CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 17th, 18th, 19th, 20th, 23rd, 24th and 25th days of August 2010 and the 8th day of August 2011, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of John Arthur Burns.

The said Court finds that John Arthur Burns aged 63 years, late of the Westminster Aged Care Facility, Sylvan Way, Grange, South Australia died at Grange, South Australia on the 17th day of September 2006. The cause of death was attributed to cerebral infarction. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. Mr John Arthur Burns died at the Westminster Aged Care Facility (Westminster) located at Fort Street, Grange. His date of death was 17 September 2006 and he was 63 years of age. Mr Burns had only been a resident at Westminster for 12 days prior to his death. An autopsy was carried out by Dr Barbara Koszyca, forensic pathologist, four days after his death. A report was prepared by Dr Koszyca and in that report she gave the cause of death as 'attributed to cerebral infarction' and I so find[1].

2. Background

2.1. Mr Burns was initially diagnosed with a frontal dementia in 2005. He was seen at the Memory Clinic at The Queen Elizabeth Hospital (TQEH). For the next 12 months or so he lived at home with his wife. He presented to TQEH again in 2006. His family was struggling to deal with his problems at home. He had behaved inappropriately

[1] Exhibit C1b

towards neighbours and other persons in a sexually disinhibited manner. He was subjected to a number of neurological tests and was diagnosed with motor neurone disease. A clinical diagnosis was made of familial motor neurone disease and frontotemporal dementia in March 2006. Mr Burns was admitted to TQEH for a number of weeks during which he had significant behavioural problems. He tried to abscond on a number of occasions and threatened staff by raising his fist when he was prevented from doing things he wished to do. He was commenced on cyproterone as an anti-androgen to try and suppress his sexual disinhibition and during his TQEH stay this seemed to be effective. He was commenced on sertraline and risperidone to help his behaviour. His behaviour was reasonably well managed at discharge and he was transferred to the Parklyn Hostel. During his short stay at Parklyn he tried to leave on several occasions and was often found near the door. He was sexually disinhibited and his behaviour did deteriorate to a certain extent. However, this was to be expected with a change of environment as he did not want to be in an aged care facility but wanted to go home.

2.2. In the meantime, a Guardianship Order was obtained on 14 June 2006 which gave Mrs Burns and their daughter, Ms Playford, full guardianship[2].

2.3. Mr Burns' wife sought to obtain a residential facility for him closer to her home and, as a result, the family made an application to Westminster for Mr Burns to be admitted there. The circumstances surrounding his admission to Westminster were not entirely clear because the admission documentation could not be found. The Director of Nursing gave evidence that she rang Parklyn at some stage before Mr Burns was accepted into Westminster and was told that they were not experiencing problems with his behaviour. However I do note that there are numerous references in the Parklyn notes[3] of Mr Burns threatening to hit residents and inappropriate handling of staff.

3. <u>Mr Burns is admitted to Westminster</u>

3.1. On 5 September 2006 Mr Burns was admitted to Westminster in a secure dementia ward. Overnight, in the early hours of 6 September 2006, Mr Burns was restless and displayed sexual behaviour towards an agency carer, Ms Clarke, and asked her

[2] Exhibit C16
[3] Exhibit C17

whether she 'wanted to get on him'. Ms Clarke reported that she left him when this occurred and that he went back to his room.

3.2. A second incident occurred at approximately 5:50 that morning when Mr Burns said to an enrolled nurse, Ms Watson, words to the effect 'do you want me to knock you off?'. Mr Burns grabbed his crotch and said words to the effect 'I've got a big horn here and I'm going to give it to you'. Ms Watson gave evidence about the incident and said she was used to this type of behaviour having come across it before. However she documented the event for the sake of keeping a proper record. The following day, 7 September 2006, at approximately 6am, Registered Nurse Hu was called to assess Mr Burns as he had been awake the whole night and was agitated. He was wanting to leave the nursing home. Nurse Hu attempted to enter the ward but Mr Burns was standing near the door. He was obviously waiting for an opportunity to abscond and Nurse Hu entered the ward via another route. Mr Burns, frustrated at this successful ploy to defeat his efforts to abscond, became very aggressive towards Nurse Hu and swore at her. He raised his fists and said he would break her nose. She firmly explained that he should desist and there was some improvement. She reported that he needed to have a review by the medical officer. Nurse Hu also related her concerns to the Director of Nursing, Ms Robertson, before she left for the day. Registered Nurse Sparrow was informed of this incident and, as a result, attended at Largs ward to assess Mr Burns. She was involved in a further incident concerning Mr Burns at approximately 9:30 that morning when he managed to get out of the ward by somehow accessing the code to the secure doors. He got as far as the main entrance of the nursing home on that occasion. Director of Nursing, Ms Robertson and Registered Nurse Bastian witnessed him at the front door and both of them attended. Between them they were able to talk Mr Burns into walking back to the Largs secure unit without further incident. Ms Robertson said she was able to employ her training strategies for distracting a patient such as Mr Burns successfully on that occasion.

