



MAGISTRATES COURT of TASMANIA
CORONIAL DIVISION



**IN THE MATTER OF THE
CORONERS ACT 1995**

AND

**IN THE MATTER OF AN INQUEST
TOUCHING THE DEATH OF
ALEXANDER PASINSKI**

**FINDINGS, RECOMMENDATIONS AND COMMENTS of Coroner Rod
Chandler following an inquest held in Launceston on 2 and 15 June
2016.**

August 2016

PREAMBLE

On 25 February 2014 Alexander Pasinski died at the Launceston General Hospital ('LGH') in Launceston. At this time Mr Pasinski was an inpatient at Northside, a division of the LGH which provides treatment and care for persons suffering from mental disorders. His presence in this facility was pursuant to a Continuing Care Order made on 27 December 2013 and confirmed by the Mental Health Tribunal on 9 January 2014.

On 2 and 15 June 2016 an inquest was held concerning Mr Pasinski's death and these are my findings arising from it.

BACKGROUND

Mr Pasinski was born at Ouse in Tasmania on 30 May 1954 and was aged 59 years. He was one of five children. He was educated in Tasmania but did not advance beyond Year 8. He worked in unskilled positions, initially in Tasmania and then in South Australia. However, for many years prior to his death he had been unemployed and dependent upon a disability pension. He was unmarried and did not have any children.

Mr Pasinski had a long history of psychiatric illness. That history is summarised in a report provided to the inquest by consultant psychiatrist, Dr Ian Sale, and made following a review of Mr Pasinski's medical and hospital records. The salient features of that history follow:

- In 1988 Mr Pasinski had his first contact with mental health services when he was hospitalised in South Australia following a self-harm incident. About two years after this event he returned to Tasmania where he sought psychiatric treatment. He initially consulted psychiatrist Dr Rosemary Schneider and then became a patient of psychiatrist, Dr Ian Martin. Documentation from Dr Martin indicates that problems with sexual behaviour were the main focus of treatment at this time.
- In 1993 Mr Pasinski was admitted to the LGH because of concerns about the risk of suicidal behaviour. He remained in hospital for three weeks where he was diagnosed with a non-specific depressive disorder in a setting of dependent personality traits. He was briefly re-admitted to the LGH later that year after he had taken two overdoses of prescribed medication. His self-harm behaviour was viewed as largely attention seeking in nature, aimed at obtaining hospital admission. He was discharged into Dr Martin's care.

- In 1994 Mr Pasinski again attended the LGH because of motor restlessness. This problem was assessed as reflecting a side-effect of the medication prescribed by Dr Martin.
- In 2000 Mr Pasinski was referred to psychiatrist, Dr S J Hyde when Dr Martin ceased practice. Dr Hyde remained involved in Mr Pasinski's care through to his hospital admission in late 2013.
- Dr Hyde reported a long history of symptoms of anxiety, depression, irritability, and difficulty with relationships. Borderline intelligence was also advised. He also described how Mr Pasinski complained of various physical symptoms, e.g. blackouts. He also noted complaints of suicidal thoughts.
- From Dr Hyde's viewpoint there was a deterioration in Mr Pasinski's well-being in mid-2013. Initially there were complaints of altered taste and dry mouth and later an altered sensation of smell. For this latter condition he was assessed by an ENT specialist but nothing unusual was found. Mr Pasinski also experienced weight loss.
- As of late 2013 psychotropic medications prescribed to Mr Pasinski comprised Nitrazepam, a benzodiazepine used for night sedation and Imipramine, a tricyclic antidepressant.
- On 11 December 2013 Mr Pasinski self-presented to the LGH complaining of being unable to smell or taste. He also complained of being unable to sense hot or cold. He indicated that he would take a drug overdose if he was unable to obtain a solution to these problems. He also said that he wanted to die, that he was paranoid and that he had lost 10 kg of weight over the previous five months. He was admitted to Northside and a provisional diagnosis was made of an acute psychotic disorder or depression with psychotic features. Within a short time of his admission Mr Pasinski was overheard voicing suicidal threats. This led to him being transferred to the high dependency unit ('HDU'). This period of hospitalisation lasted 12 days during which Mr Pasinski continued to complain of lack of sensation, that he did not exist and that he was unable to feel pain. He also continued to claim an intention to kill himself or to abscond from the unit.
- By the time of his discharge on 23 December 2013 Mr Pasinski's psychotropic medication arrangements had been revised. These now comprised Imipramine 75 mg daily, Nitrazepam 10 mg at night and the anti-psychotic agent Quetiapine 25 mg twice daily.

