
**FINDINGS and RECOMMENDATIONS of Coroner Rod
Chandler following the holding of an inquest under the
Coroners Act 1995 into the death of:**

Nigel Douglas Roberts

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Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Rod Chandler, Coroner, having investigated the death of Nigel Douglas Roberts with an inquest held in Devonport, make the following findings.

Hearing Dates

17 and 18 July 2018

Representation

Counsel Assisting the Coroner	Ms Virginia Jones
Counsel for Ms Lesley Latimer	Mr Robert Phillips
Counsel for Baptistcare Pty Ltd	Ms Carly Sluiter
Counsel for Tasmanian Health Service	Mr Paul Turner

Introduction

During the night of 30/31 January 2016 Mr Nigel Douglas Roberts died at the Spencer Clinic, the psychiatric inpatient unit of the North West Regional Hospital ("NWRH") in Burnie. At the time of his death Mr Roberts was subject to an assessment order made pursuant to s24 of the *Mental Health Act 2013* requiring his detention at the NWRH. As such, he was a person held in care as defined by s3 of the *Coroners Act 1995* ("the Act"), thereby mandating an inquest into his death pursuant to s24(1)(b) of the Act. That inquest has been held by me and these are my findings arising from that enquiry.

Background History to 2013

Mr Roberts was born in Ouse on 21 April 1960 and was one of 12 children. During the 1970s the family moved to Victoria and lived initially in Williamstown and later in Braybrook. In his teens Mr Roberts secured employment as a metal worker but this came to an end in the early '80s with the onset of serious mental health difficulties leading to a diagnosis of schizophrenia.

In 1983 Mr Roberts' father died and the family then re-located to Tasmania living at various addresses in Port Sorell and Devonport. Mr Roberts' schizophrenia was chronic and proving difficult to treat. At times he was delusional and paranoid. There were also instances where he experienced hallucinations. Religion was a common subject in his thoughts. His mental health was further complicated by significant behavioral issues featured by sexual disinhibition and assaultative conduct. He had multiple periods of hospitalization, both on the North West Coast and in Hobart.

In 2004 Mr Roberts began residing with Ms Wendy King at Tasman Street in Devonport. They had met about 4 years earlier. They continued living together up to late 2012 when Mr Roberts was re-admitted to the Spencer Clinic. This admission followed an incident where Mr Roberts allegedly sexually assaulted a patient in a hospital emergency department. By this time Mr Roberts' mental state had been compounded by physical ailments. He had developed chronic obstructive pulmonary disease (COPD or emphysema) as a consequence of smoking. He had also been diagnosed with cardiomyopathy and whilst in the Spencer Clinic a diagnosis of hyponatraemia (a condition occurring when the level of sodium in the blood is too low) was also made.

Mr Roberts' stay in the Spencer Clinic continued for about 3 months. His discharge was delayed because his state of health made it unrealistic for him to return to Tasman Street and alternative accommodation had to be sourced. The Karingal Nursing Home ("Karingal") was approached and agreed to provide accommodation for Mr Roberts. The Devonport Community Mental Health Team was to oversee the management of his mental health issues. Mr Roberts began residing at Karingal on 20 February 2013. His relatively young age coupled with his schizophrenia made him an atypical resident at the facility.

Time at Karingal

Karingal is an aged care residential facility in Devonport. It is operated by Baptcare Pty Ltd. Mrs Jillian Dunn was its Nurse Unit Manager.

From the outset Mr Roberts' schizophrenia was principally managed with clozapine, an atypical sedating antipsychotic agent which is recommended for use for patients who have not responded to standard antipsychotic drugs. The dose was 4 x 100mg tablet to be taken before bed as directed. Clozapine can have particularly serious side-effects and requires strict monitoring. In Mr Roberts' case he had monthly blood tests which over the latter months indicated elevated levels. Nevertheless, the dosage was maintained.

