IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 002131

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

Inquest into the Death of Allison Naomi Eagle

Delivered On:	19 April 2024
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank VIC 3006
Hearing Dates:	19 April 2024
Findings of:	Coroner Paul Lawrie
Representation:	Mr Jeremy Smith, Meridian Lawyers for Barwon Health
Counsel Assisting the Coroner:	Ms Ann Kho, Coroner's Solicitor
Keywords	In care, anti-psychotic medications, sudden cardiac arrythmias, obstructive sleep apnoea

I, Coroner Paul Lawrie, having investigated the death of ALLISON NAOMI EAGLE, and having held an inquest in relation to this death on 19 April 2024 at Southbank,

find that the identity of the deceased was ALLISON NAOMI EAGLE born on 5 August 1976, aged 44 years, and the death occurred on 26 April 2021 at Barwon Health, University Hospital, 272-322 Ryrie Street, Geelong, Victoria, 3220

from:

1 (a): UNASCERTAINED

INTRODUCTION

1. On 26 April 2021, Allison Naomi Eagle was 44 years old when she died at the Swanston Centre, a psychiatric inpatient unit at the University Hospital in Geelong, Victoria. At the time of her death, Ms Eagle lived alone at 1/34 The Court, Leopold, Victoria.

THE CORONIAL INVESTIGATION

2. Ms Eagle's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. Detective Senior Constable (**DSC**) Brett Hampson initially acted as the Coroner's Investigator for the investigation of Ms Eagle's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – including Ms Eagle's father, the Chief Medical Officer of Barwon Health, Ambulance Victoria paramedics and investigating officers – and submitted a coronial brief of evidence.

6. At the time of her death, Ms Eagle was subject to an Inpatient Treatment Order[1] pursuant to section 58 of the *Mental Health Act 2014*. Accordingly, she was a person who was "in care" for the purposes of the *Coroners Act* and an inquest into Ms Eagle's death is mandatory[2] unless I consider the death was due to natural causes.[3] I have concluded however, as a preliminary matter, that there is insufficient evidence upon which to find that Ms Eagle's death was due to natural causes, and so an inquest is mandatory.

7. The inquest itself proceeded in a manner that has become known as a "summary inquest". That is, where the material contained in the coronial brief has been accepted and the circumstances of the case do not otherwise require the hearing of oral evidence.

8. This finding draws on the totality of the coronial investigation into the death of Ms Eagle including the evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[4]

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[1] On 16/03/2021, the Mental Health Tribunal made a Community Treatment Order in respect of Ms Eagle that was to last until 13/09/2021 [Exhibit 1 - Barwon Health Records at p.1327]. This order was varied to an Inpatient Treatment Order by Dr Kandalama at 3.42pm on 16/03/2021 [Exhibit 1 - Barwon Health records at p.1324].

[2] *Coroners Act 1958* – s.52(2)(b)

[3] *Coroners Act 1958* – s.52(3A)

[4] 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.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

9. Ms Eagle was diagnosed with schizophrenia and bipolar affective disorder. She had substantial contact with Barwon Health in relation to her mental health from 2013 onwards. This included periods where Ms Eagle received involuntary mental health treatment as an inpatient. Ms Eagle had been admitted to the Swanston Centre on several occasions throughout her life.

10. Ms Eagle was admitted to the Swanston Centre on three occasions in 2021. The first of these admissions occurred between 28 January 2021 and 11 February 2021, after Ms Eagle suffered a relapse of her mental health conditions in the setting of medication non-compliance and the gradual loss of her community supports. During this admission her risperidone was ceased, and she was recommenced on aripiprazole, with a plan to titrate this medication upwards and consider depot injection if she was non-compliant with the medication.

11. Ms Eagle was re-admitted to the Swanston Centre between 18 February 2021 and 9 March 2021 after suffering a psychotic relapse in the setting of non-compliance with her medications. She was commenced on zuclopenthixol deconoate by depot injection. During this admission it was noted that she experienced loud snoring and had lowered blood oxygen levels (desaturation). As a result, she was referred to an outpatient respiratory clinic on 26 February 2021.

