STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest: **Inquest into the deaths of**

SHANEEN BATTS	**1811/09**
ILONA TAKACS	**2437/09**
DOROTHY HUDSON	**437/10**
IAN BIRKS	**1079/10**
DONALD MACKELLAR	**1793/10**
MOHAMMED RAMZAN	**1948/10**

Hearing dates: **12TH - 16TH March 2012 , 2nd April 2012 (submissions)**

Date of findings: **11th May 2012.**

Place of findings: **State Coroner's Court, Glebe.**

Findings of: **State Coroner, Magistrate M. Jerram**

Findings:

1. I find that **Shaneen BATTS** died sometime between the 28th and 29th June 2009 at Marrickville, in the state of NSW from the effects **OLANZAPINE TOXICITY**. I also find that the other contributing factor to her death was **CHRONIC OBSTRUCTIVE PULMONARY DISEASE**.

2. I find that **Illona TAKACS** died on the 23rd August 2009 at Marrickville in the state of NSW from **PULMONARY THROMBO-EMBOLI**. I also find the following other factors which contributed to her death were **CHRONIC AIRWAYS DISEASE** and **HYPERTENSIVE HEART DISEASE**.

3. I find that **Dorothy HUDSON** died on the 20th February 2010 at Marrickville in the State of NSW from the effects of **ASPHYXIATION** which was caused by choking on a sandwich.

4. I find that **Ian BIRKS** died on the 20th March 2010 at the Royal Prince Alfred Hospital at Camperdown in the State of New South Wales from the effects of **CARDIO RESPIRATORY ARREST**. I also find the following other factors which contributed to his death were **HYPOXIC BRAIN**

INJURY, ASPHYXIATION ON FOOD.

5. I find that **Donald MACKELLAR** died on the 21st July 2010 at the Royal Prince Alfred Hospital at Camperdown in the State of NSW from the effects of **ATHEROSCLEROTIC DISEASE**.

6. I find that **Mohammed Talat RAMZAN** died sometime between the 6th August and 8th August 2010 at Marrickville in the State of NSW from the effects of **CARDIOMEGALY**. I also find that the other contributing factor to his death was **CHRONIC LUNG DISEASE**.

Recommendations:

To the Minister for Ageing & Disability Services:

1. I recommend that that in light of the NSW Governments stated intentions to implement Boarding House reform within this State that any such reform incorporates the requirement for the mandatory registration of all current and future operators of Boarding Houses who have the capacity to accommodate two or more persons.
2. I also recommend that in the implementation of Boarding House Reform that any Legislation enacted addresses in it accommodation standards, service standards and greater occupancy protection for all Boarding House tenants.
3. I recommend that a regulatory body separate from D.A.D.H.C is enacted with powers to monitor, prosecute and arbitrate disputes between Boarding House (BH) operators and Tenants in a similar manner to a Residency Tribunal. I would also further include in this recommendation a provision for the mandatory notification and reporting by employees of Boarding Houses or service providers of any suspected or identified breaches committed under any relevant Legislation governing BH reform.
4. I recommend that included in any BH reform, consideration be given to developing strategies for the provision of financial assistance by Government and Incentives to encourage investment and compliance by BH operators with any Legislative requirements in order to comply with Recommendations 1-3.

To the Minister of Health

5. I recommend a review also be conducted by NSW Health to consider the establishment of protocols for health service providers addressing annual mandatory reviews for residents living in BH's suffering from mental illnesses or conditions.

To the President of the Royal Australian & New Zealand College of Psychiatrists

6. I recommend a review be conducted by the Governing Council of your organisation into the circumstances of all 6 deaths with a view to establishing clearer protocols for all psychiatrists in addressing the requirements for monitoring the prescription and usage of multiple anti-psychotic medications by longer term mental health patients.

File number: **1811/09, 2437/09, 437/10, 1079/10, 1948/10, 1793/10**

Representation: **Mr S. Kelly**, Coronial Advocate assisting assisted by **Ms Nicole Arnold.**

Mr R. Wilkinson (Barrister) instructed by **Ms Lee-Anne McAlister** (solicitor) appearing on behalf and for **Ramzan** family.

Mr S. Barnes (Barrister) instructed by **Ms Susan Doherty** of HWL Ebsworth Lawyers appearing on behalf and for Dr. **C. Reitberger.**

Mr G. Butler (Barrister) instructed by **Mr Tony Mineo** of Avant Law Pty Ltd appearing on behalf and for Dr. **P. Sztolcman.**

Mr R. Hewson (Barrister) instructed by **Mr Michael Swan** from Avant Law Pty Ltd appearing on behalf of and for Dr. **E. Tompkins.**

Mr G. Jauncey (Barrister) instructed by **Mr Paul Egisto** appearing on behalf and for Mr **C. Young.**

Ms K. Burke (Barrister) instructed by **Mr John Pavlakis** appearing on behalf of and for **Department of Ageing, Disability & Home Care Services.**

REASONS FOR DECISION

Introduction

1. This was an Inquest that was conducted between the 12-16th March into the deaths of the 6 named persons who all resided at 300 Hostel, a facility set up for the disabled and homeless which was owned and managed by Mr and Mrs Christopher Young, both psychiatric nurses.

2. Although in each case the cause of death was clarified by an autopsy, concerns were raised due to all the deaths occurring in a relatively short period (the first being on 29 June 2009 and the last on 8 August 2010), and all the deceased living in the same residence.

3. THE FACTS

4. During this Inquest some similarities became evident:

- Each of the deceased had been diagnosed with mental illness and were being regularly treated with daily medication of two or more anti-psychotic drugs prior to their deaths.

- All of the deaths were sudden and unexpected.

- Two of the deceased died as a result of Cardiac related illnesses whilst a third had evidence of hypertensive heart disease at post mortem, yet none of the deceased were being actively treated for this prior to their deaths.

- Two choked on food apparently leading to their deaths.

- Most if not all appear to have been in poor health, partly due to poor diet, inactive life style and in almost all cases a high level of consumption of alcohol and tobacco.

- All of the 6 deceased had been treated by Dr Tompkins (psychiatrist) at some point prior to their deaths. Whilst 5 out of the 6 were treated by Dr Reitberger,

Ms Shaneen Batts had been treated by Dr Sztolcman who were both General Practitioners.