Mr Roberts' psychiatric illness, his behavioral issues, and his physical ailments presented a serious challenge for Karingal staff, and there were many instances where they had difficulty coping. Consultant psychiatrist, Dr Ian Sale, assisted the coronial investigation with a report on Mr Roberts' overall care and management. That report includes a summary of events during 2015 which serves to illustrate the difficulties encountered by staff at Karingal in caring for Mr Roberts. It states:

- *"March 2015- senior Karingal staff contacted Mental Health Services about aggressive and sexually intrusive conduct.*

- *April 2015 -angry comments made by the director of nursing at Karingal to Mental Health staff about his incontinence.*
- *April 2015 -increasingly aggressive behaviour, possibly associated with a recent exacerbation of his respiratory illness.*
- *August 2015 – complaints made about Mr Roberts targeting a member of staff who was from Tonga.*
- *November 2015- Mr Roberts complaining, not for the first time, that Karingal staff were not providing him with oxygen or nebuliser when he sought it.*
- *November 2015-Karingal staff complained about Mr Roberts sleeping on the floor in public areas of their facility.”*

Difficulties with Mr Roberts' management continued into 2016. On 8 January Karingal's Director of Nursing complained to Mental Health Services that Mr Roberts was continuing to target a Tongan nurse and that she was concerned that there may be an occupational health and safety complaint made against Karingal. The Director hinted that alternative accommodation may have to be sought for Mr Roberts.

At this time there was in place an ongoing order for “prn” (as needed) clonazepam 500 mcgs-1daily. Clonazepam is a benzodiazepine with sedative and muscle relaxant properties. It was decided to begin a trial of the drug for Mr Roberts in the hope that it may reduce his night-time restlessness. At the same time Mr Roberts was moved to a new room which was nearer the nurses' station and where he was less likely to disturb other residents.

On 10 January there was an incident when Mr Roberts flung out his arms and a staff member was struck but uninjured. Two days later Mr Roberts attended an appointment at Adult Mental Health Services to undergo a review requested by Karingal because of the ongoing difficulties related to his behaviour. The review was undertaken by locum psychiatrist, Dr Ben Sketcher. It was his impression that Mr Roberts had a significant cognitive impairment. He felt that Karingal would benefit from some specific guidance in managing his behaviour and that the Older Adult Team may be best equipped to assist. Input was then sought from consultant psychiatrist, Dr Rita Kronstorfer of the Older Persons Mental Health Unit. She reviewed Mr Roberts' records and considered that it was most likely that he was suffering from delirium rather than dementia. She noted:

- *“All Clozapine levels in critical range > range 1000.*
- *Review/reduce anti cholinergic medication including review of need for Clozapine at this dose (? No ongoing psychotic symptoms – is there room for Clozapine reduction below potentially toxic range?).*
- *Try to give psychiatric medication (clozapine, VPA [valproic acid], paliperidone) in split doses rather than all at night to reduce high peak blood levels that can trigger confusion.”*

A management plan was then settled which identified the following problems as requiring attention:

- The cognitive decline;
- The longstanding anaemia;
- Need to investigate his electrolyte disturbance;
- His elevated clozapine levels;
- The use of medications with anticholinergic activity;
- Need for systematic oxygen administration;
- The need for monitoring and documentation;
- Reduction of psychotropic medication dosages; and
- The liaison with Karingal staff and the development of a behaviour management plan.

It seems that no steps were taken to act upon any of these matters over the remainder of the month.

By 20 January Mrs Dunn had noticed that Mr Roberts was becoming drowsy during the day. She thought it may have been attributable to the clonazepam which Mr Roberts had been receiving nightly. She requested that his general practitioner attend to review the dose. Two days later Dr K Kaur saw Mr Roberts at Karingal. He reduced the 500mcg clonazepam dose to ½ a tablet to be taken at night prn. He also prescribed prednisolone 4 x 5mgs for 3 days as a treatment for Mr Roberts' shortness of breath. This was first administered that night at 7.00pm.

