FINDINGS and COMMENTS of Coroner Robert Webster following the holding of an inquest under the *Coroners Act* 1995 into the death of:

Rex Rouse

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of Rex Rouse, with an inquest held at Hobart in Tasmania, make the following findings:

Hearing Date

17 March 2022

Counsel Assisting

Senior Constable Alisha Barnes

Notice of This Hearing

Notice of the date of this hearing was provided to Mr Rouse's senior next of kin, his sister Ms Molly Hancock, and to his niece Ms Carnie De Ruyter. They indicated they did not wish to attend the hearing but wished to be informed of the result. Written notice was also provided to the Tasmanian Health Service (THS), the Mount Esk Aged Care Facility and to the Guardianship and Administration Board[1] (GAB). No one appeared for any of those entities at the hearing.

Introduction

1. Rex Rouse (Mr Rouse) died on 26 May 2020, aged 86, at the Launceston General Hospital (LGH).

2. Mr Rouse's death is subject to the *Coroners Act* 1995 (the "Act"). The Act provides an inquest must be held where a death occurs in Tasmania and the deceased person was, immediately before their death, a person held in care.

3. Mr Rouse was, at 10.45 hours on 25 May 2020, taken into protective custody under the provisions of the *Mental Health Act* 2013. At 15.00 hours on that day he arrived at the LGH assessment centre and at approximately 16.30 hours an assessment order was made under the provisions of the *Mental Health Act* 2013 by Dr Norris, that Mr Rouse needed to be

[1] The GAB has been abolished and its functions have been subsumed by the Guardianship Stream of the Protective Division of the Tasmanian Civil and Administrative Tribunal.

assessed against the assessment criteria, that a reasonable attempt to have him assessed with informed consent had failed and it would be futile or inappropriate to attempt to have Mr Rouse assessed with informed consent. At 15.30 hours on 26 May 2020 the assessment order was extended by Dr Pearce for a period not exceeding 72 hours that is until 15.30 hours on 29 May 2020. Dr Pearce certified Mr Rouse met the assessment criteria because he had or appeared to have a mental illness that required or was likely to require treatment for his health or safety or the safety of others, he could not be properly assessed with regard to the mental illness or the making of a treatment order except under the authority of the assessment order and he did not have decision making capacity[2]. As a consequence, an inquest in relation to Mr Rouse's death was mandatory.[3] The investigation and inquest focused upon his care, supervision or treatment[4].

4. On the basis of the evidence tendered at the inquest I make the following **formal findings pursuant to section 28(1) of the Act:**

    a) The identity of the deceased is Rex Rouse;

    b) Mr Rouse died in the circumstances set out further in this finding;

    c) The cause of Mr Rouse's death was pulmonary embolism following deep vein thrombosis; and

    d) Mr Rouse died on 26 May 2020 at the LGH, Launceston, Tasmania.

Background

5. Mr Rouse was born on 21 March 1934 to Harriett and Charles Rouse. He was one of nine children. His father left the family and moved to New South Wales when Mr Rouse was about 9 years of age. There was no further contact between Mr Rouse and his father.

6. Mr Rouse grew up in the Sheffield area on the north-west coast of Tasmania and left school before completing year 10 as he obtained employment. He worked in both Mildura and Melbourne before returning to Tasmania at the age of 22 from which point he worked for the Hydro Electric Commission, as it was then known, as a linesman until he retired at approximately 60 years of age. He never married and did not have any children.

[2] These orders were tendered at the hearing and are exhibit C9.
[3] See s24(1)(b) of the Act.
[4] See s28(5) of the Act.

7. When Mr Rouse retired he lived with his mother and one of his brothers at Latrobe. He would drive to Launceston weekly to visit and assist family members including an elder brother who lived in the suburb of Summerhill. When Mr Rouse was hospitalised in late August 2019 he asked his niece, Ms De Ruyter, to stay with his brother at Summerhill to ensure he was alright. On his release from hospital in October 2019 Mr Rouse resided with his brother and niece in Summerhill. During this period he received nursing care and his niece took him to his general practitioner and to the dentist. In late October 2019 Mr Rouse had a fall at home and he was taken to the LGH where he remained until he moved into the Mount Esk Aged Care Facility at St Leonards on 19 December 2019. That facility is operated by Southern Cross Care (Tas.) Inc.