CIRCUMSTANCES LEADING TO DEATH

In the early evening of Christmas Day 2013 officers of Tasmania Police took Mr Pasinski to the LGH following an incident where he claimed to have jumped from a bridge into the Tamar River. An examination made at this time noted him to be restless, dishevelled, irritable and abusive. It was decided to re-admit him as an involuntary patient pursuant to an Initial Order made under s24 of the *Mental Health Act 1996*. (This order was followed by the Continuing Care Order referred to in the preamble to these findings.) In Northside Mr Pasinski was assessed by a locum psychiatrist who considered schizophrenia a distinct likelihood. A trial of the antipsychotic Paliperidone was commenced.

Mr Pasinski continued to present a challenge with aggressive and disruptive behaviour. He continued to voice bizarre somatic complaints: e.g. *“my guts have disappeared.”* Sedative medications were employed. On 29 December oral Risperidone was commenced.

In his submissions counsel-assisting provides a summary of Mr Pasinski's presentation over the following weeks. I adopt that summary. It follows:

“Ongoing psychiatric assessments during his admission revealed increasing evidence of a co-morbid depressive illness with melancholy features along with psychotic symptoms including a thought disorder, delusional beliefs which were both persecutory and nihilistic. His nihilistic delusions for example included that he had no feeling in his body or head, that he was not real, that he had no arms or legs (and) questioning whether others around him were in fact real or not. These delusions and disorganised thinking were associated with a decreasing capacity for self-care, a demonstrable lack of insight, depressive and suicidal thinking, aggression and disinhibition at times.....He remained what Dr Sale referred to as a ‘diagnostic dilemma’.”

Various treatment regimens were employed over this period. On 12 January 2014 the tricyclic antidepressant agent Imipramine was switched to Amitriptyline, another tricyclic agent. The dosage was increased to 150 mg daily. It was at about this time that electroconvulsive therapy (ECT) was discussed as a treatment option. It was first administered on 31 January after approval had been obtained from the Guardianship Board. It was then continued three times weekly and in all was administered on 10 occasions. However, it seems that there was no apparent benefit from the procedure. Close nursing observations were maintained and were on a one-for-one basis at the time of death as Mr Pasinski was then staying in the High Dependency Unit. ('HDU')

On Tuesday, 25 February 2014 registered nurse Dane Flynn was assigned to Mr Pasinski's care. He had cared for Mr Pasinski previously and he was well known to

him. Nurse Flynn reports that at about 8.00 am Mr Pasinski got out of bed and went to the bathroom. He then urinated over himself and the floor before returning to his bed. Nurse Flynn asked him to return to the bathroom, change his clothes and have a shower. Mr Pasinski did not respond to this request. He remained in bed for a further 15 minutes before his breakfast tray was delivered to the unit. He then got out of bed, looked at his breakfast, and then stood up and paced the room. After this Mr Pasinski began eating some Sultana Bran. There was also some toast on the tray and Nurse Flynn spread it with margarine and Vegemite. Mr Pasinski took a piece of the toast and began eating it as he walked around the room. He then returned to the table, sat down and continued eating the piece of toast. However, before he had finished that piece he picked up another and also placed it in his mouth. At this time Nurse Flynn suggested that he finish eating the first piece before beginning the second but there was no response to this suggestion. Mr Pasinski then stood up and began pacing the room again. Nurse Flynn then heard him gagging. He suggested that he go with him to the bathroom to spit out some of the toast. This advice was ignored. Mr Pasinski then gagged again. By this stage Nurse Flynn had sought assistance from another colleague, Nurse Georgia Freeman. Both nurses tried to encourage Mr Pasinski to spit out the food and were rubbing his back. It was then noted that his face had become pale and that he was unable to stand unaided. At this point the nurses assisted Mr Pasinski to the floor and placed him in the recovery position. A Code Blue was called. Mr Pasinski remained conscious and Nurse Flynn was able to open his mouth and remove some of the toast. At one stage he stood up again and began walking around unaided. When the Medical Emergency Team ('MET') arrived Mr Pasinski was again placed in the recovery position and oxygen was administered. The MET then monitored Mr Pasinski for about 15 minutes before leaving the unit. MET's attendance had been supervised by Dr Scott Parkes, the Director of the Intensive Care Unit ('ICU'). He recommended that Mr Pasinski remain in Northside and be closely supervised in its HDU.