3.3. Nurse Sparrow contacted Dr Cocchiaro, the general practitioner assigned the care of Mr Burns at Westminster, to discuss the behaviours being exhibited by Mr Burns. Dr Cocchiaro prescribed intramuscular haloperidol for Mr Burns. At about the same time, Nurse Bastian was informed by an Activities Coordinator, Ms Diana Battifuoco,

that Mr Burns had touched her on the breast and spoken to her suggestively at the same time. At this stage Nurse Bastian spoke with Ms Robertson and they agreed that it would be necessary to administer an intramuscular injection of haloperidol pursuant to Dr Cocchiaro's prescription. They entered Mr Burns' room where he cooperated in the administration of the intramuscular injection in his buttock by willingly lowering his trousers and underpants.

3.4. During the telephone conversation in which he made the oral prescription for the 10mg injection of haloperidol, Dr Cocchiaro also prescribed haloperidol to be given orally by tablet on an as needed or 'PRN' basis, but not more frequently than 4-hourly. Furthermore, he increased the dose of risperidone that Mr Burns was then receiving by doubling it.

3.5. The following day, 8 September 2006, Dr Cocchiaro entered orders reflecting his oral orders on the PRN drug chart which is to be found in the Westminster casenotes for Mr Burns[4]. He repeated the order for 10mg intramuscular injection of haloperidol on a PRN basis but not less than 6-hourly. This latter order was not administered at any time thereafter. Mr Burns was given the intramuscular injection of haloperidol, to which I have already referred, the previous day. Thereafter he was administered further haloperidol but only in tablet form.

4. <u>The administration of oral haloperidol</u>

4.1. The administration of the intramuscular, and then the oral, haloperidol during Mr Burns' stay at Westminster was the focus of much attention at the Inquest. I will attempt to summarise the occasions on which oral haloperidol was administered.

4.2. Mr Burns was administered a 5mg tablet of haloperidol at 8:30pm on 8 September 2006 by Nurse Todoran. She gave oral evidence that she could not recall why it was given but that her usual practice would have been that it would be a response to agitated behaviour. In contrast to this explanation, a contemporaneous note entered in

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[4] Exhibit C18

the progress notes by Nurse Todoran simply stated that the tablet was 'given for settling tonight'[5].

4.3. The next dose was given to Mr Burns on 9 September 2006 at 1:50pm by Nurse Pan in response to Mr Burns having escaped from the Largs secure unit. At that time an alarm bracelet was also fitted to alert staff if Mr Burns was to abscond.

4.4. At 6pm the same day, 9 September 2006, Nurse Todoran administered a 5mg tablet of haloperidol. Again in her evidence she could not recall why she did so, but referred to her general practice that it would have been given for agitation.

4.5. At 11:50pm that night (9 September 2006) Mr Burns was given a further 5mg tablet of haloperidol. The notes recorded that 'John is a little restless, in and out of his room' in an apparent explanation for that PRN dose.

4.6. The next oral dose of haloperidol 5mg was given to Mr Burns at 6am on 12 September 2006. It appears to have been given for agitation although the notes state that he was not threatening staff.

4.7. A further dose of 5mg of oral haloperidol was given at 10am. The corresponding note reads as follows:

> 'Serenace[6] 5mg ineffective. At 0800 threaten staff. Seen by CNC. EN instructed to give Serenace 5mg 4hrly today. 10am 5mg of serenace given.' [7]

4.8. Finally, the medication chart records that at 8:30pm the same day - 12 September 2006 - a further dose of a 5mg tablet of haloperidol was administered to Mr Burns. No explanation for this appears in the notes.

