OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Hazel Marie LALARA**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	2009/50
DELIVERED ON:	16 May 2013
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HEARING DATE(s):	17 June & 25 July 2011
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody; mental health care of prisoners

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
The family:	Kate Greenwood (Instructed by ATSILS)
Queensland Health:	Mr Kevin Parrott

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The *Coroners Act 2003* provides in s. 47 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of Hazel Marie Lalara. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

Introduction

Hazel Lalara was arrested in late 2008 for an alleged assault. It was apparent she was suffering from psychosis at the time. Her ongoing condition and history of schizophrenia led to her being held at The Park Centre for Mental Health (The Park) when she was remanded in custody. Over the following four weeks she was treated there for her psychiatric illness and for a number of physical co-morbidities. Early on the morning of 29 January 2009, after noticing during routine checks that Ms Lalara had not moved for more than an hour, a nurse entered her room and found her deceased.

These findings:

- confirm the identity of the deceased person, how she died, the time, place and medical cause of her death;

- examine the significance of the post-mortem toxicological results to both the adequacy of Ms Lalara's psychiatric treatment; and, whether she had access to illicit drugs in The Park;

- consider the adequacy of the health care Ms Lalara received for her other health problems; and

- examine the adequacy and appropriateness of the approach taken by nursing staff at The Park when checking on sleeping patients.

The investigation

The investigation was conducted by Detective Senior Constable James Horrocks. He compiled a coronial report setting out the findings of that investigation and gave evidence at the inquest.

DSC Horrocks commenced work at 6am on 29 January 2009 and was assigned to investigate the death of Ms Lalara. He immediately travelled to The Park where he was met by uniformed police. He inspected Ms Lalara's room and arranged for a scenes of crime officer to take a series of photographs while her body remained *in situ*. DSC Horrocks told the inquest he saw no signs indicative of Ms Lalara having been involved in a struggle prior to her death. He then seized all medical records relating to Ms Lalara.

DSC Horrocks attended the pharmacy at The Park and spoke to various staff members in order to investigate the possibility Ms Lalara had accessed medication stored on site. There was nothing to support this concern and no other evidence suggesting Ms Lalara had engaged in self harm.

DSC Horrocks arranged for statements to be taken from all nursing staff who had dealt with Ms Lalara in the days prior to her death. He obtained medical records from Ms Lalara's general practitioner and statements from some of her treating doctors. In his report DSC Horrocks included all documentation relating to Ms Lalara's arrest and her being placed into custody.

Counsel assisting obtained a medical report critiquing the adequacy of the medical care provided to Ms Lalara (including an opinion on the conduct of nursing staff on the morning of her death). He obtained another report from an independent toxicologist to assist with the investigation into the contents of the post mortem toxicology report. After receiving submissions from counsel for the family, statements were sought from two other doctors who had treated Ms Lalara in the days prior to her death. One of those doctors now suffers dementia and a statement was not pursued when it became apparent it would be of little assistance.

Once this further material had been received, counsel assisting sought and obtained an updated opinion from the independent medical practitioner engaged to examine the adequacy of the treatment provided to Ms Lalara.

I am satisfied that the scene of Ms Lalara's death was properly secured once medical treatment had ceased and that the integrity of physical evidence was maintained. I am also satisfied that all relevant material has now been collated. I commend DSC Horrocks and Mr Johns on their endeavours.

The Inquest

A pre-inquest conference was held in Brisbane on 17 June 2011. Mr Johns was appointed as counsel to assist me with the inquest. Leave to appear was granted to the family of the deceased, the QPS Commissioner, and Queensland Health.

The inquest took place on 25 July 2011. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. A significant amount of further material was collated and various further documents accepted as exhibits after that one day of oral evidence. Submissions were called for and received in relation to the hearing of further oral evidence. I concluded that further oral evidence was unlikely to assist me and asked Counsel Assisting to distribute his submissions. I have considered those submissions and the submissions of the other parties, particularly the very helpful and detailed submissions on behalf of the family of Ms Lalara, in arriving at my findings.

The evidence

Social and medical history

Hazel Marie Lalara was born on 24 February 1964. She lived a traditional life in the Northern Territory prior to her relocation to Brisbane. For cultural reasons, it is the wish of her family that personal details about her and her life not directly related to issues surrounding her cause of death remain private.