5. **The facts for each individual are as follows;**

6**. Shaneen Batts**, who died on 29 June 2009, aged 60

The first of these deaths was Ms Shaneen Batts who died on the 29th June 2009. She was 60 years of age at the time of her death and had been treated for Chronic Obstructive Pulmonary disease, asthma and Schizophrenia.

7. She was a woman who smoked a large amount of cigarettes and drank alcohol regularly despite a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). She was reviewed fortnightly by Dr Sztolcman who monitored her mental and general health. The police report into her death stated that at approximately 8.30am on the 28th June 2009 on the morning prior to her death another resident had to assist Ms Batts to her feet as she could not stand up from a sitting position.

8. The last person to see her alive was her room mate which was at about 8.30pm the previous evening when she was noticed to be sleeping. She was found the following morning by the Home Care Worker who had attended her unit to assist her with her morning shower. He reported her death to Ms Rokoua who inturn contacted Mr Young.

9. A Post Mortem was conducted on the 1st July 2009 and the direct cause of death was listed as Olanzapine Toxicity. Her blood toxicity level was recorded as 1.4mg/L which was greatly in excess of normal therapeutic levels which range between (0.01-0.1mg/L). It was also noted at post mortem that her lungs showed bronchiolitis and emphysematous change with evidence of hypertensive change in her kidneys and she weighed only 35 kgs with a BMI of 13.7 kg/m2 at the time of her death.

10. The next death was **Ilona Takacs** who died on 23 August 2009 aged 71 years.

11. The police report into her death indicated that on the 23rd August 2009 she awoke at about 6.45am and had some breakfast. At approximately 11.45am staff at the Boarding House (BH) asked Ms Takacs if she wanted to go to the kitchen for lunch. She declined but accepted some jelly in her room which she apparently consumed. A short time later

she went to the toilet and needed assistance from staff where she was assisted back to her room where she sat on her bed with her back against the bedroom wall. Ms Pani Rokoua (who was one of the employees at the BH) was concerned about her condition and believed she was incoherent and contacted Mr Young who inturn called the Ambulance. The Ambulance arrived at approximately 12.13pm and noticed Ms Takacs to be unconscious and experiencing agonal respirations. CPR was commenced however Ambulance Paramedics were unable to revive Ms Takacs.

12. A Post Mortem was conducted on the 24 August 2009 by Dr Schwartz. She found that the direct cause of death was a result of:
(a) Pulmonary thrombo-emboli complications
(b) Chronic airways disease and hypertensive heart disease.

13. She had lived at 300 Hostel for 30 years, was reclusive and inactive, and smoked heavily. Although Dr Reitberger was aware of her 'chest' difficulties, she had never been referred to any specialist for treatment. This point was commented on by Dr Cheryl McIntyre in her report to this court who stated that Ms Takacs had had no health summary and very little preventative care despite significant diagnoses and multiple risk factors for disease.

14. The next death was Ms **Dorothy Hudson**, who died on 20 February 2010 aged 60

15. At the time of her death she was 60 years of age and was being treated for '*treatment resistant'* schizophrenia. She had only been residing at 300 Hostel for 3 months before her death.

16. She choked during her meal at the hostel. This occurred at about 5pm on 20th February 2010 when Ms Hudson was having her evening meal which consisted of a peanut butter and egg sandwich. At the time Ms Hudson was located outside in the recreation area when a resident of the BH who was sitting next to her noted that she '*appeared to have gulped down her food'*. At this point Ms Hudson has had difficulty breathing as the food has lodged itself in her throat blocking her airway. Ms Hudson walked to the rear of the Hostel where she indicated she couldn't breathe. The other resident who was with her at the time had run into the kitchen and obtained a glass of

water for her. The only member of staff on duty, Ms Rokoua, had not First Aid training, and while she attempted to assist, she did not know the appropriate procedures, and telephoned the owner, Mr Young, before an Ambulance was contacted. No Post Mortem was performed, so that whether she suffered from any other known medical condition remains unknown.

17. Mr Ian Birks, who died on 20th March 2010

18. Mr Ian Birks was born on 20 December 1944 and was 65 years of age when he died on the 20th March 2010 in RPAH.

19. Mr Birks was also diagnosed with Schizophrenia and a mild intellectual disability. On the 17th March 2010 had attended an activity session with the Newtown Neighbourhood Centre through a support service called the Acting Linking Initiative ALI which is operated and funded by DADHC. It has been reported to me that prior to this, he had attended 5 other similar BBQ's and 4 other events that had been offered to residents at 300 Hostel.

20. At about 4.10pm when ALI staff arrived at 300 Hostel and asked Mr Birks if he would like to come along he beamed a smile and keenly got into the bus to go. According to staff he appeared well when he left 300 Hostel for the purpose of attending a BBQ outing to nearby Steele Park. Ms Leigh Connell (Co-ordinator) of ALI recorded that whilst at the BBQ his behaviour did not appear out of the ordinary, he drank several cups of juice (which were poured half full) to accommodate his shaking. When the BBQ was cooked he was given one sausage sandwich.

21. However shortly thereafter he collapsed in the park suddenly and unexpectedly. Whilst trying to assist Mr Birks who did not respond to verbal commands he lunged forward several times (in what was described as similar to a seizure). Staff contacted triple 0 and commenced CPR for 15 minutes until the arrival of Paramedics who subsequently transported him to RPAH. He was admitted to ICU but did not recover and his life support system was disconnected on 20th March 2010 after consultation with family members. At the time of his death he was being treated for Schizophrenia and

Tardive Dyskinesia, and prescribed Haloperidol 6.5mg per day, Risperidone 8mg daily and Tetrabenazine 25mg twice a day.

22. His Tetrabenzaine 25mg was increased on 28.07.09 to 3 times a day. Dr Tompkins reduced his Haloperidol in January 2010 after his hospital visit to RPAH although there was no notation of this change made in the Boarding House (BH) notes at 300 Hostel.

23. He also suffered from increasing exaggerated tremor and was highly psychotic.

24. In the months prior to his death in late 2009 he had a melanoma removed at Canterbury Hospital, which became infected, for which he was prescribed antibiotics. In early 2010 he was taken by Ambulance to RPA on two occasions (being 1st January 2010 and 4th February 2010. In relation to the latter visit, he was described as being septic and was rehydrated with Hartmann's solution. On both visits concerns were expressed about his prescribed medications.

