

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 3rd and 14th days of March 2003, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Erini Moustakos.

I, the said Coroner, find that, Erini Moustakos, aged 53 years, late of James House Hotel, James Street, Cheltenham, South Australia died at the Royal Adelaide Hospital, Adelaide, South Australia on the 17th day of September 2001 as a result of infarction of the transverse colon due to mesenteric/retroperitoneal haemorrhage and incisional abdominal hernia, in the setting of anticoagulation.

1. Reason for Inquest

- 1.1. On 4 September 2001, Drs Julian Kent and Andrew Beckwith, psychiatrists, made an order pursuant to Section 12(6) of the Mental Health Act, 1993, that Ms Moustakos be detained for a period of 21 days.
- 1.2. Accordingly, on 17 September 2001, Ms Moustakos 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 was therefore mandatory pursuant to Section 14(1)(a) of the said Act.

2. Background

- 2.1. Ms Erini Moustakos first attended upon Dr PE Foenander, a General Practitioner in Port Adelaide, in 1981. She had been diagnosed with a schizophrenic mental illness

as long ago as 1967. From that time onwards, Ms Moustakos was treated with anti psychotic medication.

- 2.2. Dr Foenander continued to see Ms Moustakos approximately six times a year, and he treated her with intramuscular anti-psychotic medication (see Exhibit C4a, p2). In April 2000, Dr Foenander prescribed risperidone (Resperdal), an oral anti psychotic medication, but in July 2001 a further deterioration in Ms Moustakos' condition was noted and her medication was changed to intra-muscular Clopixol.
- 2.3. In 1998, Ms Moustakos became a resident at St Eliza's Supported Residential Facility at Cheltenham.
- 2.4. The Manager of St Eliza's, Ms Sophie Brandenburg, said that Ms Moustakos' behaviour became more bizarre in July and August 2001, to the extent that Ms Brandenburg contacted the Port Adelaide Acute Crisis Intervention Service (ACIS) on 10 August 2001. Mr Terry Werner from ACIS suggested that Ms Moustakos be taken by ambulance to the Queen Elizabeth Hospital which was done.
- 2.5. Ms Moustakos was transferred from the Queen Elizabeth Hospital to Glenside Hospital in the early hours of 11 August 2001. At about 1:17am on 11 August 2001, Dr Rhett Bosnich made an order for admission and detention pursuant to Section 12(1) of the Mental Health Act 1993.
- 2.6. At 9:20am that same morning, Dr John Litt, psychiatrist, confirmed Dr Bosnich's order pursuant to Section 12(4) of the Mental Health Act and detained Ms Moustakos for a period of three days.
- 2.7. On 13 August 2001, Ms Moustakos was transferred from Glenside Hospital to the Royal Adelaide Hospital by order of Dr Barbara Kelly, psychiatrist, pursuant to Section 16 of the Mental Health Act. The transfer took place because the staff at Glenside were concerned that the delirium being displayed by Ms Moustakos may have had an organic, rather than a psychiatric basis. A letter from Dr Dan Short, a psychiatric registrar to the Emergency Department at the Royal Adelaide Hospital, makes this clear (see the Royal Adelaide Hospital case notes, Exhibit C14).
- 2.8. On 14 August 2001, Dr Julian Kent made an order pursuant to Section 12(5) of the Mental Health Act detaining Ms Moustakos for a period of 21 days. This order was

followed on 4 September 2001, as I have already outlined, with an order pursuant to Section 12(6) of the Act detaining her for a further 21 days.

2.9. During Ms Moustakos' stay at the Royal Adelaide Hospital, her condition gradually deteriorated.

2.10. I received a report from Mr Robert Britten-Jones, Emeritus Consultant Surgeon at the Royal Adelaide Hospital. Mr Britten-Jones has vast experience in abdominal and laparoscopic surgery. He has thoroughly reviewed the case notes from both The Queen Elizabeth and Royal Adelaide Hospitals, and from the South Australian Mental Health Service, as well as microfiche film of Ms Moustakos' Hillcrest Hospital file going back as far as 1974. He outlined in considerable detail Ms Moustakos' medical history, some of the significant points of which were as follows:

- Ms Moustakos had been hospitalised at Hillcrest Hospital as long ago as March/April 1967 with 'catatonic schizophrenic reaction';
- She was admitted again in March 1987 with 'brief reactive psychosis';
- In 1971 it was noted that Ms Moustakos had an incisional hernia in a vertical caesarean section scar. Surgeons were unable to operate at that stage because Ms Moustakos was obese;
- In 1996 Ms Moustakos was admitted to the Queen Elizabeth Hospital. A huge defect in the abdominal wall was noted and a strangulated incisional hernia was diagnosed. Emergency surgery was carried out which required removal of part of the small and large bowel;
- In June 1998 Ms Moustakos was admitted with a small bowel obstruction which settled with conservative management.

