FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 4903/10

Inquest into the Death of TZU LIN YANG

Delivered On:	6th July, 2011
Delivered At:	Melbourne
Hearing Dates:	6th July, 2011
Findings of:	IAIN TRELOAR WEST
Representation:	No representation
Place of death:	Eastern Health, 5 Arnold Street, Box Hill 3128
PCSU:	Senior Constable Kelly Ramsey

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In the Coroners Court of Victoria at Melbourne
I, IAIN TRELOAR WEST, Deputy State Coroner

having investigated the death of:

Details of deceased:

Surname: YANG
First name: TZU
Address: 31 Vanessa Crescent, Wheelers Hill, Victoria 3150

AND having held an inquest in relation to this death on 6th July, 2011
at Melbourne
find that the identity of the deceased was TZU LIN YANG
and death occurred on 25th September, 2010

at Eastern Health, 5 Arnold Street, Box Hill, Victoria 3128

from
1a. MULTI-ORGAN FAILURE AS A RESULT OF METASTATIC CERVICAL CANCER
2. PSYCHIATRIC ILLNESS

in the following circumstances:

1. Tzu Lin Yang was of female gender and aged 59 years at the time of her death and was subject to an Involuntary Treatment Order due to a mental disorder. She was of Chinese extraction and could not speak English and resided with her husband and adult son at 31 Vanessa Crescent, Wheelers Hill. She had a history of undifferentiated type schizophrenia and psychotic disorder and at the time of her death, she was being treated with olanzapine and diazepam prescription medication.

2. Ms Yang's death was reported to the Coroner by the Registrar of Births, Deaths and Marriages due to her Involuntary Treatment Order status.

3. On the afternoon of the 21st September, 2010, Ms Yang's husband called the psychiatric telephone triage service and reported that his wife had blood in her urine, was lethargic, had a poor appetite and had no desire to go out shopping or visit friends, which she usually did. She

was in complete denial about her medical illness when assessed later that day by two members of the Central East Crisis Assessment and Treatment Team. As the team felt that she was at risk of further physical deterioration due to her mental illness and following the obtaining of appropriate authorisation for hospital transfer, Ms Yang was ambulance transferred to the Box Hill Hospital Emergency Department. Upon assessment, Ms Yang was found to be anaemic and was given blood and a subsequent CT scan showed an enlarged uterus, multiple enlarged pelvic lymph nodes and multiple cavitating nodules at the lung bases, indicating a metastatic malignancy. Ms Yang refused treatment and on the following day, a "request for person to receive involuntary treatment from an approved mental health service" order was obtained in the setting of her refusing to answer medical related questions and refusing examination.

4. On the 23rd September, a psychiatric review was conducted in the presence of Ms Yang's family and, although she was guarded, suspicious, and unwilling to talk, she did not display any acute psychiatric behaviour. As she later indicted she was willing to stay in hospital and comply with treatment, she was discharged from her Involuntary Treatment Order, but she was informed, that if she did refuse medical treatment, an urgent guardianship order could be organised. It was decided that radiotherapy treatment would be needed in order to stop the bleeding with this procedure to be undertaken at Epworth Eastern Peter MacCallum Centre. When this was explained to Ms Yang, she displayed impaired judgement and refused treatment.

5. On the 24th September, a further psychiatric review was undertaken which culminated in an application being made to VCAT for a temporary guardianship order, with this ultimately being approved and her husband being appointed guardian. Her Involuntary Treatment Order was re instated.

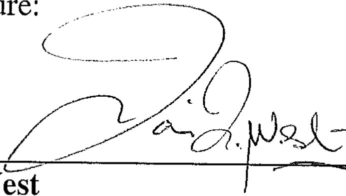
6. Ms Yang continued to bleed and it was explained to the family that there were three alternatives available regarding treatment. These alternatives were palliative treatment alone, radiotherapy to stop the bleeding, or interventional radiology to stop the bleeding. The family agreed to interventional radiology and further agreed, that in the event of a cardiac or respiratory arrest, Ms Yang would not be for cardiopulmonary resuscitation. A NFR order was signed. At 4.00pm on the 24th September, Ms Yang underwent several procedures whilst under an anaesthetic and at 10.20pm, she was returned to the ward. At 11.30am on the 25th September, Ms Yang complained of pain in her abdomen, which was firm and distended, however, she refused treatment and was given morphine for pain management. At 2.20pm, a Code Blue was called after Ms Yang was found unrousable and with a Glascow Coma Score of 3. As a NFR order was in place, all treatment was stopped and Ms Yang subsequently died at 2.55pm in the presence of family members.

7. No autopsy was performed in this case with a death certificate being signed and stating the cause of death to be multiorgan failure as a result of metastatic cervical cancer. Part 2 of the death certificate referred to psychiatric illness.

COMMENTS:
Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment connected with the death:

1. The evidence satisfies me that Tzu Lin Yang died from natural causes, and that her management and treatment at the Box Hill Hospital in the period leading up to her death, was within the parameters of reasonable healthcare management.

Signature:



Iain West
Deputy State Coroner
6th July, 2011