12. Ms Eagle's final admission to the Swanston Centre commenced on 17 March 2021 after she experienced an overall decline in her mental state. Her dosage of zuclopenthixol deconoate was increased and she was commenced on sodium valproate.

13. On 27 March 2021, Ms Eagle experienced an episode of breathing difficulty after being sedated with intramuscular ziprasidone and lorazepam. A clinician reviewed this incident and advised that care needed to be taken with the use of benzodiazepines for Ms Eagle, and she should avoid lying flat. More frequent observations were undertaken. Desaturation and

obstructive sleep apnoea were reported on Ms Eagle's handover sheet for the following few days.

14. On 28 March 2021, Ms Eagle's oxygen saturation levels were noted to fluctuate between 85% and 100%. She was encouraged to avoid sleeping on her back and regular observations were conducted.

15. On 29 March 2021, Ms Eagle's referral to the outpatient respiratory clinic was rejected, as there was no sleep clinic available at Barwon Health. Ms Eagle was advised she required a referral to a private sleep physician.

16. On 2 April 2021, Barwon Health staff noted that Ms Eagle experienced periods of loud snoring and would stop breathing for periods during sleep. It was suspected that she had obstructive sleep apnoea and a physical examination was conducted the following day. Treating clinicians discussed the potential benefits of a Continuous Positive Breathing Pressure (**CPAP**) machine with Ms Eagle, but she declined use of the device.

17. On 21 April 2021, treating clinicians contacted a respiratory specialist regarding Ms Eagle's presumed obstructive sleep apnoea, as Ms Eagle was now open to using a CPAP machine. It was noted that the specialist was booked out until late May 2021, and a referral was faxed to Ms Eagle's GP to be actioned after Ms Eagle was discharged. The social work department were notified and they commenced planning to access funding so that Ms Eagle could have a CPAP machine following her discharge, if prescribed.

18. On 24 April 2021, Ms Eagle left the Swanston Centre with her sister for a period of approved leave. When Ms Eagle returned to the Swanston Centre later that day, she reported that the leave had gone well and she was happy to have gone out. She had another period of approved leave the following day with her family, to attend a church service and have lunch. Ms Eagle again reported that this went well, and she was looking forward to being discharged on 26 April 2021.

19. On 25 April 2021, at 6.45pm, Ms Eagle had a verbal altercation with another patient with whom she was sharing a room. At 6.50pm she was given lorazepam (2mg) and olanzapine

(10mg) orally and a bed swap was arranged to assist Ms Eagle and the other patient to feel safe with their sleeping arrangements.

20. At 10.40pm, Ms Eagle requested further medication as she was experiencing sleeplessness. She was given lorazepam (1mg) and olanzapine (5mg).

21. Notes taken by nursing staff over the course of the night indicate that Ms Eagle went to sleep after receiving this medication but woke at 1.00am and requested water. She then settled back to sleep and appeared to be asleep during the remainder of her overnight checks.

22. Ms Eagle was due to be discharged from the Swanston Centre on Monday 26 April 2021. Observation notes in Ms Eagle's medical records indicate that she was observed several times throughout the night and appeared to be asleep. The last observation was recorded at 7.30am.

23. At approximately 8.15am, Ms Eagle was found unresponsive in her room by a registered nurse. A code blue was called, and cardio-pulmonary resuscitation (**CPR**) was commenced. Additional medical staff attended and assisted with efforts to resuscitate Ms Eagle. Despite best efforts, she was unable to be revived. Ambulance Victoria paramedics attended at 8.45am and verified that Ms Eagle was deceased.

24. Victoria Police also attended and examined the scene as part of a wider investigation. They identified no suspicious circumstances associated with the death of Ms Eagle.

