

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 29th and 30th of October 2002 and the 24th day of March 2003, before Anthony Ernest Schapel, a Coroner for the said State, concerning the death of Collin Ernest Eldridge.

I, the said Coroner, find that, Collin Ernest Eldridge aged 77 years, late of Kensington Residential Care, 276 Portrush Road, Beulah Park, South Australia died at the Royal Adelaide Hospital, Adelaide, South Australia on the 12th day of August 1999 as a result of multi-organ failure secondary to myocardial infarction.

1. **Introduction**

- 1.1. On 28 May 1999 Mr Collin Eldridge, the deceased, aged 77 years, was admitted to the Flinders Medical Centre following a fall. On 29 May 1999 the deceased underwent an operation to repair a fractured neck of femur. He was supplied with an Austin Moore prosthesis. This procedure is commonly known as a hip-replacement operation.
- 1.2. Following his surgery, the deceased spent some time in the critical care unit at Flinders Medical Centre. It was believed at the time that he had probably suffered a myocardial infarction (heart attack) during the operation to which I have referred.
- 1.3. When he was discharged from Flinders Medical Centre, he was suffering from a number of serious illnesses including non-insulin dependent diabetes mellitus, hypertension, ischaemic heart disease, congestive heart failure, chronic obstructive

airways disease, cataracts, trans-ischaemic accidents and acute renal failure. In addition, he had developed, while in hospital, pressure sores on the heels of each foot. This had no doubt been caused by his inability to mobilise.

- 1.4. The deceased was discharged on 14 July 2000 on which day he was transferred to the Kensington Residential Care Facility (the Kensington facility) situated at 276 Portrush Road, Beulah Park. His Flinders Medical Centre discharge summary which forms part of Exhibit C10 states:

'Due to his slow recovery, confusion and very limited mobility he was sent to a nursing home.'

- 1.5. The Kensington facility was a high care nursing home. It still is. Since the events with which this inquest is concerned it has received Commonwealth Government accreditation. The Kensington facility was by no means an acute hospital. It did not employ medical practitioners, either on a full time or part time basis. It was staffed by registered nurses, one of whom was on duty 24 hours a day on a rotational basis. As well, the Kensington facility was staffed by personal carers, the number of whom on duty at any given time would depend on the time of the day.
- 1.6. Residents of the Kensington facility were expected to engage, or have engaged on their behalf, private medical practitioners of their choosing. A resident's medical practitioner would visit the resident at the facility regularly or on an as required basis.
- 1.7. The deceased's various medical complaints were recognised and noted by the Kensington facility staff on his admission. His general health and well being deteriorated while he was a resident at the Kensington facility. It deteriorated to the point where on 3 August 2000, the deceased's medical practitioner, Dr Belinda Scrymgour (now deceased), was called to the Kensington facility at the insistence of the deceased's son, himself a nurse. The son told Dr Scrymgour that he believed the deceased had suffered a stroke. Dr Scrymgour, whose record of interview I received in evidence (Exhibit C14), and who had last visited the deceased on 16 July 1999, was surprised by the change in his condition since she had last seen him. He had deteriorated significantly. The deceased was very drowsy and unresponsive. His systolic blood pressure was recorded at 90, a fatal state of affairs if untreated. His heart rate was weak and irregular. He had chest crepitations which signified fluid on both sides of his chest and his ankles were quite swollen. Dr Scrymgour formed the

view that the deceased was in a moribund condition. She spoke to his son about the treatment his son wanted administered. The deceased's son indicated that he wanted his father treated aggressively and so it came to pass that the deceased was transferred to the Royal Adelaide Hospital on that day.