25. His medications were reviewed by Dr Tompkins on two occasions and his Haloperidol was ceased at night.

26. A death Certificate was issued citing that he died from the following:

(a) Cardio respiratory arrest
(b) Hypoxic brain injury
(c) Asphyxiation on food.

27. Donald Mackellar who died on 21 July 2010 aged 75

28. The fifth death to occur at 300 Hostel was that of Mr Donald Mackellar. He also had been diagnosed with Schizophrenia and smoked daily.

29. Shortly before his death at about 5pm on 21st July 2010 Mr Mackellar was lying in his bed eating ice cream when he began to feel pain in the middle of his chest. Mr Mackellar called out to his room mate who notified staff at the BH who inturn contacted Triple 0. Ambulance Officers attended and Mr Mackellar was taken to RPAH. On arrival it was recorded that he was conscious but having difficulty breathing with white

'blotches' covering his body. Hospital records indicated that he had a PEA arrest (pulseless electrical activity) which is a clinical condition characterized by unresponsiveness and lack of palpable pulse in the presence of organized cardiac electrical activity and shortly his condition rapidly declined.

30. Attempts to revive Mr Mackellar were unsuccessful and at 7.00pm the treating team made the decision to withdraw active treatment.

31. At autopsy, the cause of death was found to be severe Coronary Artery Atherosclerotic Disease, Chronic Ischaemic Heart Disease, and severe Pulmonary Oedema and congestion. He was listed as being overweight at autopsy weighing 96.5kg.

32. A Client Health Care Plan was prepared for him in 2007 by the NSW Sydney South West Area Health Service which recorded that he had identified risk factors for COPD and Obesity. It recommended a wide range of regular tests and procedures, most of which do not appear to have been implemented. He was never referred to a specialist for chest problems which had been noted by the General Practitioner on 6th January 2010 and the 31st March 2010. On those dates it was recorded that he had a *'chesty cough'*, & his chest had *'a few rattles'* but was otherwise ok. According to Dr Reitberger he was to have a biopsy and ultrasound done for the lump on his neck although it's not clear on the notes whether in fact a referral was ever written, however in any event he died before any such test could be undertaken.

33. Mohammed Talet Ramzan who died between 6th-8th August 2010 aged 53 years.

34. The next death was that of Mohammed Ramzan who died between 6-8 August 2010.

35. There is conflicting evidence as to when Mr Ramzan was last seen alive. It has been reported by his flatmate, Mr Clem Smith that on the evening of 4th August 2010 Mr Ramzan had been complaining of a running nose and a bad cough. He had requested

Mr Smith to go and get him some medication upon which he purchased a bottle of cough medication.

36. On Friday 6th August 2010 Ms Olga Taltavull (who was employed by Home Care Services) which was and agency funded by DADHC attended Mr Ramzan's room for the purpose of assisting him in having his morning shower. She had always found Mr Ramzan to be a kind, nice person who caused no problems.

37. She indicated that Mr Ramzan advised her that he couldn't have his shower because he was feeling sick and he was having breathing problems. He was lying on his left side and his eyes were closed although Ms Taltavull said he was still breathing. She left his room and returned later where she asked Mohammed if he could sit up. He didn't move and just said that he was feeling sick and couldn't shower. She went and reported her concerns to the owner of the premises, Mr Christopher Young. According to Ms Taltavull, Mr Young suggested that some of the residents indicate they are sick if they don't want to shower but he advised her he would go and check on him.

38. On Sunday 8th August 2010 Mr Ramzan was found deceased in his room by his flatmate Mr Clem Smith. He has advised Ms Pani Rokoua who has gone to check on Mohammed and noticed that he was lying on his left side with his back to the wall. She has touched him and noticed that he was *'cold'* to touch. She has then gone to the office and called Mr Young who called the Ambulance.

39. The first police officer on the scene was Senior Constable John Kissa from Marrickville LAC. He spoke with Mr Clem Smith who had initially indicated to him that he last saw Mr Ramzan alive on Friday afternoon on the 6th August 2010. This was apparently around 7pm when Mr Ramzan had asked him to go to Woolworths and purchase some tins of herring and a bottle of Cola for him which he did. Mr Smith stated he did this by attending Woolworths and purchasing the items utilising the keycard of Mr Ramzan.

40. Mr Smith told Senior Constable Kissa that he noticed Mr Ramzan asleep the entire day *(being the Saturday)* and he was in the same position as he had been in the night before. He asked Mr Smith if he had noticed whether Mr Ramzan had got up at all

during the day or if he had any interaction with Mr Ramzan on the Saturday to which he replied he hadn't. At a later point, Senior Constable Kissa stated that he saw Mr Smith having a conversation with Mr Young after he had arrived. After this conversation, Mr Smith approached Senior Constable Kissa and told him that his earlier version was incorrect and that he had seen Mr Ramzan alive on the Saturday.

41. Again Ms Pani Rokoua also told Senior Constable Kissa she had initially first saw Mr Ramzan on the Saturday at about 1.00pm when she said she entered the room to give him his medication. She said she thought Mr Ramzan was asleep and left the medication in the room for him. However she too approached Senior Constable Kissa after speaking to Mr Young wishing to change her earlier account and said that she did have a conversation with Mr Ramzan on the Saturday. Senior Constable Kissa maintained his account of these events in his sworn evidence.

42. I do note that Mr Ramzan was psychotic, very overweight, and while not bed ridden, very reluctant to leave his bed or take part in any activities. The pathologist who performed the autopsy was of the opinion that he had died of Cardiomegaly with Chronic Lung Disease, Diabetes and Obesity. (In fact, subsequent evidence did not sustain the finding of diabetes; he had no history of it, and blood tests performed until nine months before his death did not show any abnormal glucose levels).

43. At the time of his death, he was prescribed Seroquel and Clopixol, both antipsychotics, Cipramil, an antidepressant, and Largactil, also an anti-psychotic although apparently prescribed for insomnia.