5. <u>Ms Playford becomes concerned</u>

5.1. Ms Playford, Mr Burns' daughter, gave evidence that she became increasingly concerned about Mr Burns' level of sedation. On 13 September 2006 she contacted Dr Cocchiaro to request that he address Mr Burns' sedation. In response to this, Dr Cocchiaro altered the medication by ceasing haloperidol and lowering the dose of

[5] Exhibit C18
[6] 'Serenace' is another name for haloperidol
[7] Exhibit C18, page 115

risperidone. Dr Cocchiaro entered a record of this order on 14 September 2006 when he wrote:

> '- Excessive medication
> - Caused him to be drugged out
> - Change medication.
> - Stop IM Serenace.' [8]

This note was rather unfortunate for more than one reason. It ordered that intramuscular serenace, or haloperidol, be ceased. It did not refer to the oral haloperidol. In any event it was interpreted, presumably, to apply to all haloperidol because no further doses were administered after the last I have referred to on 12 September 2006. The use of the expression 'drugged out' is also rather unfortunate. It was the subject of dispute by Ms Robertson[9].

6. 15 September 2006 - Mr Burns' condition further deteriorates

6.1. On Friday 15 September 2006 Nurse Bastian and Ms Robertson noted that Mr Burns' health status had declined. Ms Robertson gave evidence that she and Nurse Bastian went to Mr Burns' room mid morning that day. Mr Burns was awake but when she spoke to him he did not respond verbally. He did not answer any of her questions and he looked unwell. He looked flat and had a greyish complexion. Ms Robertson said that Mr Burns appeared unwell and that she believed there was something that needed further investigation[10]. Ms Robertson said that she decided to ask Nurse Bastian to call Dr Cocchiaro to review Mr Burns and it was her expectation that Dr Cocchiaro would possibly send Mr Burns to TQEH for further investigation because he looked unwell but, in her view, not acutely unwell[11].

6.2. In the result, Dr Cocchiaro was not in fact contacted on 15 September 2006 at all and did not have any further dealings with Mr Burns until after Mr Burns had died two days later. There was some suggestion in the evidence that a member of the staff of Westminster may have contacted Dr Cocchiaro's rooms to be told that he was not available until the afternoon of 15 September 2006. What is clear is that if there were any such contact, it was not further pursued. It was not suggested that a message had

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[8] Exhibit C18, page 17
[9] Transcript, page 591
[10] Transcript, page 546
[11] Transcript, page 547

been left for Dr Cocchiaro which remained unanswered. The evidence suggested that the onus remained on Westminster to make contact with Dr Cocchiaro after he became available in the afternoon. In any event, as I have said, this did not occur.

7. The events of 16 and 17 September 2006

7.1. The notes record that at 6am on the morning of 16 September 2006 Mr Burns was very 'dozy' and was looking pale. An entry at midday records that he had remained in his room and had slid off the edge of the bed on which he had been sitting. He had eaten only a small amount of his lunch. A note at 2pm recorded that he had been found on the floor three times and the bed was lowered closer to the floor. At 2:30pm Mr Burns was discovered on the floor of his room again. At 3:30 that afternoon Mr Burns' appearance was noted to be very grey and he was provided with some oxygen.

7.2. A note made at 8:40am the following day, 17 September 2006, records that Mr Burns had had a restless night but was very slow in responding to staff interactions. At 9:40am the notes record that a staff member checked Mr Burns to discover that his colour had changed and his breathing was shallow. The carer notified Nurse Todoran who attended and noted that Mr Burns' pulse was very, very weak. A call was made to the South Australian Ambulance Service and at or about the same time Nurse Todoran noted that there was no pulse and Mr Burns had cyanotic extremities.

7.3. South Australian Ambulance Service personnel attended shortly thereafter and, despite attempting resuscitation, were unable to revive Mr Burns. Dr Cocchiaro was notified and attended Westminster. Mr Burns' wife and daughter were also notified and they too attended.

8. Cause of death

8.1. I have already noted that the examining pathologist, Dr Koszyca, gave the cause of death at autopsy as attributed to cerebral infarction. An expert overview of the case was obtained by counsel assisting from Associate Professor Whitehead, consultant in geriatric medicine and Regional Clinical Director of Rehabilitation and Aged Care in the Southern Adelaide Health Service. He provided a report dated 23 July 2009[12] and

[12] Exhibit C30a

gave oral evidence. Associate Professor Whitehead noted that Mr Burns probably had compromised breathing as a result of his motor neurone disease affecting the muscles of his chest wall leading to hypoventilation. He certainly needed oxygen for low saturations while in TQEH and this continued throughout his time at both Parklyn and Westminster.