8. On 23 December 2019 the GAB appointed the Public Trustee of this State as the administrator of the estate of Mr Rouse for a period of three years.[5]

Health

9. Mr Rouse's medical records reveal he had a long history of gastrointestinal symptoms and psychiatric difficulties. There is a history of *"stomach complaints"* as long ago as 1961 and the receipt of electroconvulsive therapy for psychological symptoms as long ago as 1970. It appears Mr Rouse received significant mental health treatment for *"depressive neurosis, impotence, schizophrenia, reactive depression* [and a] *depressive psychosis"* from 1982 until 1983. Then there was an admission to the Devon Clinic, a psychiatric clinic attached to the Mersey Community Hospital as it is now known, in 1984.

10. In 2007 the records state *"gastric problems are focus when Rex's mood deteriorates"*, *"abdo irregularities, shakiness and anxiety"*. The notes for 19 September 2007 query a secondary diagnosis of dementia. In 2016 Mr Rouse was admitted to the Spencer Clinic, the psychiatric unit at the North West Regional Hospital in Burnie, for a period of five weeks. It appears that at or about this time Mr Rouse was under the care of the very experienced psychiatrist Dr Ian Sale. In 2019 there were admissions to the LGH and to the psychiatric clinic attached to that hospital, Northside, from 25 August 2019 until early October 2019 and then again from 31 October 2019 until 19 December 2019. The admission in August was due to gastrointestinal difficulties, abdominal symptoms and symptoms of anxiety and depression whereas the admission in late October 2019 occurred as a result of a fall and recurrent right pleural effusions, urinary retention, psychosis and behavioural and psychological symptoms of

[5] This order was tendered the hearing and is exhibit C10.

dementia. The pleural effusions were related to a tuberculosis infection Mr Rouse had contracted as a child. There had been prior episodes of urinary retention.

11. Other conditions of note included cognitive and visual impairment, basal cell carcinoma in 2016 along with depression and gastritis in 2016. Mr Rouse had undergone many tests to determine the cause of his gastrointestinal symptoms however no abnormalities were ever detected.

12. Past psychiatric diagnoses have included *"depression + depression with psychosis- nihilistic and somatic themes"* and *"behavioural and psychological symptoms of dementia in* [the] *context* [of] *cognitive impairment concomitant with pre-existing depressive disorder."*

13. Due to the paranoid and psychotic symptoms being exhibited by Mr Rouse in late 2019, thought to be attributable to underlying dementia and long standing mental health issues which rendered Mr Rouse unable to make decisions with respect to his ongoing medical treatment, management and care, there was an application for an emergency guardianship order made on 7 November 2019. On that day the GAB appointed the Public Guardian as the guardian of Mr Rouse until 5 December 2019. Applications were made to the GAB for the appointment of a guardian on 28 November 2019 and the appointment of an administrator on 2 December 2019. Subsequently the GAB made the order referred to in paragraph 8.

The Events Leading up to Mr Rouse's Death

14. Over the weekend of the 23rd and 24 May 2020 Mr Rouse suffered a relapse of his depression with psychosis on a background of depression with psychotic features. The Older Person's Mental Health Unit (OPMHU) of the LGH received, on 25 May 2020, correspondence from the Mount Esk Aged Care Facility that Mr Rouse's mental state was deteriorating. Following a review by that unit and a discussion with the psychiatrist Dr Paech, Mr Rouse was brought into the LGH by ambulance for admission. He was placed under protective custody and then reviewed by the on-call psychiatric registrar, Dr Norris, with respect to the need for an assessment order and for a determination as to Mr Rouse's decision-making capacity. The history given to Doctor Norris was that Mr Rouse had been reporting he had died, he could not eat, and that he could see and smell dead bodies all over the facility. On review Mr Rouse said this had started yesterday that *"there are dead bodies everywhere, they are all over the place, I'm next on the list."* He believed he had died and that his stomach was no longer present yet he also said he was waiting to die. He felt sad and hopeless and said he could not be helped because he was *"past all that."* He had been

combative and agitated in the ambulance. A mental state examination was conducted. Dr Norris' impression was there had been a relapse of psychosis and the depressive disorder in a patient who had a pre-disposition to these conditions. The cause of the deterioration was unknown because a number of tests which were conducted[6] did not demonstrate a clear medical cause. His case manager and the team at the OPMHU were aware of Mr Rouse and noted his symptoms appeared relatively typical of past relapses and there was the potential that worsening cognition may be impacting on his current presentation.

