

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 Rosemary McQuinn.

I, the said Coroner, do find that Rosemary McQuinn, 68 years, late of Jacaranda Ward, Glenside Hospital, Fullarton, died at Glenside Hospital on the 3rd day of January, 2000 as a result of glottic obstruction by food bolus. I find that the circumstances of death were as follows:-

1. **Reason for inquest**

1.1 On 17 September 1999 the Guardianship Board of South Australia made an order detaining Rosemary McQuinn in Glenside Hospital for the period up to and including 17 March 2000 pursuant to Section 13 of the Mental Health Act 1993. Accordingly, at the time of her death Ms. McQuinn 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 Ms. McQuinn was diagnosed with paranoid schizophrenia, with a schizo-affective disorder and with a depressive illness, as far back as 1964. She also had an episode of obstructive hydrocephalus in 1981, which necessitated surgery to install a shunt. She was also diagnosed with hyperthyroidism, which also required surgery. By far her most serious diagnosis was that of Huntington’s Disease, a hereditary disease characterised by involuntary movements and dementia. This is a dreadful illness, described by Black’s Medical Dictionary (37th edition), as follows:-

“Some patients show more severe mental disturbance, others more severe disturbances of movement, but in all it pursues an inextricable downward course over a period of 10 to 20 years to a terminal state of physical and mental helplessness”.

- 2.2 At 8.40a.m. on 3 January 2000, Ms. McQuinn had breakfast, as usual, in the dining room in Jacaranda Ward at Glenside Hospital. Registered Nurse Arrowsmith saw her walk from the dining room to the sitting room at about 9.20a.m. (Exhibit C.1a, p1).
- 2.3 At about 10.05a.m. Ms. Arrowsmith went into the sitting room to attend to morning tea. She noted Ms. McQuinn sitting in a chair apparently asleep, but she appeared very pale. Ms. McQuinn checked her and immediately thought she had died.
- 2.4 Ms. Arrowsmith and some other nurses transferred Ms. McQuinn to her bedroom, and then checked her vital signs. There was no pulse, no breath sounds, no blood pressure, and her pupils were non-reactive.
- 2.5 Dr. Stephanie Cooper was called, and attended at 10.25a.m. She checked Ms. McQuinn and, at 10.50a.m., formally declared her life to be extinct (Exhibit C.2a, p2).

3. **Cause of death**

- 3.1 A post mortem examination was carried out on the body of the deceased by Dr. R.A. James, Forensic Pathologist, on 5 January 2000. Dr. James concluded that the cause of Ms. McQuinn’s death was “glottic obstruction by food bolus”. He also found cerebral atrophy attributed to clinical Huntington’s dementia (which was confirmed on neuropathological examination), and an incidental finding of sarcoidosis involving the heart and lungs was also made.

- 3.2 Dr. James commented:-

“The brain has been submitted to neuropathology for formal confirmation of the basis of her dementia. This condition is considered to be the underlying factor for her fatal glottic obstruction by a food bolus.

The unsuspected sarcoidosis involving the heart and lungs is considered to be unrelated to her cause of death”. (Exhibit C.3a, p4).

- 3.3 This matter being a death in custody, Ms. McQuinn’s death was investigated by Constable R.J. Tamits of Norwood Patrols, who submitted a report in this matter. Constable Tamits found no suspicious circumstances surrounding Ms. McQuinn’s death, nor any suggestion that her treatment was other than appropriate.

3.4 In particular, there is no evidence of any neglect or poor nursing practice in relation to Ms. McQuinn's eating. She had been assessed by a Speech Pathologist on 9 December 1999, and that assessment found no evidence of dysphasia (difficulty in swallowing). In addition to that, Ms. McQuinn was periodically reviewed by a dietitian, and there had been no directions given about extra supervision at meal times, or special diet requirements.

3.5 Ms. McQuinn had nothing unusual for breakfast that morning, and gave no sign, such as coughing or gagging, to indicate to the staff that she was in difficulty.

3.6 In all those circumstances, I can see no grounds for criticism of the standard of care given to Ms. McQuinn at Glenside Hospital.

4. **Recommendations**

4.1 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