44. GENERAL FACTS

45. 300 Hostel operated at 300 Livingstone Road, Marrickville and was a Licenced Residential Centre (LRC). Mr Chris Young was its licensee, proprietor and manager. Approximately 38 residents, mainly with various forms of mental illness, were charged a weekly fee for board and lodging which at the time it closed, shortly after the death of Mr Ramzan, was $290.00 per week. At least theoretically, besides accommodation and meals, the residence provided general supervision, personal care, medical home visits, transport and overall assistance.

46. Besides Mr Young who worked full time, his wife worked for the Hostel 3 days a week, and there was a cook and a cleaner, one other staff member and Ms Rokoua who slept at the hostel and was responsible for evening medication rounds, security and general supervision.

47. The standard of care of the Hostel was overseen by the Department of Ageing, Disability and Home Care (DADHC). The Department is charged with the duty to ensure that licence conditions are complied with, and the health, safety, comfort and proper care of the residents is maintained. Homecare staff provided personal care (e.g. showering) and made transport arrangements particularly to outside medical appointments.

48. General Practitioners Drs Reitberger *(who cared for 5 of the 6 deceased, and 15 other residents)* and Dr Sztolcman held *'clinics'* at the residence on a fortnightly basis, and administered, amongst other medical procedures, the medications prescribed by psychiatrist Dr Tompkins, who saw his patients on an infrequent basis. Although the reasons for this varied between each individual deceased, there was no set timeframe associated with any of his appointments.

49. Following the death of Mr McKellar, ALI and Homecare staff expressed serious concerns for the welfare of the remaining residents of 300 Hostel. Complaints were recorded of unclean premises, leaks in the roof, bathrooms out of order, the dangers associated with smoking in bedrooms, the failure to keep records, the poor maintenance overall of the building, non working smoking detectors as well as suggestions made to staff that in any emergency, Mr Young should be contacted before 000 was called.

50. Infact when Constable Jackson attended the premises on report of Mr Ramzan's death, he too expressed concerns about the well-being of the residents. His concerns related to residents appearing malnourished, that there was only 1 staff member on for the 35 residents on weekends, who by the way had no First Aid training.

51. DADHC conducted 21 routine monitorings between August 2008 and August 2010, hugely in excess of their normal requirements. Evidence has been presented to me via

the Ombudsman's report to Parliament that Tenants of Boarding Houses such as 300 Hostel have no tenants' rights, which makes them vulnerable to eviction without notice, and subject to unilateral decisions by owners, thus creating fear and insecurity for people who are already at risk because of their mental and physical health.

52. In 2002, there were approximately 455 such residences in New south Wales, with about 5,000 residents. Only 31 of those hostels, with approximately 600 residents were licenses. There were legislative changes in 2010 bringing in new requirements, including for staff qualifications and the administering of medication. However there have been no less than 6 Reports by the Ombudsman in recent years critical of DADHC.

53. THE EVIDENCE

54. The Officer in Charge, Detective Sergeant Beaumont presented 5 Volumes of a carefully prepared Brief. He attended 300 on 8 August 2010, the day on which Mr Ramzan was found dead, because of concerns raised by police who initially attended regarding the well being of residents. He noted the lack of staff, the low morale of residents (*"they were all outside and didn't speak to us"*), and the run-down state of the premises. He gave evidence of his discussion with Senior Constable Kissa, who had been told initially by Pani Rokoua and Clem Smith that Mr Ramzan had been inert since Friday, and then were seen in conversation with Chris Young, after which they changed their stories to say that he was certainly alive on Saturday. Senior Constable Kissa had also reported what appeared to be an attempt by Young to withhold a document relating to Mr Ramzan's treatment, when requested by police to produce his file. Sergeant Beaumont expressed strong concerns about the poor standard of the hostel and of the care of residents.

55. As I have previously indicated Ms Olga Taltavull, was a carer at the time through Homecare & Ms Marina Varone was the Homecare supervisor who co- ordinated her work and that of other carers. Ms Taltavull also criticised the conditions at the Hostel, which she called *'Third World'* and said that she only stayed because the clients needed help within such an environment. Her evidence was that there were blocked toilets, often only one working shower, no fans and unclean rooms. She also gave evidence

that up to 25 people shared one bathroom including a toilet, and she was required to bathe and dress 12 people between 7 am and 12pm. Ultimately, but only after many complaints, was a second toilet downstairs made available to clients as well as two extractor fans that were installed to assist with ventilation.

56. Mr Clem Smith shared a room with Mr Ramzan and considered him a good friend. He recalled that Mr Ramzan had been unwell all week, and was coughing a lot.

57. Mr Smith himself suffers from mental health issues & gave contradictory accounts to police, as well as in the witness box . In my view little reliance can be placed on his memory of days or timing. Of concern to me is the possibility that he was persuaded through either insecurity or his disability to alter his initial statement to police surrounding his last supposed communication with Mr Ramzan.

58. As is recorded in the evidence Senior Constable Kissa arrived at the hostel at 8.53am on Sunday 8 August & the Ambulance Officers were still in attendance at that time. I accept that he spoke to Clem Smith who told him he had last seen Mr Ramzan alive on Friday about 7pm, and that he had appeared to be asleep all day Saturday. I also accept that Mr Smith related that he found Mr Ramzan dead in the same position that he had been in since Friday, on Sunday morning.

59. Similarly, I accept he spoke to Ms Pani Rokoua the only staff member who had been present throughout the weekend who stated that she had entered Mr Ramzan's room on Saturday with his medication at about 1pm, that she received no response from him and left the medication on his bedside table. I also accept that after Senior Constable Kissa saw Mr Young speak to both Mr Smith and Ms Rokoua, 60. Mr Smith told him he wanted to change what he had earlier said, and that he had bought groceries for Mr Ramzan at Mr Ramzan's request on Saturday not Friday, and Ms Rokoua also sought to change her account.

60. She further stated that after the death, she had thrown out the pills on the direction of Mr Young. Senior Constable Kissa also confirmed what he had told Sergeant Beaumont, that when he requested documentation from Mr Young, Mr Young threw a Treatment Sheet surreptitiously from the folder in to the bin. That sheets last entry was

dated 17th March 2010 and related to the inclusion of Largactil as a as part of Mr Ramzan's medication.