15. Dr Norris made the assessment order at 16.30 hours on 25 May 2020. Mr Rouse was to be admitted to the Northside Psychiatric Clinic of the LGH and then he would be transferred to the Roy Fagan facility in Hobart when a bed became available. Until he was admitted to the Northside Clinic he remained a patient of the Emergency Department (ED) of the LGH.

16. At approximately 16.35 hours on 25 May 2020 Mr Rouse was reviewed by the emergency RMO Dr Paul. After taking a history, conducting an examination and discussing the matter with a colleague his impression was Mr Rouse was suffering from a relapse of psychotic depression and he was to be medically cleared before being admitted to the psychiatric unit. A number of tests were conducted and considered by Dr Paul who then contacted the psychiatric registrar who agreed to admit Mr Rouse to the psychiatric unit. He remained in the ED overnight and was admitted to the Northside Clinic the next morning. After being admitted to Northside Mr Rouse refused to hydrate and he refused to eat. He also refused, despite encouragement from nursing staff, to leave his bed.

17. At 15.30 hours on 26 May 2020 Dr Pearce reviewed Mr Rouse noting he was lying in bed and refusing to leave his bed or the room. It is recorded Mr Rouse said a number of things including *"I'm trying to die but the devil won't let me"* and *"the whole world is dying"*. When questioned further, Mr Rouse refused to answer questions and he became irritable. A mental state examination was conducted after which Dr Pearce diagnosed depression with psychotic features. He extended the assessment order referred to in paragraph 3.

18. At 16.30 hours a code blue was called by nursing staff and CPR was commenced. CPR was unsuccessful and life extinct was declared at 17.01 hours on 26 May 2020. Life extinct was later formally certified by Dr Parkes in a statutory declaration he made at 18.47 hours on 26 May 2020.[7]

[6] The tests were urinalysis, blood tests and a chest x-ray.
[7] Exhibit C3.

Investigation

19. The fact of Mr Rouse's death was reported in accordance with the requirements of the Act. His body was formally identified[8] and then transferred to the LGH mortuary. At the mortuary, Mr Rouse's body was examined by Forensic Pathologist, Dr Ruchira Fernando MBBS MD FRCPA. Dr Fernando also reviewed Mr Rouse's medical records. She provided a report which was tendered at the inquest[9] in which she summarised her autopsy findings in the following terms : *"[t]his 86 year old male with a history of mental issues was admitted to LGH on 25 May 2020 due to deterioration of mental state. He was transferred to Northside on 26 May. He continued to be agitated and had hallucinations. He was found deceased in the evening. Post-mortem revealed a possible pulmonary embolism which was mainly within the right ventricle but lungs also showed thrombotic material within pulmonary arteries. Histology confirmed ante mortem thrombotic material. Heart was mildly enlarged (590 g) with focal areas of fibrosis. No acute infarction. Brain showed atrophic features. No histological evidence of Alzheimer's disease. Other organs did not have significant pathology except lungs which showed chronic non-specific changes with silicotic nodules possibly related to his occupation. He has not been a smoker, worked as a hydroelectric power station employee. No active inflammation."* Doctor Fernando says Mr Rouse's cause of death was pulmonary embolism following deep vein thrombosis. She noted he was a person with dementia and significant mental health issues who was under the care of the mental health team.

20. Ms Libby Newman who is a clinical nurse specialist in forensic pathology and consultant to the Coronial Division reviewed the file in this matter including the Tasmania Police Report of Death[10], affidavit from Mr Rouse's niece[11], the general practitioner's records[12] and nursing home records[13] along with records obtained from the THS[14] and Dr Fernando's report. In her report, which was tendered at the inquest[15], Ms Newman says she had been asked to review this matter with the aim of addressing Ms De Ruyter's concerns which she noted from exhibit C8 were as follows:

    - communication from staff was rude and insensitive;

[8] Exhibit C4.
[9] Exhibit C5.
[10] Exhibit C1.
[11] Exhibit C8.
[12] Exhibit C6.
[13] Exhibit C13.
[14] Exhibit C7.
[15] Exhibit C12.

- the mental health ward at the LGH should be held accountable for how they treat their patients. In addition, one nurse and one receptionist were rude;
- more tests should have been done and *"the hospital should have done more"*; and
- Mr Rouse's mental deterioration coincided with medication changes *and "the doctors should have picked up on this"*.

