



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 28th, 29th and 30th days of January 2009 and the 16th day of December 2009, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Dulcie Janet Mary Penn.

The said Court finds that Dulcie Janet Mary Penn aged 83 years, late of Hill Community Options, 48 Main North Road, Nairne, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 3rd day of July 2007 as a result of congestive cardiac failure due to ischaemic and valvular heart disease. The said Court finds that the circumstances of her death were as follows:

1. Introduction and background

- 1.1. The deceased, Dulcie Penn, was 83 years of age when she died in the Royal Adelaide Hospital (RAH) on Tuesday 3 July 2007. Ms Penn had an intellectual disability having been born with Down Syndrome.
- 1.2. Ms Penn had been cared for in accommodation that was operated by the Hills Community Options Incorporated (HCO). The primary role of this non-profit organisation is to assist people with intellectual disabilities to live within the community. To this end HCO provides accommodation support. It has a number of residential houses and units in which the clients of the organisation are cared for by disability support workers employed by the organisation.
- 1.3. One of the houses that provided this accommodation was situated at 48 North Road, Nairne. There was another such house situated at 48A North Road, Nairne. Dulcie Penn occupied number 48 with another intellectually disabled woman by the name of

Susan Penna. Susan Penna was approximately 46 years of age at the time with which this inquest is concerned. The similarity between the two women's surnames is obvious. Number 48A was occupied by two other persons.

- 1.4. Dulcie Penn and Susan Penna occupied their own rooms within the house. A support worker would be in attendance at the house at all times, even at night. The support worker would sleep in another room that was also devoted to administration. The support worker's role was to care for the residents of the premises and this would include feeding them and attending to their personal needs. It also included the administration of medication to the residents. At the time with which this Inquest is concerned both Dulcie Penn and Susan Penna required daily administration of medication in not insignificant quantities and at different times of the day.
- 1.5. Dulcie Penn suffered from a number of comorbidities that included a heart condition for which she was prescribed Digoxin. This medication, which was consumed by her in tablet form, was taken daily at 8am. At the same time, she was administered 5 other different types of medication that do not need to be described here. This meant that at 8am every morning Dulcie Penn was administered 6 different medications consisting of 6 different tablets. She was also administered some medication daily at 6pm.
- 1.6. Susan Penna required regular medication that had been prescribed for schizophrenia, epilepsy, agitation and the side effects created by some of those medications. Susan Penna was administered her daily medication at 7am, lunchtime and at 8pm. The 7am administration consisted of the following medication:

Medication	Dose	Reason for Use	Date
Clozapine (Clozaril)	125mg (2 tablets)	Anti-psychotic	
Risperidone (Risperdal)	2mg (1 tablet)	Schizophrenia	
Sodium Valproate 500mg (Valpro)	500mg (1 tablet) 200mg (1 tablet)	Epilepsy	23/12/04
Lamotrigine 50mg	75mg (1½ tablets) 75mg (1½ tablets)	Epilepsy	19/11/04
Neulactil 2.5mg	2.5mg (1 tablet)	Agitation	11/04/05
Benzotropine 2mg	2mg (1 tablet)	Dystonia	25/09/06

It will be seen from this table that Susan Penna's medication consisted of 6 separate medications but in 7 tablets, there being 2 tablets of Clozapine together amounting to 125mg. Much of the medication that Susan Penna was regularly administered had a

sedating effect. There was no commonality as between Dulcie Penn's medication and that of Susan Penna.

1.7. In circumstances that I will discuss in the course of these findings, on the morning of Sunday 1 July 2007 Dulcie Penn was given and consumed the morning medication intended for Susan Penna. To compound the issue, Dulcie Penn did not receive her own medication that morning. The error was detected quite quickly and Ms Penn was conveyed by ambulance that morning to the RAH. It is clear that within a short space of time after Ms Penn's arrival at the RAH she physically deteriorated to a significant degree. For present purposes I do not need to recount all of the details of her admission, but by the evening of Tuesday 3 July 2007 Ms Penn was very ill and a decision was made by Intensive Care Unit medical staff and Ms Penn's next-of-kin that if and when Ms Penn suffered a cardiac arrest she was not to be resuscitated. This decision was taken in the light of her current presentation, her intellectual disability, her dementia and her large number of comorbidities. There is no suggestion that this decision was inappropriately taken. She declined as expected and was declared life extinct at 7:25pm on 3 July.

