IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 2188

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, JACQUI HAWKINS, Coroner having investigated the death of Waisele Qalubau

without holding an inquest:
find that the identity of the deceased was Waisele Qalubau
born on 28 September 1977
and the death occurred on 11 May 2017
at Sunshine Hospital, 176 Furlong Road, St Albans, Victoria, 3021
from:

1 (a) COMPLICATIONS OF LARGE BOWEL PSUEDO-OBSTRUCTION

1. Waisele Qalubau was 39 years old at the time of his death. He lived in St Albans, and was a labourer. Mr Qalubau was born in Fiji and migrated to Australia when he was 11 years old. He was married to his second wife, Saravina Qalubau, and was the father of a daughter from a previous relationship.
2. Mr Qalubau had a history of substance abuse, including cannabis, methamphetamine and heroin.
3. He had a medical history of Hepatitis B and Hepatitis C, hepatic cirrhosis (Child Pugh B), and splenomegaly. Mr Qalubau also had a medical history of long standing, relapsing schizo-affective illness that first became apparent in 1997, which required multiple inpatient admissions to hospital. Between 2000 and 2017, Mr Qalubau was admitted to the Sunshine

Adult Acute Psychiatry Unit (SAAPU), 19 times with a pattern of acute psychotic symptoms in the context of poor compliance with treatment and the use of illicit substances.

4. In 2010, Mr Qalubau's numerous admissions triggered the decision to commence him on clozapine. Clozapine can produce significant cardiological and haematological effects, and is reserved for treatment resistant illness. Accordingly, Mr Qalubau's mental and physical state was monitored closely as an outpatient.

5. The frequency of Mr Qalubau's admissions diminished in 2011, which arose out of continuing treatment with clozapine and a reported reduction, and then cessation, of illicit substances.

6. From 2014, Mr Qalubau's treatment with clozapine was complicated by neutropenia and thrombocytopaenia, which were likely caused by the development of splenomegaly.

7. Mr Qalubau's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008.*

8. At the time of his death, Mr Qalubau was 'in care' pursuant to section 3 of the Coroners Act. A coroner must hold an inquest if the deceased was, immediately before death, a person placed in care, in accordance with section 52(2)(b) of the Coroners Act. Pursuant to section 52(3A) of the Coroners Act, I am not required to hold an inquest in these circumstances, if I consider that the death was due to 'natural causes'.

9. In accordance with section 52(3B) of the Coroners Act, a death may be considered to be due to 'natural causes' if the coroner has received a report from a medical investigator, in accordance with the rules, that includes an opinion that the death was due to 'natural causes'. I have received such a report in this case. Therefore, I make my findings with respect to the circumstances and exercise my discretion not to hold a public hearing through an inquest.

10. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame, or determine criminal or civil liability [1].

[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

11. I conducted an investigation that included obtaining Mr Qalubau's medical records and a number of statements from his treating clinicians.

12. In writing this Finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

Identity

13. Mr Qalubau was visually identified by his mother, Lamba Makalesi Qalubau, on 11 May 2017. Identity was not in issue and required no further investigation.

Medical cause of death

14. On 15 May 2017, Dr Gregory Young, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an autopsy on the body of Mr Qalubau and reviewed the Form 83 Victoria Police Report of Death, medical notes from Sunshine Hospital, and the post mortem computed tomography (CT) scan.

15. The autopsy showed a large bowel pseudo-obstruction secondary to faecal loading in the rectum. Ischaemic changes were seen throughout the large bowel. There was no evidence of mesenteric arterial thrombosis, tumour, or abdominal adhesions. Patchy changes of bronchopneumonia were observed in the lungs. Cirrhosis and chronic hepatitis were confirmed in the liver. The spleen was enlarged, likely due to hepatic cirrhosis.

16. In the absence of other factors, the bowel obstruction was likely to have been caused by constipation.

17. Toxicological analysis of ante mortem blood detected the presence of chlorpromazine, clozapine, haloperidol, olanzapine, and promethazine.

18. Dr Young provided an opinion that the medical cause of death was 1(a) COMPLICATIONS OF LARGE BOWEL PSUEDO-OBSTRUCTION.

19. On the basis of the information available at the time of completing his report, Dr Young was of the opinion that Mr Qalubau's death was due to natural causes.

Circumstances in which the death occurred

20. In June 2016, Mr Qalubau's mental state had improved to the extent that he and his wife decided to gradually wean him off clozapine.

21. In August 2016, Mr Qalubau informed his treating clinicians at the Harvester Clinic, where he was treated as an outpatient, that he had reduced his dose of clozapine to 25mg daily. He

evinced an intention to withdraw from clozapine because he was asymptomatic, and it was causing morning drowsiness that affected his ability to drive safely.

22. In December 2016, Mr Qalubau relapsed and was admitted to Sunshine Adult Acute Psychiatry Unit (SAAPU) experiencing florid psychotic symptoms. In light of his previous success with clozapine, he was placed on a 75mg dose, however this treatment was complicated by the recurrence of a persistent neutropenia. It is likely that had Mr Qalubau continued with this medication, he would have become severely immunocompromised and vulnerable to developing a fatal sepsis. Accordingly, Mr Qalubau's clozapine was tapered off, and he was trialled on risperidone.

23. In early January 2017, Mr Qalubau presented as a voluntary patient to SAAPU with severe psychotic symptoms. During this admission, his mental state deteriorated considerably with irritability and aggressive behaviour. He suffered from auditory hallucinations that commanded him to harm others, which he found extremely distressing. He also experienced delusional thoughts and held a belief that he was on a divine mission and was in command of active Fijian military forces.

