CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of NICOLE LOUISE ABBOTT**
Citation:	**[2023] ACTCD 8**
Hearing Date:	**17 May 2023**
Decision Date:	**19 May 2023**
Before:	Coroner Russell
Decision:	See [2].
Catchwords:	**CORONIAL LAW** – death in care – cause and manner of death – whether issue with quality of care, treatment or supervision – whether matter of public safety arises.
Legislation Cited:	*Coroners Act 1997* (ACT) sections 3C(1)(c), 13(1)(i), 34A(2), 52, 74 *Mental Health Act 2015* (ACT) *Coroners Amendment Act 2020* (ACT), section 3BB
Cases Cited:	*Inquest into the Death of Jacob Aldan Peter Cameron* [2021] ACTCD 7
Counsel Assisting:	Ms Simone Richards
File Number	CD 145/2020

CORONER RUSSELL

1. Nicole Louise Abbott died on 25 May 2020 at Calvary Hospital, Bruce in the ACT. She was 43 years old. At the time of her death, Nicole Abbott was subject to a Psychiatric Treatment Order made 19 December 2019 for a period of six months.

Formal Findings

2. Nicole Louise Abbott died on 25 May 2020 at Calvary Hospital, Bruce in the Australian Capital Territory. The cause of Ms Abbott's death was the complications of morbid obesity. The manner of death was by natural causes. No matter of public safety is found to arise in connection with the inquest. The quality of care, treatment or supervision of Ms Abbott did not contribute to her death.

Background

3. Ms Abbott was born in Townsville, Queensland on 8 January 1977. She moved around a lot as a child, in part because of her family's involvement with the Australian Defence Force, living in Gladstone, Brisbane, and Rockhampton in Queensland, and Raymond Terrace in New South Wales.

4. She left school in year 11 in Rockhampton and worked, for a short time, in the hospitality industry.

5. In 1995 Ms Abbott married and, in 1998, gave birth to her only child, Tayla. In 1999 she was diagnosed with schizophrenia and admitted to hospital in Newcastle, NSW. Shortly thereafter, she was divorced and, unfortunately, became largely estranged from her daughter.

6. As an adult, Ms Abbott continued to move often and lived in various places in New South Wales and in Brisbane before moving to Perth, Western Australia in about 2010. She remained there until she came to Canberra.

7. Her mental health continued to be a serious problem and she was, on many occasions, admitted to psychiatric hospitals in Queensland, New South Wales and Western Australia. In about 2010 or 2011, while under psychiatric care in hospital in Western Australia, she met and formed a relationship with another patient, Darren Graham. It was with Mr Graham, that she moved to Canberra in late 2014 or early 2015. At the time of Ms Abbott's death, she and Mr Graham were still cohabiting although no longer in a relationship.

Death in Care

8. As at 25 May 2020, section 3C (1) (c) of the *Coroners Act 1997* (the Act) categorised the death of a person subject to a Psychiatric Treatment Order as a 'death in custody'. That was changed by the *Coroners Amendment Act 2020* which introduced section 3BB, pursuant to which the death of a person subject to a Psychiatric Treatment Order is categorised as a 'death in care'. I have been referred to the observations of Chief Coroner Walker in the *Inquest into the Death of Jacob Aldan Peter Cameron* [2021] ACTCD 7 with respect to that amendment, effective from 29 January 2021:

   While the nuance of this change is significant, I note that:

   a. *The Coroner retains the obligation to independently investigate both deaths in care and in custody;*
   b. *A hearing is a mandatory part of the inquest; and*
   c. *The provisions of part 6 of the Act, which prescribed additional procedural steps and obligations for the Coroner for deaths in custody, are also expressly extended to deaths in care.*

   I consider that the changes to the Act in relation to deaths in care are procedural in nature and do not create or very substantive rights and liabilities. On that basis I consider that these provisions operate retrospectively.

9. I adopt the submission of Counsel Assisting that reference to Nicole Abbott's death in these findings should be a reference to a death in care.

Jurisdiction and Functions of the Coroner

10. An inquest, including a hearing, is mandatory in relation to Ms Abbott's death. A Coroner must hold an inquest into the manner and cause of death of a person who dies in care (section 13(1)(i)) of the Act and, in such circumstances, a Coroner must not dispense with a hearing (section 34A(2)).

11. Section 52 of the Act sets out, relevantly, the principal functions of a Coroner conducting an inquest. Those are to record the identity of the person who has died, the date and place of her death and the manner and cause of that death. The Coroner must also state whether a matter of public safety is found to arise in connection with the inquest and, if so, comment on the matter.

12. In relation to a death in care, section 74 of the Act requires that findings must also be made about the quality of care, treatment and supervision of the deceased person that, in the opinion of the Coroner, contributed to the cause of death.