1.8. A post-mortem examination of Ms Penn was conducted by Dr John Gilbert, a Forensic Pathologist at Forensic Science South Australia. Dr Gilbert prepared a report following the post-mortem examination¹. In addition, he gave evidence at the Inquest. In his report Dr Gilbert expresses the cause of Ms Penn's death as:

'Congestive cardiac failure due to ischaemic and valvular heart disease.
Probable contributing factor: hypotension resulting from mixed drug toxicity.'

In his evidence Dr Gilbert also offered the same opinion. It will be noted in the recitation of that cause of death that Dr Gilbert is of the professional opinion that the mixed drug toxicity that was the product of Dulcie Penn receiving the wrong medication on the morning of 1 July 2007 was in and of itself a probable contributing factor in Ms Penn's physical deterioration and eventual demise on the evening of 3 July 2007. This was an issue that was the subject of some debate in the course of the Inquest and I deal with that in these findings.

¹ Exhibit C7

2. **Procedures for the administration of medication at HCO**

- 2.1. Ms Aileen Dawson is the Chief Executive Officer of HCO. She provided a statement to the Inquest² and she gave evidence. Among other things, Ms Dawson outlined the training that was in place with respect to support workers and, in particular, that which related to the administration of medication. As part of that training HCO heavily stressed the need to constantly cross check the contents of a resident's medication list with the resident's medication. The support workers who were involved in Dulcie Penn's care had been trained in relation to the same.
- 2.2. I heard evidence as to the procedural requirements for the giving of medication as they existed in July 2007. The house occupied by Dulcie Penn and Susan Penna had a room that was used for administration as well as accommodating the overnight support worker. In that room there was a locked cupboard in which the medication of the residents of the house was contained. I saw a video that was taken by police on the evening of 3 July 2007 and which depicted the circumstances in which the medication was stored as on 1 July 2007³. I add here that at one point during the course of the evidence some uncertainty was expressed about whether or not the video depicted the circumstances in which the medication was stored as at 1 July 2007, but I am satisfied that it did. In particular the labelling of the medication trays that are shown in the video was, I find, in accordance with that on 1 July 2007. The medication for each resident of the premises was contained in an individual tray that was stored on a shelf within the locked cupboard. As of 1 July 2007 the individual trays, in this case being two in number, were stored side by side. At that time they did not have a lid, but they bore a label that showed the christian and surnames of the residents. Medication was contained in the tray. The medication for both Dulcie Penn and Susan Penna that was administered on a daily basis, as opposed to PRN medication that was administered on an 'as required' basis, was contained in dosettes, otherwise known as blister packs. These packs were assembled by a pharmacist. They contained one week's medication. The dosettes for Dulcie Penn and Susan Penna were virtually identical in appearance. However, they clearly bore the christian and surnames of each of them. The consumer's name was depicted on the front of the dosette. The dosette contained the medication for the 7 individual days of the week. The days were labelled accordingly. In addition each day contained, in individual

² Exhibit C19

blisters, the medication that was to be administered at breakfast time, lunch time, dinner time or bed time as the case may be. In Dulcie Penn's case, the dosette had individual blisters for the daily administration of medication at 'B'FAST' and 'DINNER'. The medication in her case was administered at 8am and 6pm respectively. After the day's medication had been totally administered, the strip on the dosette that related to that particular day was torn off. In the case of Susan Penna's blister pack, her dosette was arranged in terms of 'B'FAST', 'LUNCH' and 'B'TIME'. The breakfast dosage was administered at 7am in Susan Penna's case. On the reverse side of the blister pack, and listed individually in respect of each day's administration, was a typed list of the individual tablets that were to be administered and which were contained in the relevant blisters. In the case of Dulcie Penn there were 6 such medications listed, each one typed in capital letters together with the quantity in milligrams of each medication plus the number of tablets. In the case of Susan Penna, 7 tablets were listed, it being the case that there were 2 tablets of Clozapine (otherwise known as Clozaril) administered at the same time.