Identity of the deceased

25. On 26 April 2021, Allison Naomi Eagle, born 5 August 1976, was visually identified by her sister.

26. Identity is not in dispute and requires no further investigation.

Medical cause of death

27. Forensic Pathologist, Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 30 April 2021 and provided a written report of his findings dated 6 August 2021.

28. The post-mortem examination revealed Ms Eagle's heart to be of normal weight with no coronary artery atherosclerosis or other coronary artery pathology. There were several small foci of epicardial fat infiltration and mild fibrosis but no myonecrosis to particularly suggest arrhythmogenic cardiomyopathy. No other microscopic abnormalities of the heart were identified that may have caused sudden death.

29. Dr Beer noted that Ms Eagle fell within the World Health Organisation definition of Class II obesity and had a history of obstructive sleep apnoea. He also noted that these features may be associated with sudden death, typically via a cardiomegaly mechanism.

30. Dr Beer identified no other significant natural disease that may have caused sudden death. Further, there were no injuries found at autopsy that may have caused or contributed to Ms Eagle's death.

31. Dr Beer noted that vitreous biochemistry was unremarkable, and notably showed no evidence of hyperglycaemia.

32. Toxicological analysis of post-mortem samples identified the presence of valproic acid, zuclopenthixol, olanzapine, chlorpromazine and lorazepam. The levels of chlorpromazine, olanzapine and zuclopenthixol were noted to be within therapeutic ranges. The concentrations of valproate and lorazepam were noted to be at non-toxic levels.

33. Dr Beer also noted that chlorpromazine is an antipsychotic drug with a known risk of prolonging the QT interval[5] and a risk of torsades de pointes[6] even at recommended doses. Dr Beer also observed that olanzapine and zuclopenthixol are other antipsychotic drugs with a risk of QT interval prolongation and a risk of torsades de pointes at excess doses – both were within therapeutic ranges.

34. Dr Beer explained that, while an acquired prolonged QT interval from the antipsychotic medication should be considered, it could not be proven. He also noted that schizophrenia carries an increased risk of sudden death due to apparent prolongation of the QT interval.

35. Dr Beer stated that the history and autopsy findings are suggestive of a sudden cardiac death and noted that other causes for sudden death in a young individual with a negative autopsy include epilepsy, metabolic disorders, and rapid onset of sepsis, all of which appear unlikely in this setting.

36. Dr Beer provided an opinion that the medical cause of death was 1 (a) UNASCERTAINED.

37. I accept Dr Beer's opinion.

FAMILY CONCERNS

38. Ms Eagle's father and sister-in-law raised concerns during the investigation regarding the treatment provided to Ms Eagle by Barwon Health. Whilst not all of the concerns they raised fall within the scope of this coronial investigation, I considered their concerns as part of the investigation.

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5 In an ECG, the QT interval is the time taken from the beginning of the Q wave to the end of the T wave. This represents the time taken for ventricular depolarisation and repolarisation. The QT interval shortens at faster heart rates and lengthens at slower heart rates. A prolonged QT interval is associated with an increased risk of ventricular arrythmias (such as Torsades de Pointes), whilst congenital short QT syndrome is associated with increased risk of atrial and ventricular fibrillation. Both can lead to sudden cardiac death. Episodes may be provoked by various stimuli, depending on the subtype of the condition.

6 A type of abnormal heart rhythm characterised by ventricular tachycardia.

FURTHER INVESTIGATIONS

Coroners Prevention Unit review

39. Given the concerns outlined by Ms Eagle's family, I referred this matter to the Coroners Prevention Unit Health and Medical Investigations Team (**CPU**)[7] for review.

40. The CPU considered Ms Eagle's medical treatment, including the medications that were administered to her. They opined that the PRN[8] medications provided to Ms Eagle were reasonable, well within acceptable limits, and difficult to directly attribute as a cause of death. Significantly, they noted that Ms Eagle was awake and asking for water just over two hours after her last dose of lorazepam. This circumstance is consistent with a conclusion that the dosages were appropriate.