61. Ms Pani Rakoua had worked for 11 years at 300 Hostel. Her duties were first, to prepare meals from Friday evening till Tuesday mornings for all residents, to distribute the daily medication, mainly in the office and finally after a 9pm check, to ensure that the front door was locked. She asserted that her second version of events, given to Senior Constable Kissa was correct, that she had spoken to Mr Ramzan on Saturday at around11.30 am or just before lunch.

62. Nevertheless, according to Senior Constable Kissa she had originally said that as she had received no response from him, she left his medication on the table, and that that was the first occasion in which she had done this. She denied in her sworn evidence that she had been coached by Mr Young however Ms Rakoua seemed to have trouble understanding and answering many of the questions put to her & I did not find her a credible witness.

63. She was on duty when Dorothy Hudson choked on a sandwich. She had undertaken no training in First Aid, although according to Mr Young she had been requested to do so. It appears she attempted to assist Ms Hudson, who was *'almost black'* by the time she arrived, by hitting her strongly on the back.

64. After Ms Hudson's death, she said that Mr Young added to the Staff Manual two pages about choking. As with the deaths of Mr Ramzan, Ms Takacs and Ms Batts, in Ms Hudson's case she phoned Chris Young first and he phoned for an ambulance. She insisted that this was on Mr Young's instructions & she had nothing to do with the clients BH records, although she generally seemed to eschew any real responsibility for any welfare issues which she clearly regarded as Mr Young's realm.

65. An important witness to this Inquest was **Ms Marina Varone** who had been the Service Co-ordinator for Home Care Service since February 2007 and was responsible for care for Primary and Secondary Health in Boarding Accommodation in the Inner West of Sydney, covering 8-10 residences and 260 residents.

66. She described her role as to work with doctors on medical issues arising from assessments and to maintain the GP Management Care Plan which was supposed to be drawn up for each patient (but never received any from Dr Reitberger despite multiple requests).

67. She supervised arrangements for residents to be driven to appointments and tried to persuade them to use outside services such as dental, optometry and podiatry. She first saw 300 Hostel in early 2007 and was shocked at its condition.

68. Her evidence was that it was dirty, had peeling paint, was ill-smelling, that some beds were without bedsheets, it contained dangerous stairs as well as no outside protection from the sun for residents. Care workers told her that some residents shared clothes, including underwear. Eventually she met Dr Reitberger and showed him various assessments by NSW Health, with many of which he disagreed, asserting, according to her, that patients with mental issues could not be forced to undertake hospital tests.

69. Although there was evidence given at the Inquest of examples of specialist referrals, mainly from Dr Reitberger when Mr Ramzan was referred for his hernia operation or Mr Mackellar being advised to have an ultrasound and biopsy for the lump on his neck, as well as instances of referrals instigated from Client Health Care Plans undertaken by the Sydney South West Area Health Service for some (but not all) of the deceased, and referrals made by Dr Sztolcman for Ms Batts to see a respiratory specialist, overall there was little or no evidence to suggest there was a strong multi disciplined approach between the BH or the Doctors (including GP & Psychiatrists) that was actively in place at 300 Hostel to regularly screen for and detect the most serious diseases (such as COAD or Cardiac related illnesses) arising from the side effects of their anti psychotic medications & overall poor health which Professor Lambert referred to as their Cardiometabolic and Extrapyramidal risks factors.

70. A general example of this lack of screening was the evidence given by Ms Varone of her attempts to have Dr Reitberger refer some of his patients for Spirometry examinations to test for COAD for which she said he seemed reluctant to do. Further support for Ms Verone's concerns can be found in Dr McIntyre's report where she

makes specific reference to a lack of specialist referrals in the treatment of Ms Tackas in which she made the following comments;

- No health summary and very little preventative care despite significant diagnoses and multiple risk factors for disease.

- She had not had pneumococcal vaccination despite lung problems and had not had her lung function assessed and did not appear to be on any medications for her chronic airways disease.

- She did not appear to have had basic monitoring for risk factors such as BMI calculation, exercise/diet, blood tests for kidney function / liver function / cholesterol/ blood sugar in view of an inactive lifestyle and obesity.

71. However, in late July 2010 Ms Varone met with DADHC staff and Dr Reitberger to discuss in particular the previous high rate of deaths at 300 Hostel following the death of Mr Mackellar. At that meeting Dr Reitberger had agreed to do full reviews on all his patients at the facility. Soon after, Mr Ramzan died, and by the end of the year, 300 Hostel closed down.

72. Her summary of the unmet needs of residents included: more personal care, better nutrition, the direct involvement of Mental Health workers, better medical treatment and tenancy rights (as she described many residents as being too frightened to complain). Overall She was highly critical of Mr Chris Young.

73. **Mr Peter Mathews** was the DADHC officer responsible for inspecting 300 Hostel. He told the court that legal action had been considered when, each inspection found serious problems although the legal advice given at that particular time to DADHC was that the laws governing compliance with the Licence obligations may not have been enforceable, and as a consequence prosecutions were not an option of first response. He considered 300 Hostel top of those places– dangerous to residents. There was no maintenance system in place despite there being numerous issues.

74. **Dr Sztolcman**, like Dr Reitberger had seen patients at 300 Hostel for many years. In his evidence, he described Ms Batts as anorexic, depressed, schizophrenic, emphysemic and a person who abused alcohol and tobacco. She was prescribed Olanzapine and Respiridone by Dr Tompkins from 2002 on, and his own role was merely to administer them and prescribe repeats on the advice of Dr Tompkins.

75. However, from 2009, although he agreed that it was best practice for such a patient to be reviewed regularly by a psychiatrist, he claimed that she did not want to see one, that she was both treatment-resistant and, in his view, quite stable. He considered her dosage levels appropriate and was quite surprised by the levels shown in her post mortem toxicology. Although a common side effect of the anti-psychotic drugs is increased weight, he felt he was able to assess Ms Batt's progress and noticed no side effects. Given Ms Batt's mental state, she remained stable, in his view, despite her ill health, because of the dosage.