Records from Inala Indigenous Health Service show that Ms Lalara had been a patient of that service since 2001. They also show a history of having been involved in a motor vehicle accident in 2003 and, over the following years, being seen in relation to chronic pain, a fatty liver, sciatica, schizophrenia and peripheral neuropathy. Ms Lalara had been referred to a neurologist for the last condition in April 2007 at which time it was nominated as her 'principal complaint'. When she was seen by the service in December 2008, Ms Lalara is said to have appeared in good spirits and with significantly reduced pain levels.

Ms Lalara told the service in 2008 that she had ceased all medication previously prescribed to her for schizophrenia the 'previous year'. She was always pleasant with the service staff and attended her appointments on time. Ms Lalara told the service in 2008 that she was living alone but would receive regular visits from her niece who cooked all meals for her.

Events leading to custody

On 28 December 2008 Ms Lalara was arrested by police after it was alleged she had attacked her neighbour with a knife. It is evident that her motivation for doing so was the sincere but deluded and unfounded belief that the neighbour had raped her daughter and was poisoning her food. There is compelling evidence to show this is incorrect and the distressing thoughts she had been ruminating upon for at least a week were the result of a re-occurrence of psychosis associated with her chronic schizophrenia.

After her arrest Ms Lalara was held at Richlands watch-house and, when medically assessed, she reported hearing multiple voices. On 31 December 2008 she was remanded in custody until 5 January 2009 so that a more detailed psychiatric review could take place with a view to assessing her treatment needs. On 2 January 2009, the clinical director of mental health at The Park, Dr Darren Neillie, personally assessed Ms Lalara. He issued an involuntary treatment order (ITO) after concluding:

> *Ms Lalara has been given a diagnosis of schizophrenia and presents with psychotic symptoms in the form of persecutory delusions and auditory hallucinations. Ms Lalara has not been eating for at least one week as a result of her psychotic symptoms. She requires immediate treatment.*

Ms Lalara was accepted into the high security inpatient service (HSIS) at The Park and transferred there that day. On 5 January 2009, she was remanded in custody to reappear at Richlands Magistrates Court on 6 February 2009.

The family of Ms Lalara were critical of her access to medical care during the first few days of her incarceration at Richlands watch house. It is my view that this period is too far removed from the proximate cause(s) of her death to be caught by my jurisdiction. However, I note that the period in question occurred in the Christmas holiday period when all but essential services tend to be difficult to access. There is no evidence that any delay in the provision of psychiatric services contributed to Ms Lalara's death.

Medical treatment at The Park

Ms Lalara was initially treated by a psychiatrist, Dr Jonathan Mann who saw her on 5, 7, 9 and 13 January 2009. Dr Mann agreed with the existing diagnosis of schizophrenia and continued Ms Lalara on her antipsychotic medication, risperidone. On 13 January 2009, Dr Mann increased the level of resperidone prescribed to Ms Lalara. Despite this she continued to suffer periods of psychosis.

While Dr Mann was on leave, Ms Lalara was treated by the psychiatric registrar, Dr Daniel Dagge. He was supervised by Dr Neillie.

Dr Dagge first reviewed Ms Lalara on 21 January 2009 after nursing staff expressed concern about her levels of agitation, anxiety and insomnia. Dr Dagge found Ms Lalara to be disorganised in her thoughts and preoccupied with delusional beliefs relating to her daughter and other paranoid themes. She described to him auditory hallucinations and high levels of subjective distress. Dr Dagge discussed her peripheral neuropathy with Ms Lalara. She told him her symptoms had been relieved in the past by Amitriptyline and regular marijuana use. Dr Dagge doubled the dosage of Amitriptyline already prescribed but remained concerned with Ms Lalara's unresponsiveness to anti-psychotic medication. After a conference with Dr Neillie on 23 January 2009, Ms Lalara's risperidone prescription was again increased and she was prescribed Diazepam twice a day. Dr Dagge discussed these changes with Dr Mann when he returned from leave on 26 January 2009.

At the request of Dr Neillie, Dr Peter Wheatley, a general medical practitioner, had conducted a physical examination on Ms Lalara on 2 January 2009. He provided a statement to investigating police in which he noted:

> *I was able to ascertain that Hazel Lalara had several medical issues. These included chronic lower back pain with a past history of L5 surgery, peripheral neuropathy in both lower limbs which manifested as chronic pain/hot flushes in the lower limbs and hypothyroidism.*

On physical examination he found Ms Lalara to be dishevelled, mildly dehydrated and with a slow and ‘somewhat wide-based’ gait.