Cause of Death

13. Professor Johan Duflou, forensic pathologist, conducted a post-mortem examination which involved external examination, CT scan, viral testing, toxicological testing and review of medical records. Professor Duflou determined that Ms Abbott's death was caused by the complications of morbid obesity. Those complications, he said, included a combination of progressive respiratory and cardiac failure. He noted a long-standing history of marked obesity with associated severe obstructive sleep apnoea and type II respiratory failure, and the presence of pulmonary oedema. The respiratory failure, he said, was exacerbated by the deceased's long-standing tobacco smoking and potentially by a prior chest wall injury. He was not able to determine the cause of those rib fractures but thought they could be the consequence of prior CPR attempts or the result of falling heavily. Professor Duflou noted that Ms Abbott's body mass index was 54.4 kg/m^2.

Mental Health Care in ACT

14. Ms Abbott was discharged from Bentley Hospital, in Perth, on 29 October 2014. She had been an inpatient at that hospital, on that last occasion, since 18 September but had had prior admissions in Western Australia. She was receiving zuclopenthixol by depot injection with the next injection due on 12 November 2014.

15. It is likely that Ms Abbott came to Canberra without notifying her case manager at the Western Australian mental health service. There is no record of any handover by that service to the ACT mental health service.

16. The first record of ACT Mental Health Services being involved with, or aware of, Ms Abbott was on 28 January 2015. The Crisis Assessment and Treatment Team (CATT) received a call from the Australian Federal Police, City Watch House. She had presented to the police station with a male friend who police officers thought may have been delusional. Police officers were able to convey some history to the CATT, sourced from treatment providers in Western Australia. The CATT attended but it appeared to them that the immediate issue for Ms Abbott was homelessness. They did not identify a mental health risk at that time.

17. Ms Abbott commenced more formal engagement with ACT Mental Health Services in July 2015. On 14 July 2015 Ms Abbott was brought to The Canberra Hospital by CATT and police. She was grossly thought disordered and delusional. She had been found camping on London Circuit, talking irrationally, harassing passers-by and demanding money from them. There was an allegation that she had been involved in an assault on another person in the days leading up to 14 July 2015. She was involuntarily detained. The progress notes

indicated that she had received no treatment for approximately six months. The involuntary detention order was extended by the ACT Civil and Administrative Tribunal (ACAT) on 17 July 2015 and a Psychiatric Treatment Order was made on 23 July 2015.

18. Ms Abbott was regularly involved with ACT Mental Health Services from that time until the time of her death. Nine Psychiatric Treatment Orders were made with respect to her during that time. Ms Abbott's mental health also led to many interactions with the police as a result of psychotic episodes or incidents in which police were called upon to assist mental health clinicians to administer medication.

19. In common with many others suffering from similar conditions, Ms Abbott was unable to appreciate her need for treatment and was often resistant to the provision of that treatment.

Psychiatric Treatment Order

20. Under the Psychiatric Treatment Order current at the time of her death, a plan was in place for three monthly reviews by a psychiatrist, fortnightly depot injection of zuclopenthixol and review with her clinical manager, Ms Sheena Abraham.

21. The Gungahlin Mental Health Team, the team with responsibility for Ms Abbott, had regular and frequent involvement with her in the months before her death. They often faced reluctance or refusal on the part of Ms Abbott to have her depot injection administered and, at those times, persisted, often over many days, in an attempt to get her to the point where she would accept that injection.

22. Inter alia, they arranged the engagement of the National Disability Insurance Scheme to provide services, assisted Ms Abbott and her partner with negotiations with respect to their rent and arranged comprehensive cleaning of their home. A number of these endeavours were more difficult because the effects of Ms Abbott's illness meant that she often found it difficult to accept support and was at times aggressive.

23. The records to which I have had regard indicate that Ms Abbott's father, Mr John Abbott, was deeply engaged with the Gungahlin mental health team's efforts to assist Ms Abbott.

Physical Health

24. Ms Abbott was in poor physical health. She exhibited, what her treating clinicians described as, the 'psychosocial sequelae of chronic mental illness'. Those included:

    a. *a sedentary lifestyle with no regular exercise, poor nutritional intake with high fat foods and soft drink consumption resulting in significant weight gain, and suboptimal physical health with limited adherence to medical care*.

25. Ms Abbott suffered from a series of serious medical conditions, including Chronic Obstructive Pulmonary Disease (COPD) and obstructive sleep apnoea. She continued, however, to be a heavy smoker.

26. In April 2019 she was admitted to the intensive care unit at Calvary Hospital and diagnosed with heart failure. In May 2019 she was again admitted to Calvary Hospital with a diagnosis of type II respiratory failure and an exacerbation of COPD. In August 2019 she was admitted to the Canberra Hospital and was diagnosed with infective exacerbation of COPD and acute pulmonary oedema in the setting of severe diastolic dysfunction. It was noted that she had very severe nocturnal respiratory failure.