76. According to him Hostel patients, are very complex and difficult to treat because of their mental health problems. He didn't hold any concerns as to the living conditions at 300 Hostel. His view was because the Richmond report had released mentally ill people to the community *"they had to live somewhere".*

77. **Dr Reitberger** was the general practitioner for all five of the other residents whose death were the subject of this inquest. At the time of Mr Ramzan's death he attended 300 usually on a fortnightly basis to treat at least 20 of the residents, and visited half a dozen other residences, seeing about 200 patients in all, of whom *'about 95%'* were on one or more anti-psychotic medications. He had been providing medical visits to similar boarding houses for over 40 years, and felt that they had improved over the years but still need far more auxiliary services. It was startling to hear his evidence that he had to beg medical friends to do locums when he wanted leave, as very few doctors wanted to work in such places. Asked about 300 Hostel in particular, he stated *" it was as bad as anywhere else and as good as anywhere else".*

78. In relation to Dr Reitberger, Counsel Assisting in his written submissions highlighted a number of areas of the treatment given to the individual residents by the Doctor in his written submissions. I don't intend to go into the detail of each particular example and

repeat what I already have before me however I should at the very least comment on management of Mr Birks.

79. There was evidence in the investigation that suggested to me his health had been in decline for several months prior to his death. The first sign of this was on the 28th July 2009 where it was recorded by Dr Tompkins that he appeared to be very psychotic with *'exaggerated tremor much worse than previous'* which resulted in his Tetrabenazine being increased from twice a day to three times a day. As we know he underwent a removal of a melanoma in 2009 which later became infected and he was given antibiotics. He was also taken to the RPAH on two occasions on the 01/01/10 and the 04/02/10.

80. On the most recent date, Dr Reitberger's notes recorded seeing Mr Birks on the 04/02/10 *(although in evidence he said he may be mistaken about this)*, yet there is absolutely nothing recorded in his notes about Mr Birks' melanoma removal or infection or notation of the hospital presentations during January or February 2010.

81. Concerns had been raised by the Hospital about his medications on both occasions as well as concerns about his general health by Ms Eileen Graham from DADHC to Mr Young yet it appears to me that Dr Reitberger didn't have any such concerns. Even in his statement he says, "*I didn't have any concerns of Ian's medical condition. To my knowledge Ian choked on his food at a picnic. I do not believe his medication was a contributing factor to his death'.*

82. Again Dr McIntyre also was critical of the treatment provided to Mr Birks. Her criticism was in part centred on Mr Birks admission to hospital on the 4th February 2010 for end stage EPSE in which she comments on the minimal notes recorded which did not recognise Mr Birks' condition being serious at the time of his review when he was seen by Dr Reitberger.

83. Dr Reitberger admitted that his record-keeping was very poor & he did produce some short notes to the Inquest when requested, but it has to be said that they were uninformative in the extreme. I accept my Counsel Assisting's submissions that one of the main purposes of recording information is to build up a detailed profile of a patient

for the benefit of the patients treatment and management and for any medical practitioner taking over care. There was little evidence of any formal communication between him and Dr Tompkins, an old friend, partly because they mainly discussed patients orally. There was no evidence of any formal written communication between Dr Reitberger, Dr Tompkins or Mr Young.

84. Dr Reitberger did not recall Mr Ramzan having breathing difficulties although he had seen him two days before he complained to Ms Taltavull that he had difficulty breathing and couldn't get out of bed *(which was probably the day he died).* He had left it to Dr Tomkins to decide whether it was his medication that was the cause of his lethargy, and *'assumed'* that he would have had various tests including for cholesterol when he had a short stay in hospital. He did not seek a report from a Professor Barnes whom Mr Ramzan had seen for his lungs, and not followed up on that consultation.

85. It was raised during evidence by Dr Reitberger and Mr Young that some patients were *'treatment-resistant'*, leaving little option for intervention given the residents rights to privacy and choice. There is nothing recorded to this effect. That is not necessarily surprising based on the residents' various illnesses. But I heard little to satisfy me that all *'reasonable attempts'* were made by either of them to utilise other means or personnel to obtain consent in the patients overall best interests. There was no consistent, or coordinated effort to treat and manage the significant risk factors of all these residents. This point was again reiterated by Dr McIntyre in her report who suggested that patients with intellectual disabilities or mental health issues usually require a greater level of supervision and that more preventative care responsibility rests with the GP and carers in these situations as the patients are less able to take these responsibilities for themselves. I agree with her comments.

86. **Dr Tompkins** is a psychiatrist of 50 years standing and still sees patients in three hostels. He had strong views on the use of anti-psychotic drugs, that despite modern authorities, he often found using a mix of Olanzapine, Risperidol and Halperidol better than using only one, and that side effects were to be expected as normal. He had reduced Ms Batts dosage of Olanzapine from 30 mgs to 20mg in 2002 and increased that of Risperidol, She had not showed any side effects when he had last seen her, and considered her *'normally thin'*, despite agreeing that anti-psychotic drugs normally

caused weight gain, and that the heavier the patient the greater the dose needed to be. He did not believe that Ms Batt's dosage was excessive for her size and weight, but, he had not actually seen her for three years before her death. He pointed out that although Professor Lambert criticised the level of dosage for Ms Betts he, Dr Tomkins, had reduced that level.

87. Mr Ramzan was last seen by Dr Tomkins in March 2010. He noted his drowsiness, but relied on Young to get him up and encourage activity. He agreed that his communication with Dr Reitberger was mainly verbal, although he said he sometimes wrote a note to Dr Reitberger and pinned it on the wall. Dr Tompkins did change Mr Ramzan's medication on that last visit by prescribing him Largactil 100mg (nocte) and made a notation to review his sleep pattern. Mr Ramzan had complained on that last visit being 17/03/10 of vomiting yet there is nothing to suggest that any review was undertaken by Dr Tompkins or that he communicated the change of medications to Dr Reitberger.

88. He summed up his views by saying that following the Richmond Report, it was clear that the community does not accept psychotic behaviour in public, so that the need to medicate became paramount.

89. **Mr Chris Young** the owner and Manager of 300 Hostel gave lengthy oral evidence as well as a late statement which was admitted as Exhibit 15. He disagreed with most criticisms of the Hostel and his management and was extremely defensive throughout his examination. He claimed that most of the six deceased had constantly expressed how contended or happy they were at 300 Hostel.

90. If any criticism of the state of the premises was justified, then lack of funding was the reason. He was less than credible regarding the attempts to dispose of a document in front of police, and in denying that he had pressured Ms Rokua or Mr Smith in their changed versions of what had happened to Mr Ramzan. His explanation of why Ms Rokua had never undertaken First Aid Training was absurd. At the end of his testimony, it could not be said that he had given an impression of a compassionate, caring owner or boss whose only problem was lack of Departmenal support of funding.