The following day Mr Roberts began to behave inappropriately. He exposed himself to a female resident, asked staff for sex and walked around the facility naked. Mrs Dunn suspected this behaviour may have been attributable to the prednisolone and it was withheld on the night of 23 January. The next morning Mr Roberts exposed himself to another resident. It was a Saturday and Karingal nursing staff consulted Dr Jo Green from GP Assist. She gave an order for 1000mcgs clonazepam which was given at 10.30am. An order was also given for clonazepam 3 x 500mcgs per day prn. Mr Roberts' behaviour did not present any problems for the remainder of the day. The following day Dr Kaur attended at Karingal and discontinued the prednisolone.

Over the following days staff continued to express their concerns around Mr Roberts' behaviour and on 27 January a case worker from Adult Mental Health Services attended at Karingal to counsel them.

Circumstances Leading to Death

Mr Mark Brooker is a Karingal staff member. He was working a night shift on 29/30 January 2016. At about 2.00am a sensor was activated in Mr Robert's room. This had been installed to alert staff that Mr Roberts may have left his room. Mr Brooker went to investigate. He knocked on Mr Roberts' door then entered the room. Mr Roberts was standing inside with his back to the door. He swung around and punched Mr Brooker in the face causing a laceration to his upper lip. The incident was immediately reported to the nurse on duty who called Mrs Dunn. She directed that the Mental Health Service helpline be called. She then attended at Karingal.

At around 4.00am officers of Tasmania Police arrived at Karingal. They had been informed of the incident by Mental Health Services. Karingal staff expressed their concerns for Mr Roberts' mental well-being. There was a discussion between the police officers and Mr Roberts. He voluntarily agreed to go to hospital. An ambulance was then called and Mr Roberts was conveyed to the NWRH's Emergency Department ("ED") arriving at 6.23am.

In the ED Mr Roberts was described as agitated and aggressive. He was noted to punch a wall and to act aggressively towards staff. A Code Black was called and he was physically restrained by shackling to his bed. He was also chemically restrained with a 10mg injection of olanzapine given intramuscularly. A blood test showed a low sodium level. At around 8.30am he was seen by two members of CATT (the Crisis Assessment and Treatment Team). In their view Mr Roberts was not fit to be interviewed for assessment and advised his admission to Spencer Clinic. It was noted by an ED consultant that, in his opinion, Mr Roberts' low sodium was not contributing to an exacerbation of his psychotic illness and that there was *"no current evidence of an acute physical illness to preclude admission to a mental health facility."*

Mr Roberts was then made subject to the assessment order. At 9.45am he was transferred to the Clinic and placed in the high dependency unit ("HDU"). He was seen by on-call consultant, Dr Ubenauf. He was noted to be suffering psychomotor agitation requiring physical restraint. The plan was for him to remain in HDU and for his assessment order to be confirmed. It was noted that there was a need to exclude the possibility of delirium. It was also noted: *"Frequent daily obs. O₂ saturations to be monitored-since patient was on regular O₂. Benzodiazepine administration-needs precaution due to COPD and possible respiratory depression"*. Dr Ubenauf wrote medication orders for oral clonazepam, 1-2mg prn to a daily maximum of 4mg along with olanzapine at a dosage of 5-10mg prn up to a daily maximum of 30mg.

At 10.25am Mr Roberts was administered 10mg of olanzapine orally. It was noted to have had little effect. He was released from his restraints for a short time but was re-restrained again after he *"came out with fists up and attempting to lash out and hit staff."* At 12.45pm it was noted by nursing staff that *"2mg of clonazepam was given APC (as per chart) with some effect, at time of writing is able to sit on the couch quietly. Has become more sedated and is able to rest."* His oxygen saturations were recorded at 93-94%.

At 2.00pm it was noted by a medical officer that his oxygen levels were fluctuating and that they would meet the medical emergency criteria if they fell to the 90-88% level. It was noted: *"Suggest to minimize the use of clonazepam due to risk of respiratory depression."* At 6.30pm Mr Roberts was administered 10mg of olanzapine without any noticeable effect. About an hour later he was given a follow up 2mg dose of clonazepam orally, again with minimal effect. Staff noted that he remained *"unpredictably violent."*

A progress note indicates that at 8.50pm Mr Roberts was presenting as thought disordered. There was evidence of paranoid delusions, he was 'insightless', and acting sexually inappropriately. His speech was rapid and difficult to understand.