Events Leading to Death

27. On 21 May 2020 Ms Abbott suffered a psychotic episode at the Early Morning Centre in Civic. The Early Morning Centre is a project of the Canberra City Uniting Church, which provides essential services, including breakfast to those experiencing homelessness or social isolation. The Police Ambulance and Clinical Early Response (PACER) team attended and, after consultation with Ms Abraham, transported Ms Abbott to the Emergency Department at Calvary Hospital. There she was diagnosed with congestive heart failure with worsening shortness of breath. A significant pulmonary oedema was noted on x-ray. Her respiratory condition deteriorated and she was transferred to the Intensive Care Unit (ICU). She was ventilated in the ICU. A Medical Orders for Life-Sustaining Treatment review by a psychiatrist and cardiologist concluded that, given her psychological and physiological status, invasive life-saving treatment would not be in her best interests. Her file was noted accordingly, 'not for resuscitation/intubation'.

28. Ms Abbott remained in the ICU where, at about 4:15am on 25 May 2020 the Medical Emergency Team (MET) were called because of her low responsiveness. Nasopharyngeal airway tubes were inserted in both nostrils and her airway was suctioned, causing vomiting. Observations taken at 6pm showed a high respiratory rate, low oxygen and high blood pressure. She was encouraged to eat dinner and her bedding was changed but at about 7:15pm the nurse could no longer hear her breathing and the MET were once again called. On arrival, the MET observed that her pupils were non-reactive and dilated and electrocardiography revealed an asystole rhythm. There were no recordable vital signs and she was pronounced life extinct at 7:30pm.

Quality of Care, Treatment and Supervision – s74 of the Act

29. *Calvary Hospital*

    Professor Duflou noted that Ms Abbott's respiratory and cardiac failure were progressive complications of her morbid obesity and the respiratory failure was exacerbated by her long-standing smoking habit. She had been admitted to hospital in a very serious condition in 2019. It is evident that her health was deteriorating. I accept the submission of Counsel Assisting that the treatment provided to Ms Abbott at Calvary Hospital on her last admission was appropriate and that necessary and appropriate treatment was given to her.

30. *Mental Health Services*

    Mr Abbott had expressed concern about his daughter's weight on a number of occasions in the period, between 2015 and 2020, in which she was under the care of the ACT Mental Health Services. Given the cause of her death, and in the context of these proceedings, he expressed concern that his daughter's weight gain was the result of side-effects of the zuclopenthixol and other anti-psychotic medication she received under successive treatment orders, including the final Psychiatric Treatment Order. In this respect, he questioned the quality of the care, treatment and supervision she received.

31. As a result of those concerns, further investigations were undertaken.

Connection Between Antipsychotic Medication and Weight Gain

32. Professor Duflou has advised that, in common with almost all antipsychotic medications, and many other types of medication, zuclopenthixol has metabolic effects which can include weight gain and that, while the research into this side effect for zuclopenthixol specifically is so far quite limited, in his opinion, zuclopenthixol does not have a weight gain

effect which is more common or more serious than other long lasting antipsychotic medications.

Choice of Zuclopenthixol

33. After a lengthy period of hospitalisation at the Bentley Hospital in Western Australia, in 2014, Ms Abbott was discharged on zuclopenthixol by 350 mg depot injection every fortnight, in addition to olanzapine as a 20 mg wafer per day. The treating psychiatrists in Western Australia had tried risperidone and amisulpride but she had developed hyperpolactinaemia, which, itself, can lead to weight gain. They had tried clozapine but Ms Abbott experienced problematic side-effects of dizziness, nausea/vomiting and tachycardia on that medication. The Bentley Hospital records indicate that, at the time she was being treated there, Ms Abbott already had a problem with obesity.

34. In mid-2015, ACT clinicians commenced treating her with olanzapine and were concerned to monitor her weight on that drug. It was noted by clinicians in a report to the ACAT, dated 12 January 2016, that Ms Abbott's medications required review again, because she had not been waiting at the health centre for the mandated two hours after administration of Relprevv (olanzapine). That period of observation was required, as I understand it, because there is a need for cardiovascular monitoring after the administration of olanzapine by injection. Ms Abbott was moved back onto zuclopenthixol during 2016. There was a component of oral olanzapine in her treatment until late 2017 but it was discontinued. The treating clinician specifically took her metabolic status into account in making that decision.

35. The mental health records indicate that, on a number of occasions, while Ms Abbott was on zuclopenthixol, her treating clinicians sought to adjust the dosage and monitor her response to the change.