- 2.3. Also housed within the same room were the medication folders for each individual resident. Dulcie Penn's medication folder was tendered to the Inquest⁴. Susan Penna's medication folder was also tendered⁵. The medication folder in each case was labelled on the front cover with the christian and surname of the resident. Immediately inside the front cover was a photograph of the resident together with, again, the christian and surname of the resident in large, bold capital letters. The folder in each case contained, among other things, the resident's information sheet. As well, the folder contained the resident's medication list (or sheet) that was updated whenever the medication was altered in accordance with a medical practitioner's prescription. The medication list was typed and clearly bore the christian name and surname of the resident in bold capitals. The medication list detailed the medication that was contained in the resident's blister pack, and as well, it set out the times of their administration. In Dulcie Penn's case it listed 10 medications that were to be administered daily. It can easily be deduced from the list that 6 of those medications were to be administered at 8am as we have seen. In Susan Penna's case the medication list detailed 6 medications all of which were to be administered at 7am. Some of them were also to be administered at lunch time and in the evening. It is of

³ Exhibit C4b

⁴ Exhibit C9

note that there was not one commonly administered medication as between Dulcie Penn and Susan Penna.

- 2.4. Also contained within the medication folder was a medication administration record that was marked off into individual days of the month. There was provision for the support workers to signify by way of their initials the administration of the daily medication in respect of each resident and in respect of each administration, be it that of the morning or the evening as the case may be. There was no provision for the recording of the administration of each individual tablet. Rather, what was recorded on each occasion was the administration of the totality of the tablets.
- 2.5. It was acknowledged by all during the course of the Inquest that there was an expectation that support workers would, in the course of each medication administration to a resident, cross check the medication set out on the medication list with the medication listed on the reverse side of the blister pack. The lists should correspond and, in the cases of Dulcie Penn and Susan Penna, indeed they did.
- 2.6. The support workers were naturally meant to ensure that the name of the resident on the blister pack corresponded with the identity of the resident to whom it was going to be administered. If the required cross check between the medication as listed on the resident's medication list and the medication as listed on the back of the blister pack was routinely made, it would ensure that there was absolutely no margin for error as far as the incorrect administration of medication was concerned. In recognition of this, a culture of checking and cross checking was instilled as part of a support worker's training.
- 2.7. At the time with which this Inquest was concerned there was in existence an HCO operating procedure relating to the role of disability support workers in medication handling and administration⁶. The document clearly stated that the role of the disability support worker involved much more than simply handing out medication⁷. It involved ensuring safe administration of medication which included proper identification of the client requiring that medication, a check of the client's medication sheet and a check of the print out on the back of the blister pack with that

⁵ Exhibit C13

⁶ Exhibit C18 tendered through Ms Aileen Dawson

⁷ Exhibit C18, paragraph 2.1

medication sheet⁸. The document also stipulated the very obvious requirement that prior to dispensing the medication, the disability support worker had to check the name label before removing the blister pack from the medication cupboard, to check the name label before removing the medication from the blister pack and to check the name label before returning the blister pack to the medication cupboard⁹. There are additional requirements to the effect that each blister pack should be clearly marked with the client's name. The name was in any event printed by the pharmacist on the blister pack. In both Dulcie Penn's and Susan Penna's cases, their names had been marked on the blister packs as I have already identified.

3. The incident in question

- 3.1. Ms Carolyn Chapman was the support worker who had been on night shift at Dulcie Penn's and Susan Penna's residence. She had commenced her duties at 6:45pm on Saturday evening 30 June. She spent the night sleeping in quarters within the residence dedicated for that purpose. Normally, Ms Chapman's shift would have concluded at 7:30am on Sunday 1 July 2007 with a 15 minute handover to the support worker for the day shift. However, on this occasion the day shift support worker, Ms Claire Shee-Houlmann, was running late and had telephoned Ms Chapman to tell her that. Ms Shee-Houlmann arrived sometime between 7:30am and 8am and in the event her late arrival caused Ms Chapman herself to leave late.
- 3.2. As seen earlier, Susan Penna's medications were to be administered at 8pm and 7am. Ms Chapman, who gave evidence before me, believed that she herself had administered Susan Penna's medication on the Saturday evening. There is no reason to doubt that was the case. There is also no reason to doubt Ms Chapman's assertions that she would have returned Susan Penna's blister pack to the correct tray. Ms Chapman would not have had anything to do with the administration of Dulcie Penn's medication on the Saturday because Dulcie Penn's medication was to be administered at 6pm which was before Ms Chapman commenced her shift on the Saturday evening.
- 3.3. Susan Penna attended a function on the Saturday evening and retired somewhat later than usual. Although Susan Penna was in the habit of rising early to smoke a cigarette and then to have her breakfast and receive her medication at 7am, on the Sunday morning in question she returned to bed after having her cigarette. This