8.2. Associate Professor Whitehead noted that there were levels of haloperidol still in Mr Burns' blood according to toxicology testing of bloods taken at autopsy. Associate Professor Whitehead also noted the autopsy finding of cerebral infarction which Associate Professor Whitehead believed was likely to have occurred in the days immediately before Mr Burns' death. He thought that the stroke would have lowered Mr Burns' levels of consciousness as post stroke delirium is not uncommon. In addition to this, Mr Burns was of course sedated and was also affected by respiratory muscle weakness stemming from his motor neurone disease. Associate Professor Whitehead was concerned about the amount of haloperidol that was administered to Mr Burns in the period he was at Westminster. He contrasted the experience at Westminster with that at Parklyn where there was no request for haloperidol at all. Associate Professor Whitehead said that there was a considerable amount of inconsistency in the reasons for administration of haloperidol. The notes suggested that sometimes it was given to try to get Mr Burns to sleep at night, sometimes because he was wandering, sometimes because he was agitated and trying to abscond. Associate Professor Whitehead said that it would be inappropriate to give haloperidol as a sedative to try to get someone to remain asleep at night. Associate Professor Whitehead expressed the view that the haloperidol played a role in Mr Burns' death. He noted also the roles played by the possibility of peri-stroke delirium and the respiratory muscle compromise afforded by the motor neurone disease. Dehydration with resultant increased blood viscosity may have been a further complicating factor. On the other hand, Associate Professor Whitehead noted that if Mr Burns did sustain a stroke - and this is quite clear from the autopsy findings - it may or may not have been possible to reverse the effects of sedation and Mr Burns may have died even if he had been taken to hospital on 15 September 2006.

8.3. I am very conscious of the fact that the autopsy finding as to cause of death was attributed to cerebral infarction. I would be most reluctant to make a formal finding as to cause of death that differed from that. Associate Professor Whitehead's concerns about the involvement of haloperidol may well be correct. However, it was not the opinion of forensic pathologist, Dr Koszyca, and Associate Professor Whitehead also noted the possible involvement of compromised respiratory function resulting from the motor neurone disease and post stroke delirium, which may also have led to an hypoxic condition. Each of these factors may have played a part in the final respiratory arrest leading to death. However, without the cerebral infarction, death would not have occurred.

8.4. In the result, and without in any way being critical of Associate Professor Whitehead's most helpful evidence, I am not prepared to part from the cause of death given by Dr Koszyca and I find the cause of death to be attributed to cerebral infarction.

9. **Conclusions**

9.1. I agree with Associate Professor Whitehead that there was a tendency for the nursing staff at Westminster to very quickly seek medication as a solution to behavioural problems. Certainly Parklyn managed Mr Burns without needing recourse to haloperidol. As Associate Professor Whitehead noted, Mr Burns' sexual disinhibition, whilst unpleasant, was never really carried out with any physical intent[13] and he could be generally dissuaded. It was Associate Professor Whitehead's view that a better understanding by Westminster's staff that Mr Burns had no control over these outbursts should have reduced the offence of what he said to them. Indeed, I note in particular the carer, Ms Bibi, adopted a very commendable attitude to Mr Burns' behaviour in that respect. If anything, I was struck by the relatively sympathetic attitude shown by carers, Ms Bibi and Ms Zotti (then a carer but by the time she gave evidence, a Registered Nurse) and Enrolled Nurse Watson who appeared relatively unfussed by Mr Burns' inappropriate behaviour[14]. By contrast, there seemed to be a rather harsh and unsympathetic attitude to Mr Burns' difficulties by the witnesses Nurse Bastian, Nurse Sparrow and Ms Robertson.

[13] I note the episode in which a carer's breast was touched. The nature of the touching was never investigated. It was accompanied by a suggestive remark, but the episode does not change my view.

[14] Transcript, page 444

10. **Recommendations**

10.1. Associate Professor Whitehead very helpfully provided, for the benefit of the Court, a publication dated November 2008 of the Drug and Therapeutics Information Service 'DATIS', which is a continuing medical education initiative of the Pharmacy Department of the Repatriation General Hospital, Daw Park, South Australia. The DATIS review was admitted as part of Exhibit C30a and is a comprehensive review of management of dementia in general practice with a focus on cognition and behaviour. In particular, it contains a comprehensive discussion about the effects of antipsychotic medication on mortality in dementia patients. I commend the review to the attention of medical practitioners in general practice who regularly manage dementia patients, particularly in nursing home settings and I recommend that the Minister for Health take such steps as are necessary to draw the DATIS review to the attention of such practitioners.

Key Words: Nursing Care; Medication; Dementia

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 8th day of August, 2011.

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State Coroner

Inquest Number 24/2010 (1389/2006)