The nursing nightshift commenced at 9.30pm. Registered nurse, Ms Lesley Latimer, was the incoming nurse-in-charge. She allocated registered nurse, Alicia Martin, to provide Mr Roberts with one-to-one care. Nurse Latimer noted that at the time of the shift handover Mr Roberts was asleep on a couch. She described his breathing at this time as normal, not labored and with no shortness of breath. She said that shortly afterwards she and another nurse moved Mr Roberts from the couch to a bed. This was achieved without Mr Roberts waking.

It was Nurse Latimer's evidence that from around 9.30pm onwards Mr Roberts was checked every 10 to 15 minutes by either herself or Nurse Martin. However, this is not reflected in the Clinic records. A 'Patient Observation Recording Form' records that on "30/01/2016" Mr Roberts was sighted between "15.30 – 22.30, 1:1 HCU" and nothing more. The Progress notes record that Mr Roberts was observed at 10.50pm and that is the last observation entry before a retrospective note made at 3.13am the next day and stating that when Mr Roberts was checked at 2.44am he was "*not noticed to be breathing, very pale colour, no noticeable pulse detected.*" A Code Blue was called but Mr Roberts could not be resuscitated and he was declared deceased at 3.05am.

Cause of Death

A post-mortem examination was undertaken by forensic pathologist, Dr Donald Ritchey. He reports: "*The autopsy revealed a well-developed, well-nourished adult Caucasian man with advanced lung disease caused by smoking (emphysema) and super imposed bronchopneumonia. There was moderate atherosclerosis but a definite anatomical cause of death was not identified at autopsy. Although his history includes a mention of previous 'clozapine cardiomyopathy' no myocarditis or cardiomyopathy was identified at autopsy.*"

Toxicology tests of a sample of Mr Roberts' blood showed clozapine (3.6mg/L) and olanzapine (0.7 mg/L) which are both within the reported toxic/fatal range. Valproic acid (38 mg/L) and 7-aminoclonazepam, a metabolite of clonazepam were also detected.

The toxicology report of Mr Neil McLachlan-Troupe states: "*Clozapine is a central nervous system depressant that may cause drowsiness, dizziness, tremor, agitation, muscle rigidity, confusion, fatigue, weakness, ataxia and slurred speech.*" Olanzapine is also an atypical antipsychotic agent used in the treatment of schizophrenia and Mr McLachlan-Troupe reports that it too is a central nervous system depressant with similar potential side-effects to clozapine.

It was the opinion of Dr Ritchey that the cause of Mr Roberts' death was a cardio-respiratory arrest due to mixed prescription drug sedation (clozapine and olanzapine) in the presence of advanced emphysema and acute bronchopneumonia.

I accept the opinion of Dr Ritchey upon the cause of Mr Roberts' death. It is pertinent for me to observe that Mr Roberts had been an inpatient of the NWRH for about 23 hours before he died. During this time he had been administered both olanzapine and clonazepam. His regular dosage of clozapine had also been maintained. In these circumstances logic dictates that those drugs which played a role in Mr Roberts' death were predominately, if not

exclusively, those drugs administered at the NWRH rather than any medications delivered at Karingal.

Clinical Review

I have referred earlier to a report provided by Dr Sale. It is apparent that that report prompted the Tasmanian Health Service to undertake its own review of Mr Roberts' death. The resultant report was put into evidence. It identifies a number of issues related to Mr Roberts' medical care and management, both preceding his hospital admission and during that admission. It's informative for me to highlight some of those issues.

Pre-Hospital Admission

- Mr Roberts was domiciled in a nursing home in which there was little expertise in dealing with the behaviours stemming from his mental illness and also in dealing with his complicated physical problems.
- There was little co-ordination and recognition of the possible addictive or other effects of Mr Roberts' various medications.
- While Mr Roberts was periodically reviewed by mental health services, there was a lack of continuity in care, principally due to the reliance on locum mental health clinicians and locum general practitioners.
- There was, as a result, a lack of communication between mental health services' clinicians, the mental health nursing staff, and the Karingal clinicians who were caring for him and the general practitioner involved.