⁸ Exhibit C18, paragraph 3

meant that she did not receive her morning medication at 7am. In the normal course of events Ms Chapman would have administered Susan Penna's medication at 7am, but on this particular occasion Ms Chapman decided not to rouse Susan Penna. On the other hand, Dulcie Penn's medication would normally have been administered by the oncoming support worker, except that on this occasion Ms Shee-Houlmann was late. Ms Chapman therefore decided to administer Dulcie Penn's medication herself. She did this at around 7:50am. It appears that Ms Shee-Houlmann arrived at the premises at about the time that Ms Chapman was giving Dulcie Penn her medication, but only observed the administration of it without actually seeing whose medication was being administered. Ms Chapman left the premises not long after administering Dulcie Penn's medication. It is clear that after Ms Chapman gave Dulcie Penn the medication she initialled Dulcie Penn's medication record, as contained in her medication folder, signifying that she had administered Dulcie Penn's medication at 8am on 1 July 2007. This demonstrates conclusively that Ms Chapman had at least been in possession of Dulcie Penn's medication folder at or about the time of the administration of the medication to Dulcie Penn. As seen earlier, the medication folder also contained Dulcie Penn's medication list which clearly listed the medication that she was meant to take and which corresponded to the list of medication set out on the reverse side of Dulcie Penn's blister pack. As noted previously, the folder was kept separately from the medication trays. It seems clear, therefore, that Ms Chapman at least correctly selected the appropriate medication folder for Dulcie Penn. There is no room for the suggestion that Ms Chapman was confused as to the identities of Dulcie Penn and Susan Penna respectively because the records demonstrate that Ms Chapman knew both women well and indeed, in relation to Dulcie Penn, had administered her medication on several occasions in April and June 2007, sometimes in the morning.

- 3.4. It is clear to me, and I so find beyond any doubt, that what Ms Chapman administered to Dulcie Penn around 7:50am on 1 July 2007 was Susan Penna's morning medication. In her evidence before me Ms Chapman was at a total loss to explain how this came about. She maintained that she had conducted all the necessary checks and cross checks that ought to have been conducted, including the check of the name on the blister pack as well as the all important cross check between the medication as listed on the reverse side of the blister pack and Dulcie Penn's medication list as

⁹ Exhibit C18, paragraph 3

contained within Dulcie Penn's medication folder. As seen earlier, Ms Chapman undoubtedly had Dulcie Penn's folder in her possession as evidenced by the fact that she initialled Dulcie Penn's medication record within that folder. If indeed Ms Chapman had looked at the name on the blister pack from which she administered the medication to Dulcie Penn, she would have seen Susan Penna's name. Ms Chapman knew the christian names of both these women. Accordingly, she ought to have noticed at that point that she was in possession of the wrong blister pack. As well, if all Ms Chapman had done was to have conducted the required cross check between the list of medications set out on the back of the blister pack with Dulcie Penn's medication list as contained within the medication folder, she would have seen that there was no correspondence between them whatsoever. This would also have alerted Ms Chapman to the fact that she was in possession of the wrong, i.e. Susan Penna's, blister pack. I find beyond any doubt that Ms Chapman did not examine the name on the blister pack and did not conduct the cross check between the medications as listed on the back of the blister pack with Dulcie Penn's medication list. I also find beyond any doubt that Ms Chapman selected the wrong blister pack and administered the wrong medication from Susan Penna's blister pack. As to why she did this I am unable to say. This is especially perplexing given that Ms Chapman had selected the correct medication folder.

- 3.5. Ms Shee-Houlmann had the task of administering Susan Penna's medication. She went to Susan Penna's medication tray and located the blister pack for Susan Penna which was in the correct tray. However, the tablets contained within the blister for the morning of Sunday 1 July 2007 were missing. She knew from what Ms Chapman had told her that Susan Penna had not been administered her morning medication. Ms Shee-Houlmann then examined Dulcie Penn's blister pack and observed that in spite of the fact that she had just witnessed Dulcie Penn taking medication, her tablets for Sunday morning 1 July 2007 were still there. Ms Shee-Houlmann then immediately and correctly deduced that Dulcie Penn had wrongly been given Susan Penna's medication. By that stage Ms Chapman had left the premises.
- 3.6. I observe that the toxicology report¹⁰ reveals that sub-therapeutic concentrations of Lamotrigine and Risperidone were detected in an ante mortem blood sample of Dulcie Penn and that these two substances were foreign to Dulcie Penn's medication list but