41. The CPU also noted that Ms Eagle underwent an electrocardiogram (**ECG**) on 24 February 2021 which did not reveal any evidence of a QT prolongation.

42. The CPU agreed with Dr Beer that it was possible that Ms Eagle suffered a fatal arrythmia, and it was possible that her antipsychotic medications increased the risk of this occurring. However, they noted that the medications administered to Ms Eagle were reasonable for her condition, and this may be a rare, but recognised adverse effect of such medications.

43. The CPU found no opportunities for prevention and made no further recommendations.

44. I accept the opinion of the CPU.

Barwon Health clinical review

45. Barwon Health conducted a clinical review following the death of Ms Eagle. A copy of the review report was provided to the court. The review concluded that the sedatives provided to Ms Eagle were consistent with regular practice and noted that she had previously

[7] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[8] 'Pro re nata' – medication to be taken as needed.

received the same drugs in the same doses without issue. The review found the decision to administer the medications was in line with Ms Eagle's PRN medication order, commensurate with her presentation at the time, and administered in line with Barwon Health medication administration procedures.

46. The review did note that a medical review, as required by the Barwon Health "Management of Acutely Disturbed Patients – MHDAS and ED Only" procedure, was not undertaken and formalisation of a medication plan did not occur. However, it was not possible to determine if this would have changed the clinical management of Ms Eagle or the outcome.

47. The review highlighted the need to strengthen a number of Barwon Health processes, including:

    a) more regular review of PRN sedative medications, clarity of the difference between acute sedation and ongoing PRN medications, and guidelines surrounding medication dose escalation (including depots);

    b) the need for a clear policy surrounding routine ECGs for consumers on psychotropic medications and guidelines on appropriate use of investigations in inpatient units;

    c) nursing observations overnight and after sedation were not outlined in procedures;

    d) the medical handover process in the Swanston Centre was not articulated;

    e) documentation of non-medical strategies employed to reduce agitation should be improved, and

    f) the way nursing visual observations are to be undertaken was not articulated in the procedure.

48. The review noted that the procedure for night-time observations has been updated to require:

Night-time observations, or observations to consumers who are sleeping require close observation and recording to confirm breathing via usual observation of chest rise and fall, audible breathing and movement in bed. Where this cannot be confirmed the consumer will require rousing and vital signs if unarousable.

FINDINGS AND CONCLUSION

49. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the overlay of caution required by *Briginshaw v Briginshaw*.[9] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

50. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    g) the identity of the deceased was Allison Naomi Eagle, born 5 August 1976;

    h) the death occurred on 26 April 2021 at Barwon Health, University Hospital, 272-322 Ryrie Street, Geelong, Victoria, 3220, from unascertained causes; and

    i) the death occurred in the circumstances described above.

51. Despite an exhaustive post-mortem examination and biochemistry and toxicological investigations, I am unable to determine the exact cause of Ms Eagle's death. I cannot say with sufficient certainty whether the medications administered to Ms Eagle contributed to her death.

[9] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

52. Having considered all the evidence, I am satisfied that there are no suspicious circumstances associated with Ms Eagle's death. I am also satisfied that Ms Eagle was provided with appropriate medications at dosages that were within accepted clinical ranges.

53. I am satisfied that Barwon Health has appropriately reviewed the care provided to Ms Eagle in the lead up to her death. Whilst the issues identified in the Barwon Health review are not causative, the consequent recommendations are properly directed toward the improvement of clinical practices. I am also satisfied that appropriate steps have been taken to address the issues identified in the review.

I convey my sincere condolences to Ms Eagle's family for their loss.

PUBLICATION

Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

DISTRIBUTION

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

Daryl Eagle, Senior Next of Kin

Barwon Health, c/o Kellie Dell'Oro, Meridian Lawyers and Lorraine Judd

Senior Constable Georgia Fraser, Coroner's Investigator

Signature:

Coroner Paul Lawrie

Date: 19 April 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.