From 9.00 am on this day a weekly Clinical Review meeting was being held in Northside. It was being chaired by Dr Franco Giarraputo, the consultant psychiatrist with clinical responsibility for Northside's inpatients. Also present was Dr Ben Elijah, the unit's Clinical Director. At the meeting Mr Pasinski's treatment plan was revised and included the decision to cease the ECT, to replace the tricyclic antidepressants with a more contemporary antidepressant and to cease all benzodiazepines. However, it seems that these changes were not in response to the choking incident, although both Drs Giarraputo and Elijah were aware of it. In fact no consideration was given as to whether that event in itself required a re-assessment of the appropriate care and treatment for Mr Pasinski. In particular the choking incident did not provoke a decision to introduce a soft diet for Mr Pasinski pending a further investigation of the event and its possible cause(s).

Mr Pasinski largely spent the remainder of the morning in his room, seemingly asleep. There was another occasion when he went to the bathroom and again urinated on his clothing and the floor. On Nurse Flynn's prompting he showered and changed his clothes.

Mr Pasinski's lunch was delivered to the unit at about noon. It included a chicken dish. Nurse Flynn observed Mr Pasinski through the window in the adjoining office. He saw him begin his meal by picking pieces of chicken from a bone and placing them in his mouth. He thought that he appeared to be eating normally. He was then seen to leave the table and go to his room. He then returned to his meal. Mr Pasinski continued eating but made two further brief visits to his room. Nurse Flynn then observed him again sit down at the table and then noticed *"Alex place his head down, he was leaning forward. I didn't think it looked right."* Nurse Flynn then left the office to attend Mr Pasinski. Nurse Janita Roberts was with him. Mr Pasinski was still at the table and was gagging. The nurses encouraged him to try and regurgitate the food in his mouth. Nurse Flynn assisted him to stand but he then appeared to lose consciousness. A Code Blue was called and Mr Pasinski was laid on the floor in the recovery position. Nurse Flynn attempted to remove food from his mouth but was unable to do so because his jaw was clenched shut. (It was Dr Parkes' evidence that the clenched jaw was probably attributable to Mr Pasinski suffering an hypoxic event.)

The MET responded immediately and arrived at Northside as soon as it could. It comprised Dr Armit Gangli, an ICU registrar and two ICU nurses. Dr Gangli was unable to clear the airway although by this time Mr Pasinski's jaw had relaxed. Specialist Intensivist Dr Vikram Patil then arrived and took charge of the situation. He attempted to clear the airway using a pair of Magill forceps but could not do so whilst Mr Pasinski was lying on the floor. He was then lifted onto a bed where Dr Patil was able to obtain a better view of his airway. He could see that it was completely obstructed by a large mass of meat which he was able to remove piece by piece with the forceps. He describes the mass of meat *"as being equivalent to a 'fistful,' ie. a 50-60 millimetre pulp mass, which consisted of multiple pieces of meat partially mashed or chewed up. It was solid and compacted."* It needs to be noted that Northside was equipped with a suction device but Dr Patil advised that its use *"would have been pointless because of the size and compaction of the solid mass."*

CPR, which had been initiated by Nurse Flynn and his nursing colleagues, was maintained for approximately 30 minutes but Mr Pasinski could not be revived. He was pronounced deceased at 1.15 pm.