36. The selection of the right medication, at the right dosage, for Ms Abbott was a complex matter, dependant on both her ability to be compliant with the requirements for her physical well-being on the medication, as well as her ability to tolerate any side effects. The records establish that those treating Ms Abbott were very conscious of the side-effects, including weight gain, of the antipsychotic medications with which she was being treated.

Requirement for Antipsychotic Medication

37. Ms Abbott's mental health condition was serious and intractable. She suffered from serious delusions, thought disorder and at times, exhibited aggressive behaviours. Her delusions were often of a nature which caused her very significant distress. For that condition to remain untreated so as to avoid any side effects, including weight gain, from the medication would have had significant consequences for her safety and, in all probability, the safety of others. I am satisfied that there was no feasible alternative available to clinicians other than to treat her schizophrenia by way of antipsychotic medication and that the choice of zuclopenthixol at the dosages given was an appropriate clinical response to Ms Abbott's needs. With respect to the drug treatment regime prescribed for her, the quality of care, treatment and supervision of Ms Abbott did not contribute to the cause of her death.

Efforts to Encourage and Assist Abbott to Manage her Physical Health

38. The mental health notes demonstrate repeated efforts by the mental health teams aimed at improving Ms Abbott's physical health and well-being. There were repeated discussions about diet with her and attempts to get her to exercise and to stop smoking. Those efforts were largely unsuccessful.

39. She was also encouraged to attend medical and ancillary health appointments and, at times, taken to those by mental health workers, or transport was otherwise arranged for her. Ms Abbott was, however, often unable to accept that she was physically unwell. On a number of occasions, Ms Abbott's delusions, beliefs that she had new lungs or that the creatures causing her physical illnesses had been removed, appeared to prevent her accepting assistance. The records indicate that the clinical manager was concerned that Ms Abbott did not take the prescribed medication for her physical illnesses. She rebuffed attempts by Ms Abraham to monitor her blood pressure at home.

40. Following her admission to Calvary Hospital in April 2019, efforts were made to encourage her to use a continuous positive airway pressure machine at home to manage her obstructive sleep apnoea and to have her attend a sleep clinic but Ms Abbott was unable to manage, or be consistent in the use of, that non-invasive ventilation at home and would not, despite the efforts of the mental health team, attend the sleep clinic. Once again, Mr Abbott was engaged in these attempts to encourage his daughter and to assist her, including by providing financial support for the continued supply of the machine.

41. It was noted in the discharge record from hospital in August 2019 that Ms Abbott was not suitable for non-invasive ventilation at home because of her inability to manage, or be consistent with the usage of, a continuous positive air pressure machine and that she could not be given home oxygen because of her smoking.

42. I am satisfied that the mental health team engaged appropriately with Ms Abbott in an attempt to encourage her to take better care of her physical health, including to ameliorate her weight gain, and to assist with necessary help for her. They were actively engaged in trying to assist her and interacted with her at least every few days.

43. A Psychiatric Treatment Order made under Part 5 of the *Mental Health Act 2015* authorises the compulsory psychiatric treatment, including drug treatment, of a person, such as Ms Abbott, with respect to whom an order is made. There is no power under a Psychiatric Treatment Order to compel a person to accept treatment for their physical health needs. I am satisfied that, in that context, the mental health team treating Ms Abbott did what they could to help her to address her physical health needs.

44. The records do not support any finding that, with respect to the involvement of the Gungahlin Mental Health Team or the ACT Mental Health Services more generally, the quality of care, treatment or supervision contributed to the cause of Ms Abbott's death.

Matter of Public Safety

45. Ms Abbott's death was the result of the complications of morbid obesity. That morbid obesity developed in the context of her long-standing, predating her arrival in the ACT, struggles with mental illness and the psychosocial consequences of that illness. For the reasons given above, I can make no finding that the care provided to Ms Abbott by mental health agencies in the ACT was deficient. I am satisfied that no matter of public safety arises in connection with the inquest.

Closing Remarks

46. Ms Abbott struggled for most of her adult life with serious mental illness. That illness has clearly had consequences for Ms Abbott's ability to engage with health professionals and to make, and adhere to, positive decisions about her physical health. It has also clearly had an effect on her capacity to engage with her family. Despite that, on the records available to me, her father, Mr John Abbott, has, in what must have been difficult circumstances, done all he could to assist her. I thank him for his involvement in this inquest and express my condolences to him and to the rest of Ms Abbott's family.

47. I thank Counsel Assisting and her team and note that I have been significantly assisted by her submissions.

48. I close this inquest.

I certify that the preceding fortyeight [48] numbered paragraphs are a true copy of the Reasons for Decision of her Honour Coroner Russell.

Legal Officer: Rebecca Evans

Date: 19 May 2023