¹⁰ Exhibit C2a

form part of Susan Penna's medication list. None of the other drugs that formed part of Susan Penna's medication were detected in the sample. The failure to detect those other medications is explicable on the basis of the quantity of fluid that Dulcie Penn was administered in the RAH. When Ms Shee-Houlmann examined Susan Penna's blister pack, all of the meds that had been contained within it had been administered. There is no reason to suppose that Ms Chapman would only partially have administered the contents of that blister to Dulcie Penn. In any event, the presence of Lamotrigine and Risperidone, substances that were not part of Dulcie Penn's own medication regime, is conclusive proof that Dulcie Penn received Susan Penna's medication.

- 3.7. It will be observed that a consequence of Dulcie Penn receiving Susan Penna's medication was that Dulcie Penn did not receive her own medication, at least in the first instance. The most significant item of medication as far as Dulcie Penn's wellbeing was concerned was the Digoxin that had been prescribed for her heart condition. Dulcie Penn should have been administered that medication along with the other medications at 8am. The evidence reveals that there was considered to be a grace period, as it were, whereby residents might have their medication given to them up to approximately 1 hour after the due time. Dulcie Penn's medication chart from her admission to the RAH following these events reveals that she was next administered Digoxin in her usual dosage at 8:20am on 2 July 2007. This involved a gap of 48 hours since her last administration of Digoxin. There is no direct evidence before me as to what adverse effect, if any, Dulcie Penn's not having her Digoxin on 1 July 2007 had on her.
- 3.8. Sunday morning 1 July 2007 was not the first occasion at HCO on which Dulcie Penn had inappropriately consumed Susan Penna's medication. There was an incident that occurred on 12 May 2007 where Dulcie Penn had grabbed and consumed Susan Penna's tablets before staff had a chance to stop her from doing so. This had occurred in the morning. I note from Susan Penna's medication list that it had last been updated in March 2007. I therefore infer that what Dulcie Penn had consumed on the occasion in May was identical to what she consumed on 1 July 2007. On that earlier occasion, Dulcie Penn had been taken to the RAH and had been observed. She had become increasingly sedated throughout the morning, in keeping with the expected clinical effects of the medication that she had wrongly taken. She was kept in the

RAH under observation until 14 May 2007 when she was returned to the residence. There is no evidence, as far as one can glean from the RAH clinical record relating to that admission, that Dulcie Penn had been in any mortal danger. She survived that experience. It appears that unlike what transpired on the July occasion, Dulcie Penn had been administered her regular medication, including Digoxin, at or about the appropriate time. I am not clear as to whether she had that at the residence or at the hospital. In the period between the May incident and 1 July 2007, Dulcie Penn's physical health was unremarkable, even having regard to her many comorbidities.

4. Cause of death

- 4.1. On July 1 2007, Ms Penn was at first apparently unaffected by what she had consumed. Ms Shee-Houlmann was more concerned by the fact that Ms Penn had not taken her own heart tablets but, not unreasonably in the circumstances, decided against giving Ms Penn any further medication.
- 4.2. Ms Penn was immediately despatched by ambulance to the RAH and Ms Shee-Houlmann went with her. It is recorded that Ms Penn was processed at the RAH Emergency Department at 9:31am. There are clear references in the RAH clinical record of the fact that Ms Shee-Houlmann accurately described to medical staff what medication Ms Penn had wrongly consumed. In addition, it was also clearly recorded that Ms Penn's usual medication consisted of the administration every morning of 62.5mg of Digoxin.
- 4.3. Ms Shee-Houlmann observed that while at first Ms Penn seemed to be herself, she became drowsy and her increasing drowsiness is in fact noted on the Emergency Department clinical record¹¹.
- 4.4. In the clinical record taken in respect of Dulcie Penn's initial presentation at RAH, it is recorded that the administration of the medication that she had received had led to hypotension, which is abnormally low blood pressure, and sedation. It is clear, however, that during the course of Ms Penn's admission there was an occasion or occasions when her presentation improved. Ultimately, as I have already observed, her vital signs diminished and she went into a cardiac arrest and died.