POST-MORTEM EXAMINATION

This was carried out by forensic pathologist, Dr Donald Ritchey. In his opinion the cause of Mr Pasinski's death was consistent with asphyxia due to choking on food. Significant contributing factors were a clinical history of major depression and paranoid schizophrenia. Dr Ritchey comments; *"The finding of food in the posterior pharynx adjacent to the airway supports the clinical observation of apparent asphyxia due to choking on food."* He further notes; *"Significant natural disease was not identified at autopsy."*

WAS DEATH ACCIDENTAL OR INTENTIONAL?

The circumstances surrounding Mr Pasinski's death, including his medical history and the choking incident at breakfast, raise the question whether his death was the consequence of a deliberate act on Mr Pasinski's part to take his own life. On this subject Dr Sale has made these observations:

- That choking incidents, including fatalities, are not rare for persons who suffer a significant mental disorder or are in a psychiatric facility.
- That whilst threats of self-harm had been a prominent feature of Mr Pasinski's history those threats appeared to have been a means of prompting the concern of others.
- Studies indicate that risk factors associated with choking as a cause of death include polypharmacy, age, the presence of organic conditions and 'fast eating.' As to this latter factor it was the evidence of Mr George Pasinski, a brother of the deceased, that Mr Pasinski ate his food *"very very fast,"* on one occasion he told him to *"slow it down"* but that it was a habit which *"was in his character."*
- Mr Pasinski was being prescribed Amitriptyline, a tricyclic anti-depressant, along with antipsychotics Paliperidone and Chlorpromazine. Dr Sale says that studies suggest that these antipsychotics may have an adverse impact upon the mechanism of swallowing. Further he says that a side-effect of Amitriptyline can be a drying of secretions including dry mouth which may impact upon swallowing.

Dr Sale provides this concluding opinion: *"While the possibility that choking was self-induced cannot be entirely excluded, the more probable explanation is that this man's choking was accidental, but was made more likely by his treatment regime which at that stage included amitriptyline, multiple antipsychotic agents such as chlorpromazine, and repetitive anaesthetics necessary for administration of ECT."*

Dr Giarraputo was also of the view that death was accidental. This evidence leads me to conclude that Mr Pasinski's death was accidental and was not a consequence of an intentional act on his part to take his own life.

THE EMERGENCY RESPONSE

It was the evidence of Dr Parkes that a patient with a completely blocked airway will lose consciousness within 2 minutes and will suffer a cardiac arrest within "*no more than 5 minutes.*" After this, it is my understanding that death will occur within a further 5-7 minutes if oxygen is not provided and cardiac function resumed. These facts made it critical for Mr Pasinski's airway to be cleared of the chicken mass at the earliest opportunity if his life was to be saved.

I am satisfied that the Code Blue call was made in a timely manner and that Nurse Flynn and his colleagues at Northside acted appropriately when Mr Pasinski's airway became obstructed. I am satisfied too that MET made a timely response to the Code Blue. However, the members of MET are attached to ICU which is located in the body of the hospital and a considerable distance from Northside which is sited on a different level on its western perimeter. Because of this geography at least 5 minutes had elapsed by the time the MET arrived at Northside. By this time it seems clear that Mr Pasinski had experienced a cardiac arrest with hypoxia as evidenced by his clenched jaw. It is clear too that the MET, with the involvement of Dr Patil, acted promptly in removing the mass of chicken meat and clearing Mr Pasinski's airway. However, I am satisfied that by the time this was achieved any realistic opportunity of successfully resuscitating Mr Pasinski had passed.

Dr Parkes described the circumstances surrounding this choking event as a "*perfect storm*", a description which I consider to be most apt given:

- The rarity of an event where a patient suffers a completely blocked airway. It was Dr Parkes' evidence that he had not encountered a similar event in 20 years practice as a consultant intensivist. Similarly Dr Giarraputo, in his 23 years of practice as a psychiatrist, had not encountered such a circumstance.
- Mr Pasinski's hypoxia causing his jaw to clench thereby preventing the Northside nursing staff from clearing his airway, either manually or with a suction unit and thereby mandating the urgent need for MET's attendance.
- MET's location within the hospital which prevented it from attending Mr Pasinski before at least 5 minutes had elapsed.
- The need to use Magill forceps to remove the chicken mass in a piecemeal fashion.