- 1.8. The deceased was conveyed to the Royal Adelaide Hospital by ambulance. En-route he required extensive resuscitation with oxygen, atropine and adrenaline. On admission to the Royal Adelaide Hospital, the deceased's condition was very poor. His blood pressure was still dangerously low as was his bodily temperature. I do not need to go into the details of this, but because of his existing severe heart failure, he suffered constant ventricular failure and his renal function continued to deteriorate. It was suspected that he had suffered a stroke, but definitive tests for this could not be implemented because the deceased did not stay still enough for an MRI scan to be performed.
- 1.9. The deceased improved briefly while at the Royal Adelaide Hospital, but he deteriorated generally where by 7 August he had multi-organ dysfunction syndrome of a cause which at that time could not be precisely determined. It was thought that his condition may have been due to sepsis or a myocardial infarction. On 7 August 1999 the deceased's son indicated that the deceased's family from that point onwards desired palliative care only. There was little clinical improvement over the days that followed and the deceased died on 12 August 1999 at the Royal Adelaide Hospital.
- 1.10. While the deceased was in the care of the Royal Adelaide Hospital, his ulcerated heel sores were noted. A staphylococcus aureus infection was identified in connection with these ulcers. He was placed on antibiotic treatment for that infection.
- 1.11. There can be no suggestion that the deceased received other than expert care at the Royal Adelaide Hospital. The inquest did examine, however, whether the deceased had been accorded the appropriate level of care at the Kensington facility and in particular whether any act or omission that had taken place at that facility had contributed to the cause of the deceased's demise.

2. **The deceased's cause of death**

2.1. A post-mortem examination of the deceased's body was conducted on 16 August 1999. It was conducted by Dr Ross James, then Chief Forensic Pathologist at the Forensic Science Centre. The post-mortem report (Exhibit C13) is signed by Dr James and one Neeru Arora, who is described in the report as a trainee pathologist. It cites the cause of death as follows:

- '1. Multiorgan failure secondary to myocardial infarction.
2. Methicillin resistant Staphylococcus aureus (MRSA) infection of pressure ulcers.'

The pressure ulcers referred to were those present on the heels of the deceased.

2.2. Dr James gave evidence before me. It is appropriate firstly to discuss the evidence given by Dr James as to the role, if any, played by the staphylococcus aureus infection in the deceased's death. One of the issues with which this inquest was concerned was whether the deceased's heel ulcers had been accorded adequate nursing care and treatment at the Kensington facility.

2.3. It will be remembered that the pressure sores first appeared during the deceased's admission to the Flinders Medical Centre in May, June and July of 1999. They were still present during the entire period of the deceased's residence at the Kensington facility. Their presence and condition had there been observed. The deceased still bore the pressure sores upon his admission to the Royal Adelaide Hospital and it was there that the associated staphylococcus aureus infection was identified by bacterial culturing.

2.4. I am bound to observe that the post-mortem report gives the reader the impression that the staphylococcus aureus infection associated with the deceased's pressure sores was a matter of special significance as far as the cause of the deceased's death is concerned, especially so when it is remembered that the deceased suffered from myriad ailments. Dr James told me, however, that the post-mortem report had been initially framed by his assistant, Dr Arora, the second signatory to the report. Dr James said that the inclusion of the reference to the MRSA infection associated with the pressure ulcers was something of a distraction. In his view the deceased's death would have occurred with or without the existence of those ulcers. In cross-examination by Mr William Boucaut, who appeared for the proprietor of the

Kensington facility, Dr James was asked to explain what he meant by his referring to the MRSA infection as a distraction. Dr James said this:

'We were talking about the usage of the reference to MRSA in the listed cause of death. I put two factors in the cause of death. Number one, the multi-organ failure and his acute myocardial infarction. That undoubtedly was true. The second point listed, the MRSA, I think is one of a litany of things that was causing him problems. Why I picked, or my registrar picked that particular one rather than a variety of other things I could have mentioned, his diabetes, his hypertension, his TIA's, his emphysema, suppurative bronchitis and so on; is something that perhaps was unwise. I think it was unwise because it's distracted attention from the immediate cause of death, why he died on the 12th. He died on the 12th because he had an acute myocardial infarction that I could see down the microscope. His MRSA, he might have had that for weeks and if he didn't have his other problems, he presumably would have lived on for many years.' (T127)

Dr James went on to say that the infection was not the primary causative factor in the deceased's death. Indeed, in my opinion, there is little or nothing to suggest that the existence of the MRSA infection in any sense hastened the death or had debilitated the deceased to a level where his death from another cause became more likely.