¹¹ Exhibit C6a, page 176

- 4.5. As well as providing his post mortem report, Dr Gilbert gave evidence in the Inquest. He had access to Ms Penn's clinical record for the admission in July 2007. Dr Gilbert has noted that very early in her admission to the RAH she was hypotensive and sedated with progressive loss of consciousness that resulted in her intubation within the Emergency Department. She was admitted to the Intensive Care Unit in those circumstances. In his report, Dr Gilbert states the following:

'The autopsy findings and clinical course were consistent with death due to congestive cardiac failure. This resulted from aortic valve stenosis with associated left ventricular hypertrophy and ischaemic heart disease due to coronary atherosclerosis. While the deceased could have died suddenly at any time due to these conditions, it is probable that her death was precipitated by hypotension complicating inadvertent mixed drug toxicity. Although the hypotension resolved, she continued to exhibit breathing difficulties attributable to pulmonary oedema.'¹²

- 4.6. In his evidence Dr Gilbert elaborated upon his conclusions. He specifically pointed to the fact that within the Emergency Department Ms Penn had experienced a systolic blood pressure as low as 87. According to Dr Gilbert, in an elderly lady, particularly one with aortic stenosis as she had, 87 systolic was a low figure. In the ambulance en route to the RAH, a systolic pressure of 120 had been noted. The figure of 87 therefore represented a marked decrease in her blood pressure. Dr Gilbert observed that during the course of her admission her blood pressure had fluctuated. He regarded periods of hypotension, as exemplified by the figure of 87, as having had a tendency to aggravate her underlying cardiac conditions. Dr Gilbert was of the view that the hypotension that Dulcie Penn initially experienced was the probable, but not definite, precipitating factor in her decline¹³. Dr Gilbert also pointed to another particular episode of hypotension and a low oxygen level in her blood. This had corresponded with a point in the course of her admission where she experienced severe stridor on the afternoon of 2 July 2007. The lowered oxygen level in her blood would again have worked against her heart. Dr Gilbert could not directly ascribe the subsequent episodes of hypotension to the medication toxicity, but opined that they may have been a manifestation of her cardiac disease starting to become more and more problematic. Dr Gilbert said:

'She's on a downhill spiral. But I think the first episode can reasonably be attributed to the effects of mixed drug toxicity though I can't absolutely exclude the possibility that it was spontaneous but the timing in relation to the drugs and her diminishing conscious

¹² Exhibit C7, page 2

¹³ Transcript, page 24

state in the emergency department all sort of fitted with the mixed drug toxicity and I think that's the clinical impression as well.'¹⁴

- 4.7. Dr Gilbert was of the view that there was a reasonable clinical correlation between Ms Penn's initial decrease in blood pressure and drop in conscious state in the Emergency Department and the combined effect of the drugs that she had taken¹⁵. He said:

'I think it's reasonable to conclude that the drug toxicity has not killed her outright but certainly set the ball rolling with her pre-existing disease to ultimately cause her death.'¹⁶

In fact Dr Gilbert went on to say that it was difficult to reach any conclusion other than that Ms Penn had not been adversely affected by those drugs. He pointed out that initially she had been fine and had walked to the ambulance but by the time she arrived at hospital she had to be assisted off the barouche and as the morning progressed she showed a progressive loss of consciousness and her blood pressure dropped to a significantly low level. He said:

'I think it's hard to escape the conclusion that that was the result of being given a drug cocktail which was designed for a much younger other patient than with significant - this other patient had significant mental problems and drugs of this class and in this number in a frail 80 year old lady are likely to have adverse consequences and the whole clinical picture is that that happened.'¹⁷

- 4.8. Dr Gilbert did not overlook the earlier incident in May in which the effect of the sedative drugs on that occasion had not been as profound. To this Dr Gilbert suggested that the occasion of 1 July 2007 was in a sense the straw that broke the camel's back. Dulcie Penn was a very frail and elderly woman with significant heart disease and it would not have taken much to push her over the edge. This naturally distinguished her position from that of Susan Penna in respect of whom the cocktail of drugs that Dulcie Penn had erroneously taken had been prescribed. Susan Penna was a 46 year old woman whereas Dulcie Penn was a much older woman with an existing cardiac disease.
- 4.9. Dr Gilbert rejected the possibility that Dulcie Penn's failure to have her regular Digoxin medication that morning had anything to do with her initial deterioration, particularly having regard to the very short period of time in which she declined following administration of the incorrect medication. In his view there is no reason to

¹⁴ Transcript, page 25

¹⁵ Transcript, page 26

¹⁶ Transcript, page 26

¹⁷ Transcript, page 36

suppose that the deprivation of her Digoxin for that very short period of time would have led to such a sharp and sudden deterioration.