I am satisfied that this “*perfect storm*” created a situation where Mr Pasinski’s life could not be saved, despite the prompt and appropriate endeavours of both the Northside staff and the members of MET.

During the course of the inquest some consideration was given upon whether I could make any recommendations which may assist to avoid another death occurring in similar circumstances. From the outset I accept that it would not be feasible, or in the interests of LGH patients generally, for the MET to be attached to a ward other than ICU and/or for its members to be based elsewhere in the hospital. Too, I accept that it is not feasible for a second MET to be established which was located in closer proximity to Northside. This leaves for consideration whether Northside staff could be realistically trained to provide an on-the-spot MET service to its patients who suffer a choking event which causes a complete obstruction of the airway. On this subject it was Dr Parkes’ view that it may be possible to train clinicians in Northside in the use of Magill forceps to remove obstructions from a patient’s airway. However, Mr Pasinski’s case was complicated by his clenched jaw. This phenomenon required the administration of adrenaline or other muscle relaxants by injection to force the jaw’s release. Dr Parkes opined that the administration of such injections require a level of special skill which could not realistically be delegated to either the medical or nursing staff within a psychiatric ward such as Northside.

The evidence of Dr Parkes, which I accept, leads me to **recommend** that the LGH give consideration to putting in place a programme to train members of the Northside unit in the use of Magill forceps. (I need to note that it was Dr Parkes’ understanding that Northside had, subsequent to Mr Pasinski’s death, been equipped with Magill forceps. However, Nurse Flynn “*had not seen them.*” This is a situation that requires clarification.)

REPORT IN ACCORD WITH S28(5)

At the time of his death Mr Pasinski was being detained at Northside as an involuntary patient under a Continuing Care Order made pursuant to s28(1) of the *Mental Health Act 1996*. As such Mr Pasinski qualified as a person held in care as defined by s3 of the Act. In this circumstance I am required by s28(5) to report upon the care, supervision or treatment provided to Mr Pasinski. This requirement raises several issues for me to consider.

The first concerns the level of observation in place for Mr Pasinski. The evidence is that his management plan required him to be accommodated in HDU and for one-on-one observation to be maintained. This plan was, in my view appropriate, and was in place at the time of the fatal event. At this time Nurse Flynn was the person responsible for maintaining observation and the evidence shows, in the period leading up to the choking, that he was either inside the HDU with Mr Pasinski or

alternatively in the adjoining nursing station from where he maintained a view of his patient via its glass partition. When he realised that something was amiss he responded quickly by attending Mr Pasinski, attempting to help him regurgitate the chicken and by making a Code Blue call. Overall I make no criticism concerning Mr Pasinski's observation.

Another matter to consider is whether a soft diet should have been introduced for Mr Pasinski following the choking incident at breakfast? It was Dr Parkes' evidence that in hindsight a soft diet should have been adopted following the morning incident. On this subject, Dr Sale in his substantive report comments; *"It would have been preferable to restrict Mr Pasinski's oral intake to fluids until this situation was clarified."* This comment was made in the context of a recommendation made following a Significant Incident Review ('the Review') and which I will refer to in more detail in a moment. Specifically the recommendation stated that; *"RMO review post event. This entails physical/neurological assessment or any other assessments deemed necessary and relevant to the incident."*

In my view the choking incident at breakfast was a significant event which caused Mr Pasinski to fall unconscious and which generated a Code Blue and the involvement of MET. In these circumstances it is my view that it would have been prudent for Mr Pasinski to have been placed on a soft diet pending the outcome of the assessment which has since been determined as being warranted following the Review. This course would have reduced the risk of a subsequent choking event, a risk which was not necessarily inconsequential in the light of Dr Sale's assertion, based upon a review of the literature, that; *"Choking incidents including fatalities are not rare in individuals who suffer significant mental disorder or who are in psychiatric facilities."*

What of Mr Pasinski's medical management?