- 2.5. The evidence of Dr James concerning the significance of the MRSA infection leads me to the view that there is insufficient evidence from which it can be concluded that the infection was a substantial cause of the deceased's death, or indeed had any causative connection at all. To use Dr James' expression, the infection was one of the lesser of his problems. To my mind, it is also impossible to say that the infection in any real sense formed part of the circumstances of the deceased's death.
- 2.6. In the event, Dr James told me that the cause of death was properly described as multi-organ failure secondary to myocardial infarction.
- 2.7. Dr James explained that the deceased had, for a substantial period of time, been a very sick man. He had disease in almost all of his bodily organs and the primary cause of his ills was a degenerative disease of the arteries supplying these organs. The degenerative arterial disease had resulted essentially from a background of diabetes mellitus and high blood pressure. Dr James also referred to the fact that the deceased suffered from cardiomegaly (an enlarged heart). The deceased's heart was more than 50% larger than the upper limit of normal. The enlargement of the heart was caused by the deceased's arterial disease and the complicating feature of an enlarged heart is the fact that the coronary arteries that supply blood to the heart muscle do not enlarge.

This puts the heart at risk of myocardial infarction. During the post-mortem examination Dr James observed the presence of infarcted heart muscle from a heart attack, or possibly heart attacks, that he had suffered in the past. I have already referred to the fact that the deceased suffered a heart attack during his hip replacement operation in May 1999.

2.8. Dr James also observed evidence of a more recent myocardial infarction that had in his view occurred only a matter of days before his death. In this regard it is to be observed that Royal Adelaide Hospital staff had suspected that the deceased's chronic heart failure there may have been occasioned by an infarct. Dr James' evidence confirms those suspicions. Dr James was of the opinion that his recent myocardial infarction was the immediate cause of the sudden decline in the state of the deceased's health and was the dominant reason why he died on 12 August 1999 and not on some other day. The recent myocardial infarction had led to multi-organ failure and the deceased's death was inevitable.

2.9. Dr James said that the deceased's low systolic blood pressure and dangerously low temperature (hypothermia) as observed on 3 August, the day he was removed from the Kensington facility to the Royal Adelaide Hospital, was a reflection of his various illnesses. The low bodily temperature in particular was not occasioned by environmental factors associated with his accommodation at the Kensington facility. He said:

'He was a very sick man, in fact he was a dying man. All his organs were diseased, he was manifesting this multiple organ failure in different ways, and one of those ways was that he was hypothermic. I doubt if he had been a healthy man in that same environment with the same bedding, the same clothing as presumably a group of other patients were, that he would have become hypothermic.' (T120)

2.10. Dr James examined the deceased's brain. He found no evidence of stroke.

2.11. I accept Dr James' evidence in its entirety. It demonstrates in my view that the decline in the deceased's condition as observed at the beginning of August 1999 was the natural progression of a multitude of chronic illnesses that in the main stemmed from his degenerative arterial disease. That natural decline continued into the period of admission at the Royal Adelaide Hospital. He suffered a further heart attack, another inevitable consequence of his pre-existing cardiac pathology, and he suffered multi-organ failure as a result.

2.12. I find the cause of the deceased's death to be multi-organ failure secondary to myocardial infarction.

3. Whether any act or omission that occurred at the Kensington facility contributed to the death

3.1. I have found, based on the evidence of Dr James, that in essence the cause of the deceased's death was the inevitable consequence of a number of maladies which had existed for some time, and certainly prior to the deceased being placed in the care of the Kensington facility. There is no evidence on which I could find that the MRSA infection was a contributing factor in the deceased's death. In that event, I have been unable to find evidence to suggest that any perceived shortcomings in the care provided by the Kensington facility contributed to the decline in the deceased's health or well-being or contributed to his death. Moreover, in my view, it cannot be determined that the events at the Kensington facility formed part of the circumstances of his death save and except for the obvious temporal connection arising out of his period of residence there some weeks before his demise. In the event, I do not consider it appropriate to deal with the issues raised in this inquest concerning the care provided by the Kensington facility.

4. Recommendations

4.1. I do not perceive the necessity to make any recommendations in this matter.

Key Words: Nursing Care

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

Seal the 24th day of March, 2003.

Coroner