- 4.10. To my mind the connection between the administration of the incorrect medication at approximately 7:50am that morning and Ms Penn's significant drop in blood pressure and her progressively diminishing conscious state is clear. Quite apart from the chronological juxtaposition of those events within the Emergency Department, her adverse response is what one might have clinically expected from the ingestion of that kind of medication.
- 4.11. Dr Salu who appeared for and on behalf of Hills Community Options Incorporated suggested that the possibility of Dulcie Penn not receiving her usual medication, particularly Digoxin, had not been excluded to the extent that it was not possible for me to conclude on the balance of probabilities that Ms Penn's death was due, at least in part, to the mixed drug toxicity that she experienced. Dr Gilbert told me that Digoxin is a drug that assists the heart in contracting more efficiently. It is a drug that is prescribed in relation to chronic heart failure. It is of significance in my view that the cause of Ms Penn's death has as its central element congestive cardiac failure. I have given careful thought to Dr Salu's submission. It is true that there is no evidence from a clinical perspective as to what generally, or specifically in Dulcie Penn's case, the deprivation of her heart medication may have meant. While I would reject the suggestion that her initial deterioration in RAH Emergency on 1 July was the product of her not having her own medication, it is somewhat less easy to say that it had no significant effect in the long run. On the other hand, she received it on the morning of 2 July 2007, although that meant that she had not taken her medication for 48 hours. Having given the matter careful consideration, I do not think it is appropriate to recite the hypotension resulting from the mixed drug toxicity as a contributing factor in the anatomical cause of Dulcie Penn's death. Although I am satisfied that her initial episode of hypotension and altered state of consciousness did result from that mixed drug toxicity, and while I think that on balance the initial hypotension played some role in her decline and demise, at the very least as having set the scene for that demise, in my view a fairly balanced recitation of the anatomical cause of death would arguably also need to include reference to the possible effects of the deprivation of Ms Penn's own medication. It is difficult to ignore the possibility that Dulcie Penn's failure to have her usual medication was in itself a substantial

contributing factor in her death. In this regard it is not without significance that in the May incident, which had occurred only a matter of a few weeks prior to this occasion, she had consumed the exact same substances in the exact same quantities with similar but much less serious consequences. On that occasion she had been administered her usual medications, a feature that distinguished her presentation in July.

- 4.12. The debate as to the respective possible contributions to the cause of death made by the wrong medication on the one hand and the deprivation of the correct medication on the other is in many ways an arid one. There is no doubt that the main precipitating factor in Dulcie Penn not receiving her usual medication was the fact that she was given the wrong medication. But for Ms Penn having been given Susan Penna's medication, it is clear from the evidence that she would have been given her own. It was clear to clinical staff at the RAH that Ms Penn had not that day been given her regular medications. It is also clear that a conscious decision was made on 2 July 2007 that she should be given her usual medications on that day. There is no evidence that any decision that may have been made not to administer Ms Penn's own medication on 1 July 2007 was an unreasonable one. There is no evidence that the chain of events that began with Ms Penn receiving the wrong medication and which culminated in her death was in any way interrupted by any unreasonable action on the part of any person. In my view it is clear that the consumption of the wrong medication set the scene for what later transpired and that but for that consumption, the chain of events that led to her death probably would not have occurred.
- 4.13. To my mind, Dulcie Penn's death was a consequence of her receiving the incorrect medication on the morning of 1 July 2007.
- 4.14. I find the cause of Ms Penn's death to be congestive cardiac failure due to ischaemic and valvular heart disease.
- 4.15. During the course of the Inquest I heard evidence as to changes that had been made in respect of HCO procedures regarding the administration of medication. These changes have been designed to minimise the opportunity for error to occur in the course of providing clients of the organisation with their regular medications. Included in the changes is a requirement that support workers identify and specifically record the administration of each individual item of medication. This measure is

designed to ensure that the support workers are conscious of the type and quantity of medication that is administered at a given occasion.

- 4.16. In all of the circumstances I was satisfied that the actions undertaken by HCO were entirely appropriate. Accordingly, I do not see the need to make any recommendations in respect of this matter.

Key Words: Incorrect Medication; Intellectually Disabled

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the ?? day of December, 2009.

Deputy State Coroner