After her arrival at The Park, Ms Lalara was referred to the medical officer in charge of general health services, Dr Melville Court. He saw her on 28 January 2009 at which time Ms Lalara complained of sensory loss in her legs and feet and tightness up to the waist. Dr Court referred Ms Lalara to a neurologist, Dr Peter Mann, who she was able to see later that day.

Dr Peter Mann confirmed a diagnosis of peripheral neuropathy and considered the results of a number of pathology tests. Despite these tests and his examination, no specific cause could be identified for the condition. Dr Peter Mann’s contemporaneous notes state:

> *Sensory symptoms adequately controlled by present dosage of Endep.*

Dr Peter Mann provided a statement in which he said:

> *As the patient's symptoms were adequately controlled by medication, no other therapies were recommended. Further investigation of peripheral neuropathy would have required a significant improvement in the patient's mental state and probable transfer to a public hospital with neurological facilities.*

It is evident from the progress notes in Ms Lalara’s medical records that, at times, the nursing staff found her difficult to manage. I am satisfied, though, that neither this, nor any other factor resulted in a deficiency in the quality of physical or mental health care provided to her. I am grateful to counsel for the family of Ms Lalara for preparing a detailed chronology of her reported symptoms and the medication administered by nursing staff. It is evident from this that, commencing on 21 January 2009 Ms Lalara was given olanzapine, sometimes in combination with either diazepam and/or paracetamol in order to relieve her anxiety. I will comment on the significance of this later in these findings.

Ms Lalara is found deceased

In addition to her two medical appointments on 28 January 2009, records show that Ms Lalara participated in a swimming session. Nursing notes suggest that she participated well in this session although at around 1pm she became somewhat vocal and defiant in her dealings with staff. At 3:50pm Ms Lalara was given 2.5mg of olanzapine for anxiety and received her regular medications at 7:30pm as usual.

At 11pm and again at 11:15pm Ms Lalara used her buzzer to call nursing staff to her room. On the first occasion she needed help adjusting her clothes and on the second she wanted a message passed to another patient to the effect

that the other patient was welcome to access Ms Lalara's fridge. Nursing staff attended to each and, on finding the other patient asleep notified Ms Lalara who seemed content with the situation.

It was the practice in the HSIS ward at The Park for nursing staff to check on patients every 30 minutes unless more regular checks were required. The two male nurses who conducted these rounds between 11:30pm and 3:30am recall seeing Ms Lalara sleeping and noted nothing out of the ordinary.

Tram Tran was assigned to conduct checks on the patients from 4am until the end of her shift at 7am. She told the inquest that she had been trained to conduct these checks in the least intrusive fashion possible while ensuring the patient was safe and breathing. Ms Tran did this by shining a torch through the glass panel on the patient's door onto the ceiling rather than directly onto the patient. It was her experience that patients in the HSIS could become extremely distressed in circumstances where they are unexpectedly woken. She also told the inquest that in her experience it was not uncommon for patients to remain in the same sleeping position over the course of two or three observation periods.

When Ms Tran looked into Ms Lalara's room at 4am, she noticed that Ms Lalara was lying on the side of the bed closest to the observation window and facing the door. Her right leg and foot were hanging over the side of the bed but not touching the floor. She satisfied herself that Ms Lalara was asleep.

At 4:30am, Ms Tran found Ms Lalara lying in the same position. She was able to satisfy herself that Ms Lalara was asleep but did make a mental note to check whether there had been any movement when she next checked the room.

At 5:00am, there had been no change and after observing her for some minutes it became clear that Ms Lalara was not breathing. Ms Tran sought the help of another nurse, Diane Fraser. Ms Fraser could not make an assessment from outside the room. It seems that, like Ms Tran, Ms Fraser placed a great deal of importance on not waking a patient unless there was clear evidence of an emergent need to enter their room. In this case she was sufficiently concerned that she sought help from another nurse, Luis Fernandez. Mr Fernandez opened the door to Ms Lalara's room with a key and then checked for vital signs. He could detect no pulse or any breathing. He and Ms Fraser found Ms Lalara to be extremely cold and noted some rigidity. It was only at this time that a 'code blue' was called.

The acting nursing manager, Stephen Allen, responded to the code blue. He was told by the other nursing staff present that they could find no signs of life and on conducting his own examination it was clear Ms Lalara was not breathing and had no pulse. After this quick initial assessment Mr Allen's immediate reaction was to run to obtain an oxygen cylinder and mask which

he brought back to Ms Lalara's room. On his return he again checked for vital signs and on this occasion noted Ms Lalara was cold to the touch, her pupils were fixed and un-reactive. He formed the view that resuscitation attempts would be futile and discussed this view with the other staff members.