(Exhibit C12b)

2.11. In relation to the final admission to the Royal Adelaide Hospital on 13 August 2001, Mr Britten-Jones said:

'Ms Moustakos was assessed by the medical registrar on 14 August 2001 as having "quite significant features of delirium". On 15 August 2001 she was seen by the medical consultant in charge Dr Michael Chia and assessed as "psychiatric rather than organic delirium". She was thoroughly investigated and no organic cause for the delirium could be found. On 17 August 2001 the deceased was to be transferred back to Glenside but developed a fever and further investigations were carried out. On 24 August 2001 there was a sudden deterioration in her condition. She complained of some lower abdominal pain for the first time. There was a mild fever and low blood pressure. On the result of a V-Q x-ray scan it was thought likely that she had suffered a pulmonary embolus and

anti-coagulation treatment was commenced. Because of the abdominal pain the treating medical team asked for a surgical review. The surgical registrar recorded that her abdomen was distended and obese but soft and “unlikely to be surgical pathology”.

On 26 August 2001 profuse diarrhoea was recorded and a small vomit of bile. The surgical registrar examined the deceased again noting that she still complained of some pain in the left iliac fossa according to the nursing staff although he could obtain no history from the patient. On examination of the abdomen he noted multiple anterior abdominal wall herniae. He noted mild tenderness in the left iliac fossa but no guarding or rebound and stated that “the herniae seemed reducible and do not appear to be incarcerated”. An abdominal x-ray was ordered and reported as “significantly distended loops of ileum were seen with fluid levels – appearances suggest a distal small intestinal obstruction”. As she was passing profuse loose bowel actions and there was gas and faeces in the rectum and no clinical signs of strangulated (i.e. ischaemic) bowel, he diagnosed partial small bowel obstruction.

Again on 28 August 2001 she was seen by the surgical registrar who found on examination that the abdomen was soft, non-tender and herniae not as pronounced. A CT scan x-ray was carried out and reported as “the patient is markedly obese. There is a very large hernia involving most of the abdominal wall. Loops of bowel and even part of the liver are in the hernia. No evidence of ischaemic gut, no focal abdominal or pelvic fluid collections”. For some days the patient has been incontinent of urine and a urinary tract infection was confirmed by laboratory tests and anti-biotic treatment was commenced. Since her admission the nursing notes contained frequent references to confusion, disorientation, non-compliance, inappropriate behaviour, difficult to obtain history, constantly removing gown and sheets. Her arms had to be shackled to prevent her from grabbing at staff and pulling at catheters, intravenous lines etc. On 29 August 2001 the medical registrar records “continues to be significantly confused and disorientated”. 30 August 2001 surgical registrar reviews again stating that the abdomen is soft, non-tender currently pain free, no surgical problems identified. On 3 September 2001 the medical Intern records “the patient has pain in the left iliac fossa (but does not look particularly distressed), difficult to take history from patient and when she answers appropriately it is difficult to assess reliability”.

On 5 September 2001 the nursing notes state that the patient is eating well, able to feed herself with some assistance and drinking well. She is afebrile and does not appear to be in pain, bowels have opened twice, recognised her sister but her sister said, “Erini is confused”. On 6 September 2001 it is recorded that the patient was eating well, bowels were open and loose but she was complaining of pain in the abdomen. She was seen again by the surgical registrar who noted that the abdomen was distended and the herniae were very prominent and tense “cannot exclude sigmoid volvulus”. He ordered a rectal tube be passed in an attempt to deflate the abdomen. This was successful with a large amount of gas and fluid faeces being expelled with the result that the abdomen was recorded as very much softer.

On 7 September 2001 the staff surgeon recorded that the abdomen was soft and non-tender and ordered “continue conservative treatment”. On 10 September 2001 the surgical registrar notes the abdomen to be soft and non-tender and notes that the obstruction has resolved with conservative treatment and the patient is alert and tolerating diet, eating and drinking well. He further records “I can review in the future if

the need arises, no plan for operative intervention at this stage". On 14 September 2001 the medical consultant in charge Dr Chia records "not improving at all despite maximal therapy, prognosis is very poor and her chance of recovery to normal mobility and a useful lifestyle very slim, not for resuscitation.