24. On 1 February 2017, Mr Qalubau's legal status was changed to that of an involuntary patient because of his rebound psychosis. It became necessary to care for him in a seclusion room due his aggressive and violent behaviour that was directed towards staff members with whom he had previously had a positive relationship.

25. Dr David Fenn, Consultant Psychiatrist, and Director of Clinical Services for Mid West Area Mental Health Service, became involved in reviewing Mr Qalubau's treatment protocol. Mr Qalubau was well known to Dr Fenn because he had coincidentally treated him between 2000 and 2007 when he was employed by SAAPU. In his capacity as the Director of Clinical Services, he had also been involved in a number of discussions with other psychiatrists regarding Mr Qalubau's complicated psychiatric presentations. In light of the complexities involved in Mr Qalubau's care, his treating team presented his case in formal peer review meetings at Sunshine Hospital, which Dr Fenn attended. Dr Fenn's opinion was sought regarding the likely benefit and safety of a course of ECT for Mr Qalubau. He supported an early application to the Mental Health Tribunal for a course of ECT.

26. The Mental Health Tribunal authorised a Treatment Order comprising a course of ECT on 2 February 2017. It was noted at the time that Mr Qalubau had an elevated creatine kinase level raising the possibility of a neuroleptic malignant syndrome, and a persistent neutropenia.

37. Later that evening, the surgical registrar reviewed Mr Qalubau and attempted a manual rectal dis-impaction. A fleet enema and an olive oil enema were also prescribed.

38. Shortly after midnight on 10 May 2017, Mr Qalubau began to vomit faecal matter, and collapsed. A 'Code Blue' was initiated and a Medical Emergency Team activation occurred, which resulted in the rapid transfer to the Emergency Department. Upon arrival, he was hypotensive with blood pressure of 80/60 and was profoundly hypoxic despite oxygen therapy. He had a reduced consciousness state with a Glasgow Coma Scale of 7. His faeculent vomiting continued. Ausculation revealed poor air entry to his chest, and an examination of his abdomen revealed a distended, firm and tender abdomen, with absent bowel sounds.

39. Mr Qalubau's low blood pressure was treated with intravenous fluid and vasopressors. In light of Mr Qalubau's severe hypoxia and reduced consciousness, he underwent rapid uncomplicated intubation, which confirmed gross aspiration of vomitus in his trachea. He was maintained with ongoing sedation and mechanical ventilation to maintain his oxygen saturations at a suitable level.

40. Blood tests revealed acute renal failure, severe lactic acidosis with failed respiratory compensation, and a marked coagulopathy. Mr Qalubau's aspiration and possible intraabdominal sepsis were treated with broad spectrum antibiotics.

41. A CT scan of the abdomen initially failed to detect an acute cause for his deterioration beyond a possible bowel obstruction in the form of severe rectosigmoid faecal impaction. Those findings were reviewed by the medical and surgical registrars, who had been present during the resuscitation. Mr Qalubau appeared to be suffering from several conditions in the form of an acute bowel obstruction that had caused aspiration pneumonia, and subsequent adult respiratory distress syndrome. He was transferred to the Intensive Care Unit for ongoing care.

42. At about 6am, Mr Qalubau was seen by Dr Ingra Bringman, General Surgeon. She introduced a rectal cannula to relieve his faecal loading, but it did not have any effect.

43. At 10am, the gastroenterology team performed a decompression colonoscopy, but due to faecal soiling, this was unsuccessful. Mr Qalubau continued to deteriorate and since an abdominal compartment syndrome could not be excluded and his inotrope requirements were continuing to increase, the decision was made to proceed with a laparotomy.

44. The laparotomy occurred at 12.30pm. Surgeons found a very distended and near ischaemic colon. Due to Mr Qalubau's cardiovascular deterioration, and in consultation with the intensivist consultant, the surgeon, and the anaesthetist consultant, the procedure was aborted

as his condition was deemed to be fatal. Mr Qalubau's colon was decompressed and the enterosomy was secured with a suture. Upon placing Mr Qalubau's bowel back into his abdominal cavity, his colon burst open. To control the leakage, the abdomen was dressed, and Mr Qalubau's family were invited to see him before he passed away.

45. In consultation with his family, palliative pain relief was continued until Mr Qalubau deteriorated further and was pronounced deceased.

46. Having considered all of the circumstances, I am satisfied that Mr Qalubau's medical care and management was reasonable and appropriate.

Findings

47. Having considered the evidence I am satisfied that no further investigation is required.

48. Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

49. I find that:

    a. the identity of the deceased was Waisele Qalubau born 28 September 1977; and

    b. Mr Qalubau died on 11 May 2017 from 1(a) *Complications of large bowel pseudo-obstruction*;

    c. in the circumstances described above.

50. I am satisfied that Mr Qalubau's death was due to natural causes.

51. Pursuant to section 73(1B) of the Coroners Act, this finding must be published on the internet.

52. I wish to express my sincere condolences to Mr Qalubau's family. I acknowledge the grief and devastation that you have endured as a result of your loss.

I direct that a copy of this finding be provided to the following:

The family of Mr Qalubau;

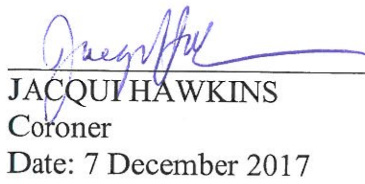
Dr Neil Coventry, Office of the Chief Psychiatrist;

Mr Peter Kelly, North Western Mental Health;

Ms Nicola Caras, Western Health; and

Information recipients.

Signature:



JACQUI HAWKINS
Coroner
Date: 7 December 2017