Dr Shannon McCluskey attended at 5:25am and declared Ms Lalara deceased.

Expert evidence and investigation findings

The investigation found no evidence of the involvement of a second person in the death of Ms Lalara. No evidence was found indicating that Ms Lalara was suicidal in the lead up to her death or had taken any steps to end her life. Initial investigations into the possibility she may have gained access to medication held on site at The Park indicated she had not and toxicology results were consistent with the medication she had been prescribed.

Dr Griffiths is a general practitioner employed by the Clinical and Forensic Medicine Unit (CFMU). After considering the police report and relevant medical records he concluded that the decision not to attempt resuscitation of Ms Lalara was a reasonable one. He was, though, critical of the procedures and equipment available at The Park for the response to calls of 'code blue' (medical emergency).

Dr Griffiths later considered a report obtained from Dr Peter Mann and again reviewed the clinical notes relating to Ms Lalara in order to consider whether there were any clinical indicators of 'decompensated heart failure' that ought to have alerted staff. He confirmed that, in his opinion, there were not. He did express some concerns about a possible link between the drug olanzapine and incidence of fatal arrhythmias. I will address this issue in my conclusions.

In his final report Dr Griffiths came to the following conclusion:

> *I do not believe this was a preventable death*.

Professor Olaf Drummer is Head, Department of Forensic Medicine at Monash University. He was asked by counsel assisting to provide a brief opinion on possible links between the drugs detected during the post mortem toxicological analysis and the cause of death. He nominated oxycodone as the only drug likely to have had any significance in the death but noted that if Ms Lalara had been prescribed this drug then it is likely she had built tolerance to it and, in that case, it would have little causal connection to the death. In Ms Lalara's case this drug had been prescribed.

A root cause analysis (RCA) was conducted by Queensland Health into the circumstances surrounding Ms Lalara's death. That analysis did not identify any problems relating to the circumstances in which Ms Lalara was found deceased. It did, though, state:

During the course of the RCA whilst reviewing the documentation and consumer's medical records, it was noted that certain services (clinical/non-clinical) that had contact with the consumer or had provided care and/or treatment to the consumer had not made any documentation within the consumer's medical record.

In particular this appeared to relate to contact Ms Lalara had with ATSI support services and medical rehabilitation services. A recommendation was made in the following terms:

Review the minimal documentation requirements for all services (clinical/nonclinical) who provide service to the consumer at The Park Centre for Mental Health, and update the facility's "Clinical Documentation" procedure ensuring these requirements are clearly stated.

Autopsy results

An autopsy was undertaken on Ms Lalara's body by an experienced forensic pathologist, Dr Alex Olumbe, on the morning of 30 January 2009.

Samples were taken for histological and toxicological examination.

Dr Olumbe found no signs of recent injury. Toxicological results showed the presence of multiple drugs and their metabolites. These could be attributed to the medications Ms Lalara was receiving at the time of her death. Dr Olumbe noted that some of these were at levels above that which would be expected from the ingestion of therapeutic doses. He concluded, though, that in none of these cases was there a link with the cause of death. As noted above, this is a view shared by other doctors who have reviewed the findings.
Dr Olumbe stated:

Autopsy examination showed a significant finding of a dilated heart (possibly dilated cardiomyopathy) which is sufficient to have caused the sudden death.

There was moderately severe pulmonary (lung) emphysema and morbid obesity which could have contributed to her death.

There was no injury or any other natural disease which could have contributed or led to her death.

Dr Olumbe issued an autopsy report on 6 November 2009 in which he recorded the cause of death to be:

1(a). Dilated cardiomyopathy;

Other contributory factors*:*
2. Emphysema, Obesity

Toxicology testing also detected the presence of a metabolite of cannabis. Dr Griffiths noted that only the metabolite of cannabis rather than the active 'parent substance' was present.

Notes taken in preparation for her admission to The Park record that Ms Lalara had been using five cones of cannabis a day prior to her arrest in late December 2008. Dr Griffiths concluded:

> *The presence of the inactive acid carboxy metabolite alone and in the absence of its psycho-active parent, cannot be taken to mean that Ms (Lalara) had been exposed to THC during her last period in hospital and can readily be explained by her previous chronic exposure.*

Conclusions

I conclude the medical care provided to Ms Lalara while a patient at The Park was adequate and appropriate. It is clear she had at times a fractious relationship with nursing staff but there is nothing connecting this to her death; nor is it something that gives rise to a need for further inquiry. I am satisfied the level of care she received was commensurate with that which she might have reasonably expected in the community.