91. **THE EXPERTS**

92. **Associate Professor Jo Duflou** is the Senior Forensic Pathologist at the Department of Forensic Medicine at Glebe. He reviewed the circumstances of the death of Ms Batts, and provided his Report to the Ombudsman and to the Coroner. (Brief Tab 40). His opinion primarily went to the effects and possible causes of the dramatically high level found in Ms Batt's femoral blood of Olanzapine. He explained that in a person on Olanzapine long-term he would expect to see about 0.1 milligrams per litre of blood. Ms Batt's level was 1.4mg.

93. He discounted the likelihood of her having taken an overdose, for in order to reach such a level, she would have had to take between 25 and 50 tablets a day before her death. Her weight was an appallingly low 35 kilograms, and A/Professor Duflou agreed that a patient's weight would normally be a consideration in the dosage. This was also the opinion of Professors Lambert and Snowdon on this issue. However, the finding of the Olanzapine toxicity had come as a surprise to him, as the cause of death had been expected to be attributed to her COAD.

94. He emphasised that the drug level found post mortem can, taken alone, be misleading, as the level absorbed depends on the user, their clinical features and co morbities as well as their synthesis. He noted that her blood toxicity was never tested, and that the observation the day prior to her death that she was having difficulty walking should have alerted staff to seek medical intervention.

95. **Dr Cheryl McIntyre's** expert report is at Tab 26. A long experienced General Practitioner, she gave evidence by Audio Visual Link from Inverell. She criticised the paucity and lack of detail in what notes were provided by the Hostel's Doctors. Her experience was that a higher duty of care and responsibility is required of GP's treating patients with special needs and that Dr Reitberger's attention to Mr Ramzan was '*less than adequate'.* She noted that he appeared to have been over sedated without psychiatric advice being sought, had no engagement with other health services and should have been seen and checked on several times a day.

96. She also said he should have been screened for diabetes and for Cardiac Issues with his level of obesity (however only the Post Mortem identified the Cardiomegalopoly which usually takes time to develop).

97. As I have previously mentioned in an earlier point, she considered Ms Takacs to have had little preventative care, no vaccinations or assessment of her lung function, no treatment of Chronic Airways Disease and no engagement with other services. In Dr McIntyre's view, an Ambulance should have been called immediately for both Ms Takacs and Ms Hudson and it was of great concern that the staff member had no training in First Aid, and that there was no alarm of buzzer system.

98. For almost all of the deceased residents, she criticised the fact that there were no or (minimal and illegible) GP notes regarding treatment or medication, no indication of full investigations including blood tests for suspected illnesses and an overall sense that the GP was not recognising the seriousness of most of the patient's conditions.

99. In Mr Birks case, there were only 3 Boarding House entries in 2 years, even though he had undergone surgery at Canterbury Hospital in 2009 and been the subject of 2 Hospital presentations to RPAH in 2010.

100. She agreed that patients with a mental illness tend to have a resistance to treatment, making it very difficult for medical practitioners. Nevertheless, she held a strong view that refusal of treatment does not exonerate the GP of responsibility. Hospitalisation as an option should always be considered.

101. **Professor Tim Lambert** is a Senior Psychiatrist at the University of Sydney practising at Concord Hospital. He has an expertise in the effects of anti-psychotic medications and his report was at Tab 52. His oral evidence was impressive and essentially unchallenged. These patients he said as a group, are the most at risk of premature mortality and morbidity. They require as essential, a close liaison between their GP, and an experienced psychiatrist and community psychological services with an active shared Case Plan. He considered the standard of any notes kept for residents of 300 Hostel as unacceptable.

102. Ms Batts was at the top tier of Cardiometabolic risk but it was not managed. Her weight loss was extreme, and adjustments should have been made to her Olanzapine dosage. Her not gaining weight would have predicted high blood toxicity levels if she was taking her medication as prescribed. She and the others on anti-psychotic drugs all should have had blood tests every 6 months for their lifetime.

103. The average full dose for a healthy middle aged patient is 40 and hers was 1400. Professor Lambert gave vivid explanations of the effects of both old and new type medications. Those which most of these residents were taking were *'a pretty risk combination of drugs unless examined weekly'* and there was no evidence of any of the 6 being examined for side effects. He queried why Mr Ramzan was on such a cocktail as he was and why he was never properly screened.

104. In his report he was critical of the use of Tetrabenazine in Mr Birks case. He said with this drug there is a concern regarding a patient choking. He believed that the use of such drugs to suppress movement disorders should be undertaken by an expert in such a condition. In regards to Mr Birks Hospital presentation on the 4th February 2010 he believed Mr Birks diagnosis could have been similar to Neuroleptic Malignant Syndrome. He was also critical of the Hospital for sending Mr Birks home and that there was not good reason for him to have been prescribed Risperidone twice a day with Haloperidol.

105. Overall, Professor Lambert was deeply critical of the lack of resources in New South Wales, and of the services at 300 Hostel including little or no psycho-social programme ie for physical activity. Patients such as these are very complex and need very good community care but *'people in their 50's in this Century should not die'.*

106. He also said that Community Centres and outside treatment are very scarce. The whole health system in his view has neglected persons with special needs, in the community. Indeed, in this State, they are lucky to have any care at all. A concerted will at a political level is needed to bring about radical change. The College of Psychiatrists now has a Committee forming Policy on Mental / Physical Health and the College of General Practitioners is involved. However, he appeared to be less than optimistic that major changes would be seen in the near future.

107. The court had two further independent expert reports from **Professor John Snowdon,** who is an aged cared psychiatrist based out of Concord Hospital. He gave an opinion to the Ombudsman's office and this court in relation to the deaths at 300 Hostel. Although he wasn't called at the Inquest to give evidence *(as he was at the time outside the jurisdiction)* his reports have formed part of the evidence of this Inquest.

