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 22nd and 24th days of April, 2003, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Johannes Leonardis Stephanes Kerkman.

I, the said Coroner, find that, Johannes Leonardis Stephanes Kerkman aged 75 years, late of Glenside Campus, Fullarton Road, Glenside died at Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 6 April 2002 as a result of multi-organ failure due to sepsis secondary to hospital acquired pneumonia.

1. Reason for Inquest

1.1. On 21 November 2001, the Guardianship Board of South Australia made an order pursuant to Section 13 of the Mental Health Act 1993 that Mr Kerkman be detained in the Glenside Campus of the Statewide Mental Health Service up to and including 21 May 2002. Other orders were made for Mr Kerkman's treatment pursuant to Section 19 of the Act.

1.2. Accordingly, on 6 April 2002, Mr Kerkman 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 1975, and an Inquest into his death was therefore mandatory by virtue of Section 14(1a) of the said Act.

2. Background and Treatment

2.1. Mr Kerkman was diagnosed with Alzheimer-type dementia in February 2001. He continued to live with his wife until September of that year, when he was admitted to "The Lodge" aged-care facility at Wayville.

2.2. Unfortunately, Mr Kerkman's behaviour deteriorated, and he was admitted to Glenside Campus of the Statewide Mental Health Service, and orders were made pursuant to Section 12 of the Mental Health Act for his detention. These orders continued until the order was made by the Guardianship Board on 21 November 2001 to which I have already referred.

2.3. On 18 February 2002, it became apparent that Mr Kerkman's conscious state had deteriorated and it was suspected that he may have suffered a cerebro-vascular accident ("CVA"). He was transferred to the Royal Adelaide Hospital for assessment and ongoing care. Appropriate orders were made pursuant to Section 16 of the Mental Health Act giving effect to that transfer.

2.4. Upon admission to the Royal Adelaide Hospital, Mr Kerkman was treated by Dr Jemmy Lao, Medical Registrar under the Supervising Consultant Dr Bartolomeus. A CT scan confirmed that Mr Kerkman was suffering from "white matter disease" of the brain consistent with small vessel ischemia (lack of blood supply), together with a CVA of the brain stem. The CVA to the brain stem had decreased Mr Kerkman's conscious state and had exacerbated the white matter disease.

2.5. Mr Kerkman's condition improved to the extent that he was discharged back to Downey House at Glenside Hospital on 28 February 2002.

2.6. On 4 March 2002, nursing staff at Glenside noticed a large lump in Mr Kerkman's abdomen and he was diagnosed with urinary retention. An indwelling catheter was inserted and the urinary retention was relieved, during which blood clots were noticed in the urine. Mr Kerkman was then transferred back to the Royal Adelaide Hospital, and again appropriate orders were made pursuant to Section 16 of the Mental Health Act.

2.7. On 5 March 2002, Mr Kerkman was assessed at the Royal Adelaide Hospital and diagnosed with "urosepsis". He was treated with antibiotics and showed some improvement, however his urine continued to contain blood. This produced a treatment dilemma in the sense that Aspirin had been prescribed in the course of treatment for the cerebral ischemia, but was ceased so as not to exacerbate the urinary tract bleeding.

2.8. On 1 April 2002, Mr Kerkman's condition deteriorated further, and he developed pneumonia and resultant atrial fibrillation and subsequently hypoxia. These conditions were treated, but his condition continued to deteriorate and, after discussion with Mr

Kerkman's family, it was decided that there would be no active resuscitation measures taken to prolong his life.

2.9. Treatment in the form of antibiotics continued to be provided but by 5 April 2002, Mr Kerkman had suffered renal failure and it became apparent that the sepsis was spreading.

2.10. On 6 April 2002, the sepsis had led to multiple organ failure and eventual cardio-respiratory arrest, and death was diagnosed at 5:00am (see the statement of Dr Anderson, Exhibit C2a).

3. Cause of Death

3.1. Dr Lao gave the opinion that the probable cause of Mr Kerkman's death was sepsis secondary to hospital acquired pneumonia resulting in multiple organ failure and consequent cardio-respiratory arrest (Exhibit C1b, p4). I accept Dr Lao's opinion in this regard and find that the cause of death was as he described.

4. Conclusions and Recommendations

4.1. Having regard to the evidence before me, I conclude that there is no cause for concern about the standard of treatment provided to Mr Kerkman during his illness. Decisions were made in consultation with designated members of his family, and appropriate measures were taken during the palliative stage of his illness.

4.2. There are no recommendations pursuant to Section 25(2) of the Coroners Act 1975.

Key Words: Death in Custody

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 24th day of April, 2003.

Coroner