As I have already noted Dr Sale undertook a comprehensive review of Mr Pasinski's two admissions to Northside in 2013 and this included the consideration of his medical management. He acknowledges that his behaviour was *"difficult and challenging"* and that he represented, as I have already said, a *diagnostic dilemma*." Dr Sale does not assert that the diagnoses and treatment plans adopted by Mr Pasinski's treating psychiatrists were wrong or inappropriate and I accept this to be so. However, he does point out that the history shows that over an extended period Mr Pasinski did not appear to be responding positively to his treatments and that in fact his condition may have been deteriorating. He postulates that it may have been appropriate, at an earlier stage, for an overall review of his treatment including the continuation of ECT (he suggested this therapy should possibly have been limited to 5 procedures) and the maintenance of his antipsychotic medications.

In his evidence Dr Giarraputo explained that in his view ECT is often an effective therapy, more so than antidepressants. He explained too that in Mr Pasinski's case

two of the procedures were not considered to be valid because of “*problems*” related to the anaesthesia. Finally, and coincidentally he explained, as I have already noted, that at the Clinical Review meeting conducted on the morning of Mr Pasinski’s death both Drs Giarraputo and Elijah agreed to revise the treatment plan by ceasing ECT and adjusting Mr Pasinski’s medications including the tricyclic antidepressants.

I make no criticism of Mr Pasinski’s diagnosis and treatment as overseen by Dr Giarraputo. Mr Pasinski was a particularly difficult patient and the decisions made by Dr Giarraputo and his colleagues were, in my view, properly considered and appropriate to the patient’s presentation. They were of course aided and informed by Dr Giarraputo’s and the Northside staff’s daily contact with Mr Pasinski. I accept that there may be some merit in Dr Sale’s observation that Mr Pasinski may have benefited from an earlier re-assessment of his management plan but this is an opinion made with the benefit of hindsight and does not warrant a criticism of the real-time decisions made upon Mr Pasinski’s care and management whilst in Northside.

In summary, for the purposes of s28(5) of the Act I am satisfied that the level of observation in place for Mr Pasinski was appropriate and properly maintained. I am satisfied too that his diagnoses and treatment plans were reasonably suited to Mr Pasinski’s presentation and do not warrant criticism. My one criticism relates to the failure, following the choking incident at breakfast, to initiate a comprehensive review of that event and for Mr Pasinski, in the meantime to be placed on a soft diet pending its completion. This is a shortcoming identified by the Review and which has led to the specific recommendation which I have referred to and which I endorse.

THE REVIEW

This was chaired by Associate Professor Len Lambeth, Chief Civil and Forensic Psychiatrist. In addition to that recommendation which I have already set out, the Review made these further recommendations:

1. *“Update and upgrade of resuscitation equipment on Northside.*
2. *Lab results to be signed as cited by medical team.*
3. *Development and implementation of an extensive suicide risk assessment where indicated.*
4. *Complex case review for all patients after 30 days admission.*
5. *Swipe access for code blue team members.”*

I accept these recommendations to be appropriate and support them.

Allied to recommendation number 4, Dr Sale, during the course of his evidence, made the suggestion, which Dr Giarraputo supported, that a high risk and complex case panel be established to review long-term psychiatric patients, most particularly

those held on an involuntary basis and to be at high risk from a clinical viewpoint. It was suggested that the panel could be Statewide, that it comprise two senior clinicians not associated with the patient, and that at 28 day intervals it provide review and feedback on a patient's diagnosis and management to the treating consultant. I believe this suggestion to have merit and **recommend** its consideration by the Tasmanian Health Service.

FINDINGS IN ACCORD WITH s28(1)

I find:

1. The identity of the deceased is Alexander Pasinski;
2. Mr Pasinski died at the LGH (in Northside ward) in Launceston on 25 February 2015.
3. The circumstances of Mr Pasinski's death are set out in these findings.
4. The cause of Mr Pasinski's death was asphyxia due to choking on food.

CONCLUDING COMMENTS

I extend my sincere condolences to Mr Pasinski's family and loved ones.

Mr C N Dockray was counsel assisting. I acknowledge and thank him for his excellent work. I acknowledge too the attendance by members of Mr Pasinski's family at the inquest and their participation in the process. It is hoped that it may have been of some benefit to them in dealing with this sad event.

Dated: 16 August 2016 at Hobart in the State of Tasmania.

Rod Chandler
Coroner