108. In relation to Ms Batt's death, he was of the view that her low body *'weight'* should have been factors taken into consideration in any review to determine the appropriateness of the dosage she was being prescribed. He also said that it was *'best practice'* to only give one antipsychotic' if possible. He also believed she should have been seen by a community team with expertise in long term care for people with schizophrenia on at least an annual basis. In so far as Mr Birks was concerned, he too indicated that it was not good practice to prescribe Haloperidol and Risperidone together *(although he conceded)* that he is aware that it is often done. He also raised some concerns regarding the administration of Tetrabenazine as the MIMS he said lists Dysphagia and *'choking attacks'* as potential adverse effects of Tetrabenazine. He also mentioned that he would have avoided using Haloperidol in particular when a patient has EPSE.

109. Tendered was correspondence from the office of the NSW Ombudsman with DADHC regarding the need for reporting systems in the disability sector in relation to complaints and serious incidents, which if mandated might bolster the safeguards for vulnerable individuals and create a mechanism for immediate or fast response to critical events and / or emerging problems. The Ombudsman's Report to Parliament of August 2011 which expressed huge concerns about the disabled boarding house industry was tabled.

110. CONCLUSIONS

111. If a society is judged by it's treatment of it's most vulnerable members, then ours is failing miserably. Certainly, caring for the mentally ill is a hugely difficult issue. People with Mental Illness requiring housing, care and medical supervision are not always easy. Their needs are complex. Some residences, licensed or not meet the high

standards required much better than others but Government funding is never enough, staff hard to find or retain, and Medical Practitioners prepared to make regular Hostel visits, scarce.

112. There can be no question that the six who died at 300 Hostel between June 2009 and August 2010 were uncared for, poorly treated medically, and neglected. On weekends, there appears to have been just one, unqualified staff member available for up to 35 residents, and even she was hardly on duty at night. DADHC raised concerns about this several times, but little if anything was done by Mr Young to increase staffing.

113. The standards of hygiene and nutrition at the hostel were poor, facilities run down or not usable, and overall care sadly lacking. The weekend staff member had no training in First Aid, and Mr Young's explanation for this was not credible. Further, there were reports made of Fire fighting safety equipment being outdated on one inspection and parts of the buildings posed high risks. In the last 2 years before closure, there was over 20 complaints recorded against 300 Hostel.

114. DADHC staff, although very concerned, and investigating these complaints seem to have been to some extent powerless to enforce compliance with the licensing requirements. I do note that in the final months of operation at 300 Hostel, consideration was being given to withdrawing the license. Unfortunately, that consideration was not acted upon so as to benefit the six residents who died in that time. It is significant that after 300 Hostel closed, the evidence shows that the remaining residents who were moved to alternative Boarding Houses, all showed improvements in their health and demeanour.

115. Despite Mr Young's assertions of compassion and sacrifice, the fact is that he and his wife were making a living from the Boarding House, and while undoubtedly hampered by lack of resources, appear to have been reducing services to residents to perhaps cut costs, and to have provided, at least in the last years, very little supervision or basic care to those most in need of it.

116. Medical treatment was, as Dr McIntyre noted, less than adequate. I accept that it is difficult to find practitioners willing to treat residents in hostels, but that does not

absolve those who do from providing a high standard of care to patients. There was little evidence of a co-ordinated approach between doctors and outside services or doctors and management. Reviews of medication, if they took place at all, were not properly recorded, and medical note-taking was negligible to the point of negligence.

117. There was barely any management of the more significant risk factors for any of the six, and no follow up after hospitalisation. No effort or encouragement to the residents to overcome their treatment resistance was demonstrated by any of the doctors or by Mr Young and his staff.

118. Medication compliance amongst the patients was poor, and dangerously ill-supervised. After Mr Ramzan died, police found a garbage bin holding numerous tablets and medication that had been disposed of. DADHC staff had noted in August 2010 that at least one resident was not taking medication as prescribed.

119. The need for the use of multiple anti psychotic medication in the treatment of all the deceased was highly questionable. As I have previously indicated both Professor Snowdon and Lambert were of the view that it is not recommended or considered best practice that one or more anti psychotic agents be used in the treatment of schizophrenia. Each of Ms Batts, Mr Ramzan and Mr Birks quite possibly were impacted adversely in both their mental and physical health up until the time of their deaths, while not necessarily having a direct role in the cause of their deaths. I could not avoid seeing emerging a Dickensian picture of over-sedated people reduced to a state of inertia or lethargy in order to keep them quiet.

120. Ms Varone of DADHC had raised concerns about Dr Reitberger, and Mr Van Dam also gave evidence of concerns. Even material ultimately provided to this court by Dr Reitberger did not include any notes on earlier consultations. Apart from Dr Reitberger's perhaps having become fixed in his ways after 40 years and not alert to the patient's real needs, fortnightly visits were insufficient for a doctor to deal with complex and specialist needs of each of these patients.

121. In the August 2011 Ombudsman's report which was tabled in Parliament, it said, *'the majority of people living in Licensed Boarding Houses have a mental illness that*

requires ongoing treatment and support. In addition, our review of the deaths of people in Licensed Boarding Houses have identified that many residents have considerable physical health concerns, including chronic health problems such as emphysema, ischaemic heart disease and diabetes, deteriorating health related to ageing, and are at high risk of further health problems as a result of obesity, high blood pressure and heavy smoking'. All these comments apply to 300 Hostel and it's residents. Mr Young and those providing medical services to the resident's failed in their duty to address those problems.

122. Yesterday, the NSW Minister for Disability Services, Mr Constance announced reforms which will subject boarding houses such as 300 Hostel to stronger controls and penalty regimes. Proposed changes include stiffer penalties for non-compliance with regulations and a requirement for all staff to be subjected to periodic criminal record checks. Residents will be given greater occupancy rights and government workers enhanced powers to enter premises to monitor the welfare of residents. So-called unlicensed boarding houses which cater to people on low incomes, as well as licensed boarding houses for people with mental and intellectual disabilities, will be required to register with NSW Fair Trading. The Minister described the Federal Governments $1billion budget commitment to a National Disability Insurance Scheme as 'hopelessly inadequate'.

123. Apart from this summary, and a letter from the Minister today I have not at the time of completing this Finding, seen the full proposal. I can only endorse its intentions and concur with every proposal which improves the lives of our most vulnerable.

124. Suffice to say, I do believe that it would be appropriate for this Court to make Recommendations that have arisen from the issues that were determined at this Inquest and I propose to do so.

Magistrate M. Jerram
State Coroner of New South Wales
11th May 2012.