CORONERS ACT, 1975 AS AMENDED

SOUTH  *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 12th and 22nd days of September, 2000, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Judith May Fisher.

I, the said Coroner, do find that Judith May Fisher, aged 62 years, late of 16B Scholz Avenue, Nuriootpa, died at the Royal Adelaide Hospital on the 8th day of February, 1999 as a result of ventricular fibrillation associated with congestive cardiomyopathy. I find that the circumstances of death were as follows:-

1. **Reason for inquest**

1.1 On 1 February 1999 Dr. N. Barbato made an order detaining Judith May Fisher to the Adelaide Clinic for twenty-one days pursuant to Section 12(5) of the Mental Health Act 1993. Accordingly, at the time of her death Ms. Fisher was "detained in custody pursuant to an Act or law of the State" within the meaning of Section 12(1)(da) of the Coroners Act, and an inquest was therefore mandatory pursuant to Section 14(1a) of the said Act.

2. **Background**

2.1 On 15 January 1999 Ms. Fisher was admitted to Angaston Hospital suffering from an anxiety state. She had become increasingly anxious and agitated following diagnosis of cardiomyopathy (disease of the heart muscle) in September 1998.

2.2 On 19 January 1999 Ms. Fisher was transferred to the Adelaide Clinic as a voluntary patient. On admission, she was found to be depressed, anxious and suffering from panic attacks. She was treated with anti-depressants and psycho-therapy.

2.3 On 29 January 1999 Ms. Fisher's mental state deteriorated to the extent that she was psychotic, confused, paranoid and a risk to herself. Dr. M. Ewer detained her pursuant to Section 12(1) of the Mental Health Act, and this order was confirmed on 30 January 1999 by Dr. Ryan. On 1 February 1999 Dr. Barbato reviewed Ms. Fisher's mental state, and detained her for a period of twenty-one days from that date pursuant to Section 12(5) of the Mental Health Act.

2.4 By 3 February 1999, Ms. Fisher's mental state had improved somewhat, but on 5 February 1999 she had become anxious again, although this is noted to have "settled by lunch-time" in the nursing notes.

2.5 At 3.27p.m. on 5 February 1999, Ms. Fisher collapsed while talking to her sister on the telephone. An emergency response team attended within less than a minute, an airway was inserted and active attempts at resuscitation were made. Ms. Fisher was defibrillated twice.

2.6 An ambulance arrived at 3.35p.m. and took over the resuscitation. Ms. Fisher was conveyed to the Royal Adelaide Hospital, and admitted to the Intensive Care Unit. Ms. Fisher was found to be unresponsive neurologically. She had suffered severe anoxic encephalopathy, with a poor prognosis, after her cardiac arrest.

2.7 Ms. Fisher's condition did not improve over the next few days, and in consultation with her family, active therapy was withdrawn.

2.8 On Monday 8 February 1999, about 9.00a.m., Ms. Fisher was found to have died (see the statement of Dr. Tay, Exhibit C.2a).

3. **Cause of death**

3.1 A post mortem examination was carried out by Dr. R.A. James, Forensic Pathologist, on 9 February 1999. Dr. James found that the cause of death was ventricular fibrillation associated with congestive cardiomyopathy. Ms. Fisher's heart was grossly enlarged at 1,042 grams (approximately three times the normal weight). Dr. James commented:-

> "The deceased apparently was receiving treatment in the Adelaide Clinic for anxiety at the time of her unexpected collapse on 5/2/99. She remained unconscious in hospital for several days. Post mortem has shown a gross cardiac abnormality with the heart weighing 3 times the normal weight. The appearances are those of a

> decompensating congestive cardiomyopathy. Given the disease of the mitral valve requiring a valve prosthesis it is not possible to say that this condition was a primary cardiomyopathy and may have reflected underlying valvular disease. There is no evidence of significant coronary artery disease, hypertension or amyloid". (Exhibit C.3a, p4).

3.2 On the basis of Dr. James' opinion, I find that the cause of Ms. Fisher's death was unrelated to her detention at Adelaide Clinic.

4. Investigation

4.1 Being a death in custody, Ms. Fisher's death was investigated by Detective Senior Constable Paul Blackmore of Holden Hill Investigations. Detective Blackmore has conducted a thorough and professional investigation into the circumstances surrounding Ms. Fisher's death, and the investigation has disclosed no grounds for concern about the quality of either the medical or psychiatric treatment received by Ms. Fisher.

5. Recommendations

5.1 There are no recommendations pursuant to Section 25(2) of the Coroners Act.

Key Words: death in custody

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

Seal the 22nd day of September, 2000.

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Coroner