21. In respect of the communication issues Ms Newman says these are not something she can comment upon. If Ms De Ruyter has ongoing concerns Ms Newman quite rightly points out that this aspect of the matter should be pursued by her with the hospital itself or with the Health Complaints Commissioner. Ms Newman agrees the LGH from the ED through to the Northside Clinic can be *"held accountable"* for their treatment of Mr Rouse but she does not perceive any "red flag" moments in his care and management. On the contrary she says his care in the nursing home, by the OPMHU, in the ED and at Northside appear to her to be appropriate, timely and caring. She notes Mr Rouse was cleared in the ED and there does not appear to be any clinical observations or descriptions of his condition and/or assessment findings which raise concern or which could have predicted the acute deterioration in Mr Rouse's condition and death later on 26 May 2020. She notes Mr Rouse was cared for in Northside by psychiatric nurses and was reviewed readily by a psychiatric consultant and registrars. She notes there are no concerns identified with respect to his resuscitation. She says there were changes to his medication regime when he began to exhibit signs of deterioration but it was not obvious to her that any particular change in medication proceeded Mr Rouse's decline. Finally she says there is some published literature (Elikowski et al 2011 and Zhou et al 2011) about patients who have had depression, who have been on antidepressant therapy and have had a pulmonary embolus. Ms Newman says *"Mr Rouse appears to have been more sedentary as he became more mentally unwell, refusing to get out of bed and so on. He developed a deep vein thrombosis in one of his legs (it would be very difficult to pinpoint when the deep vein thrombosis began) which was not identified prior to death – this is not a criticism, rather it was clear from his progress notes that staff at his nursing home had been encouraging him to mobilise."*

22. Mr Rouse's medical care and treatment was reviewed by Dr Anthony Bell MB BS MD FRACP FCICM, Medical Advisor to the Coronial Division of the Magistrates Court. Dr Bell provided a report (which was also tendered at the inquest[16]) in which he noted Mr Rouse's past medical history of significance which included multiple admissions for depression and

[16] Exhibit C11.

anxiety, tuberculosis (TB) with right recurrent pleural effusion and prescription of anti-TB drugs and the fact Mr Rouse was assessed for residential care, had endured multiple hospital admissions for psychotic depression and was case managed by outpatient Mental Health Services. Dr Bell says on the weekend of 23 to 24 May 2020 Mr Rouse suffered a mental health relapse at his residential aged care facility, Mount Esk Care Facility, at which time he was reviewed by his consultant and referred for inpatient care. Mr Rouse was combative in the transporting ambulance and treated with benzodiazepine. On review he was diagnosed with psychosis and depression. A number of risks were noted and an assessment order made. No cause for delirium was found clinically or on blood tests and he was cleared for admission to the Northside Clinic. Treatment was commenced by way of mirtazapine, oxazepam and olanzapine. On 26 May 2020 he was reviewed by the consultant psychiatrist. Nursing staff noted he refused hydration. Later in the afternoon he died suddenly because of pulmonary embolism due to a deep vein thrombosis. Dr Bell says Ms De Ruyter's concerns with respect to staff management of patients on the ward as well as her relationship with staff are beyond the scope of a medical report. In addition I note a Coroner has no power under the Act to investigate and report on such issues. Dr Bell goes on to say the management of Mr Rouse was to a good standard and the assessment and management plan made by the consultant psychiatrist was extensive and of a good standard. He concludes by saying *"[t]he patient suffered sudden death due to pulmonary embolism. There are no issues about the care provided."*

23. I accept the opinions of Drs Fernando and Bell and Ms Newman. They are experienced in their respective fields and well qualified to express their opinions.

Conclusion

24. The evidence tendered at the inquest satisfies me that Mr Rouse was appropriately treated and cared for while he was a *"person held in care"* as defined by the Act.

25. I find that the care and treatment of Mr Rouse was appropriate, attentive and competent. Mr Rouse had significant and longstanding mental health symptoms which required increasing medical intervention as his symptoms deteriorated. He died of an unrelated medical condition which was not identified prior to his death. If he had mobilised, as he was encouraged to do by nursing staff, then this may have guarded against the development of deep vein thrombosis. Unfortunately he was not compliant in that regard. I find that his non-compliance was a consequence of his worsening mental health.

26. The assessment and treatment Mr Rouse received at the LGH before his death was, in Dr Bell's view (which I accept), appropriate medical care.

27. The care Mr Rouse received at Mount Esk Aged Care Facility was entirely appropriate.

Comments and Recommendations

28. In the circumstances there is no need for me to make any further comments or recommendations.

29. In concluding, I convey my sincere condolences to all those whose lives were touched by Mr Rouse.

Dated: 21 March 2022 at Hobart in the State of Tasmania.

Robert Webster
Coroner