a short time frame after the administration of midazolam and notes that the dose was very small.

7.5 Professor Yee was of the opinion that appropriate doses of opioids and other analgesia were prescribed and acknowledges that the post-mortem toxicology showed therapeutic levels of these drugs. Professor Yee speculated that Irene's death could have been caused by respiratory depression, pulmonary embolism, an acute coronary event or a cardiac arrhythmia but based on the available information was unable to state definitively which was likely to have been the primary cause.

## 8. Changes implemented at Ryde Hospital

8.1 After Irene's death a number of changes were implemented at Ryde Hospital which were aimed at improving various systems and processes. Whilst not all of these changes were as a direct response to Irene's passing, a review of her care provided opportunities for improvement which were acted upon. The launch of the e-Meds system in December 2017 created electronic alerts for consideration of venous thromboembolism prevention medication. A change in the role description of the Clinical Nurse Consultant within the mental health team has improved awareness about the Specialist Psychiatry Consultation Review program and resulted in an increase in referrals from all inpatient services. And the screening process for patients at risk of delirium has been updated with the Abbreviated Mental Test Score (AMTS) now the recommended initial brief cognitive screening tool.

## 9. Conclusions about the care and treatment of Irene

9.1. The expert opinions address any concern that clozapine was administered in an inappropriate dose. I accept that this was not the case. Irene presented as a complex patient, both with her physical co morbidities and her high complex mental health diagnosis. The hospital treated her with respect and medically she was treated as well as possible, given that Irene was not accepting treatment.

9.2. Dr Tillekeratne gave evidence and provided a statement. He treated Irene in a manner to try and save her life. His treatment of her was appropriate in the circumstances and there was urgency in trying to ensure Irene was hydrated given the serious risk of death that she was facing unless she received treatment, which she was resisting. His team did consult with the psychiatric team, but at the time he was not aware of the Specialist Psychiatry Consultation Review program, but he now is. On the evidence before me in Irene's matter, further consultation would not likely have affected the sad outcome.

9.3. Dr Pokorny had reviewed the experts reports and was able to assist the inquest in determining, on balance of probabilities the cause of death. I am also satisfied on the evidence that Irene died as a result of natural causes.

9.4. It appeared also that given the fact that Irene was not free to do as she pleased as a result of being a mentally ill person, that she was still afforded good care in her lifetime, living a fulfilling and creative life while at Lavender House with the support of staff who remember her fondly, and family who supported her in her life.

**Acknowledgements**

Thank you to Sergeant Chytra who has kept this matter for many years, for the efforts at gathering necessary evidence and brining the matter to conclusion for Irene's family.

**Recommendations**

After hearing the matter and noting the changes that have been made there are no additional recommendations that now arise from the death of Irene.

**Findings required by s81(1)**

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.

***The identity of the deceased***

The deceased person was Irene Charlish

***Date of death*** *11 June 2017*

***Place of death***

Ryde Hospital. Ryde, New South Wales

***Cause of death***

Complications of a fall with contributing factors of respiratory failure, respiratory disease, coronary artery disease and acute kidney disease, further complicated by the underlying schizoaffective disorder.

***Manner of death***

Misadventure (fall) compounded by underlying natural causes.

I extend my sincere condolences to the family and friends of Irene Charlish.

I now close this inquest.

Deputy State Coroner E Kennedy

6 March 2023