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 5th and 14th day of December 2001, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Harold Kelvin Overland.

I, the said Coroner, find that Harold Kelvin Overland aged 74 years, late of St Michael's Rest Home, 494 Fullarton Road, Myrtle Bank, South Australia, died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 27th day of July 2001 as a result of myocardial infarction. I find that the circumstances of the death were as follows:

1. Reason for inquest

1.1. On 24 July 2001 Dr M Crost purported to make an order pursuant to Section 12(5) of the Mental Health Act 1993 detaining Mr Overland at the Royal Adelaide Hospital for a period of 21 days.

1.2. This order is recorded in the Royal Adelaide Hospital medical record (Exhibit C2b) with a note signed by Dr Crost as follows:

> 'Mr Overland appeared extremely unwell and was not easily rousable. In view of his gross delirium and the possible need for further treatment and procedures his detention has been confirmed.'

1.3. Dr Crost's use of the word 'confirmed' is inapt in this situation. An initial order for detention had been made by Dr A Guterres pursuant to Section 12(1) of the Mental Health Act 1993 on 21 July 2001. This order was confirmed by Dr P J Hay, Psychiatrist on 22 July 2001 pursuant to Section 12(4) of the Mental Health Act 1993. Dr Crost was not involved in confirmation of Dr Guterres' order, she was making an

order for further detention pursuant to Section 12(5) of the Mental Health Act 1993 for a period of 21 days.

1.4. Section 12(9) of the Mental Health Act 1993 states:

> 'A psychiatrist who makes an order for detention under subsection (5) or (6) must forthwith furnish the director of the treatment centre with a written report of the results of his or her examination of the patient and of the grounds on which the order was made.'

1.5. An order in the usual form (Form 3 as prescribed by Regulation 5(c) of the Mental Health Regulations 1995) appears to have been filled out by Dr Crost giving the results of her examination and the grounds for making the order. However, she has neither signed nor dated the form.

1.6. The question therefore arises as to whether Mr Overland was in lawful detention at the Royal Adelaide Hospital on the date of his death on 27 July 2001 through Dr Crost's failure to comply with Section 12(9). This is an important issue because clearly, the Director of the Treatment Centre should receive advice that a patient has been detained, and Section 12(10) of the Mental Health Act 1993 requires the Director to forward a copy of the report to the Guardianship Board. This is an important safeguard to ensure that the appropriate authorities are notified when a patient is detained.

1.7. In favour of the validity of the detention, it is clear that Dr Crost was appropriately qualified to make the order and there were appropriate grounds for making the order.

1.8. In all the circumstances, although I consider failure to comply with Section 12(9) is a serious matter, I conclude that it did not invalidate the Detention Order made by Dr Crost. Accordingly, at the time at the time of his death on 27 July 2001, Mr Overland was 'detained in custody pursuant to an Act or law of the State', within the meaning of Section 12(1)(da) of the Coroner's Act, and an inquest was therefore mandatory pursuant to Section 14(1a) of the said Act.

2. Background

2.1. Mr Overland had been a resident of St Michael's Rest Home at Myrtle Bank for about eight years. His brother-in-law, Mr J T Butler, gave a statement saying that Mr Overland's health had been declining over the last three or four years. (Exhibit C1a).

2.2. On 20 July 2001 Mr Overland was admitted to the Emergency Department of the Royal Adelaide Hospital with a diagnosis of hypokalaemia (reduced blood potassium level) and a suspected sigmoid volvulus (a twisted or obstructed bowel). An x-ray was taken which demonstrated the volvulus and a distended bowel. When the Consultant Surgeon suggested a gastrograffin enema to try and treat the bowel obstruction, Mr Overland refused. He also refused to allow the medical staff to take blood to determine his potassium levels (see the statement of Dr M S Valentine, Exhibit C2a).

2.3. In view of his condition, Mr Overland was detained by Dr Guterres, as I have already mentioned. Following detention, Mr Overland was restrained and appropriate treatment given.

2.4. On 22 July 2001 Mr Overland remained combative and uncooperative.

2.5. By 23 July 2001 Mr Overland's conscious state was deteriorating and an electro-cardiogram showed evidence of a recent myocardial infarction. A CT scan did not show evidence of a stroke, although Dr Valentine said that a stroke could not be excluded.

2.6. Mr Overland's condition continued to deteriorate, and no further surgical intervention was attempted due to Mr Overland's unwillingness for treatment (Exhibit C2a, p5).

2.7. At 3:15pm on 27 July 2001 Mr Overland was found by the nursing staff to have died. Dr Valentine formally pronounced life extinct at 4:15pm that day. Dr Valentine said:

> 'I have spoken to the Senior Registrar Dr Peter Day and he and I are both of the opinion that he died from a heart attack arising from natural causes and are prepared to give a cause of death '
>
> (Exhibit C2a, p5)

2.8. I accept Dr Valentine's evidence in that regard and find that the cause of death was a myocardial infarction.

2.9. The police officer who investigated this matter on my behalf, Senior Constable N R Dawkins of Sturt Investigations, has advised that he considers that there are no suspicious circumstances surrounding Mr Overland's death. I accept Mr Dawkins' advice in that regard.

2.10. In all those circumstances, I find that Mr Overland died as a result of a myocardial infarction. There are no grounds for concern about the quality of the treatment he received at the Royal Adelaide Hospital.

3. Recommendations

3.1. There are no recommendations pursuant to Section 25(2) of the Coroner's Act.

3.2. The failure to comply with Section 12(a) of the Mental Health Act 1993 cannot be the subject of a recommendation, since it does not touch upon the cause of death. However, I draw this matter to the attention of the Director of Mental Health Services, the Chief Executive Officer of the Royal Adelaide Hospital and the President of the Guardianship Board for their attention.

3.3.

Key Words: Death in Custody; Psychiatric/Mental Illness

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 14th day of December, 2001.

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Coroner