At the NWRH

- There appears to have been no or minimal recognition of the problems associated with Mr Roberts' chronic respiratory illness and the effects upon this of the medications used to control his behaviour.
- There was a lack of monitoring of oxygen administered and the prescribing of suitable rates of oxygen administration.
- There was no evidence of an assessment to exclude the possibility of Mr Roberts' behaviour being due to a delirium.
- Although the psychiatric registrar made a note stating that the possibility of a delirium needed to be excluded there was no evidence of this being acted upon.
- Mr Roberts was prescribed further antipsychotic medication and benzodiazepines as well as his regular medication of two antipsychotics and a mood stabilising medication. This was in the context of one of his regular antipsychotics (clozapine) being classified as a high risk medication and being very sedating.
- The order prescribing the observations required for Mr Roberts was vague and failed to specify the particular observations and their frequency.
- That in the Spencer Clinic Mr Roberts was administered antipsychotic medication and benzodiazepine on a prn basis.
- That the combination of prn and regular medication very likely caused or contributed in a major way to a delirium and to Mr Roberts' unrousable state.

The Review led to these findings being made:

- *“There was a lack of communication and coordination between the areas responsible for (Mr Roberts’) care, namely: Mental Health Services, the nursing home and the General Practitioner.*
- *There was a failure to develop a comprehensive management plan which would focus on both the mental health problems and (Mr Roberts’) physical problems.*
- *It is evident that all mental health clinical staff require regular updating with respect to the deteriorating patient and clinical handover/communication.*
- *Mental health patients often present with severe physical problems, in particular respiratory problems, metabolic syndrome and cardiac problems indeed, it is well known that patients with chronic mental illness have a lifespan of between 10 and 20 years less than the normal population. It is imperative that attention be paid to appropriate education of all clinicians involved in the care of the chronically mentally ill.”*

The Review concluded with the following recommendations:

- *“Given that insufficient and appropriate communication has been identified in most of the areas concerned with the treatment of Mr Roberts, we recommend that systems be developed to improve communication with specific reference to communications between the following:*
 - *Spencer Clinic and the Department of Emergency Medicine.*
 - *Spencer Clinic and General Medicine, NWRH.*
 - *All mental health services and outside agencies involved in the care of patients including General Practitioners and Aged Care facilities.*
- *Nursing handovers in Spencer Clinic need to be structured to include discussion regarding physical illness and observations.*
- *There should be a process developed to ensure the continuous training and up-skilling of clinical staff in basic life support, IV cannulation and other procedural skills.*
- *A formal mental health examination needs to be recorded for each mental health patient for each shift.*
- *A formal process needs to be developed with respect to registrar handover after hours and on the weekends.*
- *A system needs to be developed to improve case-specific and general discussion between nursing administration in Spencer clinic and NWRH nursing specialist staff.*
- *NWRH should consult with the Respiratory Department at Royal Hobart Hospital regarding adoption of the oxygen prescription Guideline for COPD.*
- *Processes need to be developed to ensure that direct admission patients are appropriately monitored with particular emphasis on patient safety and a comprehensive evaluation of the whole patient with physical medical review within 24 hours of admission.*
- *A State-wide system should be developed to ensure that patients seen in DEMs have a complete medical assessment.*

- *Discussion should be instituted to align where possible the seclusion and restraint procedures initiated in DEM with the requirement of the Mental Health Act 2013. This should also consider those patients in DEM requiring restraint or seclusion, but who are not under the Mental Health Act 2013.”*

Prior to the Clinical Review the Tasmanian Health Organisation carried out a Process Review of the events surrounding Mr Roberts’ death and a report on the Review was put into evidence including its recommendations. In many respects the issues identified by this Review, along with the resultant recommendations, replicate those made by the Clinical Review. It was the evidence of Dr Suchita Telang that the recommendations arising from the Process Review are largely in the course of implementation.