I am not persuaded that there is any discernable link between Ms Lalara's physical symptoms as reported to medical staff at The Park and her ingestion of olanzapine. Symptoms relating to her leg pain as well as references to drowsiness are evident even without corresponding use of this drug. There is nothing on which it could be reasonably concluded that a medical practitioner should have foreseen the likelihood of the markedly dilated heart that led to Ms Lalara's death.

I do not consider Ms Lalara's death was caused by any action or inaction by medical staff at The Park and adopt the opinion of Dr Griffiths that, sadly, this was not a preventable death.

While I readily accept the family's submission that it is always preferable for Indigenous patients to have access to an Indigenous Liaison Officer to maximise the potential for effective communication, I am not persuaded that the absence of such a service contributed to this death. I note Queensland Health are also committed to providing this service whenever possible. I accept their evidence that considerable difficulties have been encountered in recruiting to these positions.

The rare but known link between olanzapine use and fatal arrhythmia has to be balanced against the benefits of the drug. There is no suggestion that dispensing of this medication was in any way inappropriate for a woman of Ms Lalara's medical history and presenting symptoms.

I accept that the decision made by the acting nurse manager, Mr Allen, not to attempt resuscitation was reasonable in the circumstances. Certainly it is evident now that it would have been futile although there of course must be a bias towards making an attempt if there is any doubt at the time. On this occasion there was sufficient evidence to support the decision of Mr Allen.

The family submit I should not find 'heart failure' as a cause of death, correctly pointing out that in almost every case the heart ceases to operate before or at the point of death. I accept that. However, dilated cardiomyopathy is something more: it is a heart muscle disease affecting the left ventricle limiting the ability of the heart to effectively pump blood. It can lead to heart failure in a variety of ways.

Findings required by s45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how she came by her death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings.

Identity of the deceased – The deceased person was Hazel Marie Lalara.

How he died - She died from natural causes while remanded in custody and the subject of an involuntary treatment order in the high security section of The Park Centre for Mental Health.

Place of death – Ms Lalara died at Wacol in Queensland.

Date of death – She died on 29 January 2009.

Cause of death – Ms Lalara died from dilated cardiomyopathy.

Comments and recommendations

Section 46 provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

This inquest raised two issues that warranted consideration from this perspective:

- The manner in which sleeping patients at The Park are monitored; and
- The response to the code blue.

Monitoring of sleeping patients

It is evident that staff conducting night checks at the Park must constantly weigh the competing purposes of first, ensuring a patient is alive and safe; and second, not causing unnecessary distress by unexpectedly waking them. The latter consideration is particularly important given the potentially volatile patient population in the HSIS and the benefit many would receive from uninterrupted sleep. In this case I accept the explanation given by Nurse Tran as to why she did not seek assistance to enter Ms Lalara's room until she had noticed her to be in the same position for over an hour. It was not unreasonable, given her experience with other patients, to consider the fact Ms Lalara had not moved between 4:00am and 4:30am particularly unusual or alarming.

It is evident that the circumstances surrounding Ms Lalara being found deceased have been widely discussed at The Park at all levels. There is no evidence that nursing staff at the Park are giving disproportionate weight to not waking patients over the need to ensure they are alive and safe. In these circumstances I do not consider any recommendation by me is desirable.

Response to code blue

In his initial report Dr Griffiths noted:

> *The code blue protocols required nursing staff to contact security via a landline who then must summon the duty doctor and nurse manager.*
>
> *If this is indeed the procedure currently in place, it seems cumbersome, and in the absence of a dedicated MET (medical emergency team) with full resuscitative equipment on permanent standby, a code blue called to an un-witnessed arrest at this facility would be unlikely to result in a successful outcome.*

In his evidence at the inquest, the clinical director of the HSIS, Dr Darren Neillie, confirmed that the code blue (medical emergency) system relied on a paging system that would prompt medical staff to call a land line telephone. He was otherwise uncertain about other aspects of what kind of response (and with what equipment) a code blue ought to elicit. I agree that for a facility such as this, resuscitation equipment at least equal to that available in other corrective service facilities should be available.

Recommendation 1 – Review of ‘code blue’ procedures

I recommend the clinical director of the HSIS at The Park review the procedures to ‘code blue’ calls to ensure that equipment and procedures are at least the equal of those available to medical staff in other correctional facilities.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
16 May 2013