On the 16 September 2001 rectal tube decompression of the abdomen was again successfully carried out with passages of flatus and faeces. A pre-decompression abdominal x-ray had shown multiple dilated loops of large bowel. She was found to be less distended after the decompression. The following day Erini Moustakos died, her condition having gradually deteriorated over the previous two weeks.'

(Exhibit C12b, p3-5)

2.12. Mr Britten-Jones considered a number of issues arising from Ms Moustakos' treatment which had been raised by Ms Moustakos' son, Dr Buly Cardak. A number of those issues were not concerned with the cause and circumstances of death, but raised issues such as communication with relatives and so on which are not germane to my inquiry.

2.13. As to the cause and circumstances of Ms Moustakos' death, I summarise Mr Britten-Jones' conclusions as follows:

- That the decision to refer Ms Moustakos to the Royal Adelaide Hospital to exclude an organic cause for her delirium, particularly a urinary tract infection, was correct;
- That a urinary tract infection was diagnosed and treated appropriately with antibiotics, but this made no difference to Ms Moustakos' ongoing mental confusion and disorientation;
- A diagnosis of pulmonary embolism made on 24 August 2001 on the basis of a 'V-Q x-ray lung scan' was reasonable and that the anti-coagulation treatment ordered was appropriate;
- The dosage of anti-coagulant medication (Warfarin) was appropriate, although on 6 and 8 September, the levels were dangerously high indicating that Ms Moustakos was suffering a possible internal haemorrhage. Following the high reading on 8 September the administration of Warfarin was ceased;
- The findings of extensive retroperitoneal (and mesenteric) haemorrhage in the bowel was probably due to over anti-coagulation from 6 to 8 September 2001, but this was not critical to the cause of death;
- Repeated surgical consultations from 24 August (when Ms Moustakos first complained of abdominal pain) until 10 September 2001 recorded no signs of strangulation of the transverse colon. There was no indication for surgical intervention since there were no signs of complete intestinal obstruction (there were periods on incomplete obstruction which were relieved with conservative management).

Mr Britten-Jones commented:

'It would have been a major surgical undertaking in a very sick confused, non-compliant and disorientated patient who at times required shackling of her arms to the side of the bed, and I very much doubt that she would have survived the operation ... I believe the surgeons were correct in not operating on Ms Moustakos and if they had I do not think it would have prevented her death, in fact it would probably have hastened it.'

(Exhibit C12b, p7)

He added:

'I am particularly impressed with the standard of the nursing and medical progress notes during Ms Moustakos' illness in R.A.H.'

(Exhibit C12b, p8)

2.14. I have received written submissions from Dr Buly Cardak, Ms Moustakos' son. Dr Cardak has raised a number of further issues including:

- He, as the next of kin, was not aware that a 'Not for Resuscitation' order was in existence in relation to Ms Moustakos;
- The medication record is missing from the Clinical Record maintained by the Royal Adelaide Hospital (Exhibit C14);
- The Royal Adelaide Hospital did not obtain Ms Moustakos' Clinical Records from The Queen Elizabeth Hospital in relation to her medical history, even though they were having trouble diagnosing her organic condition;
- The Royal Adelaide Hospital clinicians did not consult Ms Moustakos' family in relation to her medical history;
- The Royal Adelaide Hospital clinicians failed to keep him and his family informed of the progress of his mother's condition, particularly when her condition became critical.

2.15. As I have already said, Dr Britten-Jones considered a number of these issues, and I accept his opinion that they do not touch upon the cause and circumstances of death. They are issues which have been appropriately raised, and I will draw them to the attention of the Chief Executive Officer of the Royal Adelaide Hospital.

3. Conclusion

3.1. Having regard to these matters, there is no evidence upon which I could find that Ms Moustakos' attending clinicians should have diagnosed a strangulated transverse colon on the basis of her presentation to them on August 2001. Even if such a diagnosis had been made, the only possible treatment would have been emergency surgery. Unfortunately, Ms Moustakos' psychological and psychiatric condition would have prevented this from being undertaken. On the basis of these conclusions, I can find no grounds for criticism of the clinicians attending Ms Moustakos during her admission to the Royal Adelaide Hospital in August 2001.

4. Recommendations

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

Key Words: Hospital treatment; psychiatric illness; death in custody.

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

Seal the 14th day of March, 2003.

Coroner