Report under s28(5) of the Coroners Act 1995

I have recorded earlier in these findings that, at the time of his death, Mr Roberts was a person being held in care as defined by the Act. As such, I am required by s28(5) of the Act to report on his care, supervision or treatment while held in care. This obligation arises from the assessment order made after Mr Roberts arrived at the NWRH and therefore only concerns his time at the hospital and does not relate to his residency at Karingal.

The requirement under s28(5) leads me to report upon an aspect of Mr Roberts’ care which is particularly apt to the outcome which has presented here.

It was known that Mr Roberts’ schizophrenia was being treated with clozapine and that he suffered from COPD. His behaviour whilst in hospital necessitated pharmacological restraint. These factors together exposed him to the risk of respiratory depression. The management of this risk, in my opinion, required:

- Ongoing re-evaluation of his medication needs particularly having regards to their cumulative effects and if necessary involving specialist respiratory input.
- The use of a pulse oximeter to provide ongoing monitoring of Mr Roberts’ oxygen saturation levels and to inform nursing staff if those levels met the medical emergency criteria.
- Regular monitoring by nursing staff of Mr Roberts. It was, in my opinion, insufficient to simply observe at 10 to 15 minute intervals that Mr Roberts was present and safe. Instead the monitoring should have included at the very least the taking and charting of his respiratory rate.

By failing to take the above steps the NWRH and the Spencer Clinic in particular did not provide Mr Roberts with the level of care which his condition required and which best protected him from the consequences of respiratory depression.

Findings Required by s28(1) of the Coroners Act 1995

I find:

- a) The identity of the deceased is Nigel Douglas Roberts;
- b) Death occurred in the circumstances detailed in these findings;
- c) The cause of Mr Roberts' death was a cardio-respiratory arrest due to mixed prescription drug sedation (clozapine and olanzapine) in the presence of advanced emphysema and acute bronchopneumonia; and
- d) Death occurred on 31 January 2016 in the Spencer Clinic at the North West Regional Hospital in Burnie, Tasmania.

Comments and Recommendations

I have found that Mr Roberts died whilst a patient of the Spencer Clinic from a cardio-respiratory arrest which was attributable to prescribed drug sedation upon a background of COPD and acute bronchopneumonia. The evidence shows that the medical staff involved in Mr Roberts' care were alert to the risk of this outcome and it was thus incumbent upon them to take all possible steps to minimize this risk. This included the need for a strict regime to be in place to monitor Mr Roberts, most particularly with respect to his respiration. Unfortunately this did not occur with his otherwise preventable death being the consequence.

It is clear that Mr Roberts' complex mental illness coupled with his physical ailments presented Karingal with significant difficulties in his management and care. I am satisfied that, despite those difficulties, Karingal did its very best to provide Mr Roberts, for the duration of his residency, with a safe and caring home. However, Karingal is in essence a facility designed, equipped and staffed to provide residential care for the elderly. It is not suited to the care of younger persons who suffer serious mental illness. This circumstance leads me to **recommend** that Tasmanian Health Service, in concert with other relevant governmental authorities, co-ordinate a strategy to establish a suitable facility on the North West Coast which can provide supported accommodation for persons suffering from mental illness and who are unable to care for themselves.

I have referred in these findings to the Clinical Review and the Process Review which both arose from Mr Roberts' death. Those reviews were thorough and identified multiple shortcomings related to Mr Roberts' care and management. Many of those shortcomings were also apparent from this inquest. I support the recommendations which arose from the reviews and **recommend** that the Tasmanian Health Service continue and complete the implementation of all of them.

Concluding Comments

I extend to Mr Roberts' family and loved ones my sincere condolences for their loss. I trust that this inquest has been of some benefit to them all in coping with it.

I wish to record my thanks to counsel assisting Ms Virginia Jones and to coroner's associate Sergeant Lisa Heazlewood for their excellent work in preparing for and conducting the inquest.

Dated: 4 January 2019 at Hobart in the State of Tasmania.

Rod Chandler
Coroner