

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 20<sup>th</sup> and 30<sup>th</sup> days of July 2004, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Robert Norman Curnow.*

*I, the said Coroner, find that Robert Norman Curnow aged 81 years, late of the Glenside Campus of the Royal Adelaide Hospital, Eastwood, South Australia died at Eastwood, South Australia on the 6<sup>th</sup> day of November 2002 as a result of myocardial infarction.*

### **1. Reason for inquest**

- 1.1. On 11 October 2002 Dr Jacqueline Symon, Psychiatric Registrar, made an order pursuant to Section 12(1) of the Mental Health Act 1993 ('the Act') for the admission and detention of Mr Curnow to Glenside Hospital. The grounds for Dr Symon's order were that Mr Curnow had a cognitive deficit and impaired judgment, with a recent history of aggression. Dr Symon concluded that Mr Curnow was a risk to himself and others.
- 1.2. On 12 October 2002 Dr Philip Kneebone, Psychiatrist, confirmed Dr Symon's order pursuant to Section 12(4) of the Act.
- 1.3. On 14 October 2002, Dr Sarojana Hapuarachchi, Psychiatrist, made an order pursuant to Section 12(5) of the Act detaining Mr Curnow for a period of 21 days.
- 1.4. On 4 November 2002, Dr Joanne Pieters and Dr Terissa Page, both Psychiatrists, made an order pursuant to Section 12(6) of the Act for a further period of 21 days.

The basis of this order was that Mr Curnow was suffering from severe dementia and had a significant cognitive deficit. It was considered that he required treatment in a secure ward with psychotropic medication.

- 1.5. Accordingly, at the time of his death on 6 November 2002, Mr Curnow 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**

- 2.1. The statement of Dr Geoffrey Symons (Exhibit C13a) records that Mr Curnow had been diagnosed with dementia since about 1992 and that by October 2002 he had been steadily deteriorating over the last few months.
- 2.2. On 11 October 2002 Dr Symons referred Mr Curnow to the Rural and Remote Unit at Glenside Hospital because his family, and in particular his daughter Mrs Jennifer Swaby, was having increasing difficulty looking after him. He had become both verbally and physically aggressive and his personal hygiene and other issues had become particularly difficult.
- 2.3. In consultation with Dr Symons, Mrs Swaby and her husband drove Mr Curnow to Glenside Hospital where he was admitted as a voluntary patient (see Mrs Swaby’s statement, Exhibit C14a).
- 2.4. Upon admission to Glenside Hospital, Mr Curnow was seen by Dr Jacqueline Symon, the on-duty Psychiatric Registrar in Downey House East. Physical examination was difficult because Mr Curnow was uncooperative. Dr Symon ordered the continuation of medication that had been prescribed for Mr Curnow on an earlier visit to the Royal Adelaide Hospital. This medication included olanzapine (2.5mg twice daily) and carbamazepine (100mg in the morning and 200mg at night).
- 2.5. As I have already outlined, Dr Symon detained Mr Curnow pursuant to the Act on that occasion.
- 2.6. Over the ensuing weeks, Mr Curnow was noted to be improving somewhat. On 4 November 2002, Dr Symon noted that he was ‘coming good’ (Exhibit C7a, p4). On 16 October 2002, Dr Symon found that Mr Curnow was over-sedated so she adjusted

his medication. Subsequent adjustments were made on 23 October, 24 October and 31 October 2002.

- 2.7. On Wednesday 6 November 2002 at about 11am Mental Health Nurse Rex Orr saw Mr Curnow sitting on the floor directly outside the staff office windows. Mr Orr picked up an 'activity tray' which was on the floor near him and put it away. When he returned after an absence of only 5 or 10 seconds he saw Mr Curnow lying on the floor on his left side. He found Mr Curnow unresponsive, pale and cyanosed. Both his arms were 'tremoring'.
- 2.8. Mr Orr summoned the acting Clinical Nurse, Mr David Patching and Enrolled Nurse Heather Le Fevre. The three nurses noted that Mr Curnow's colour was returning and that he became rousable so they conveyed him to his room using a 'lifter'. Dr Benjamin Wells accompanied the three nurses to Mr Curnow's room.
- 2.9. By the time they reached Mr Curnow's room he was again quite pale. As soon as he was placed on the bed cardio-pulmonary resuscitation was commenced. Dr Symon entered the room and administered adrenaline via an intravenous line.
- 2.10. A medical emergency was called and an ambulance attended. Intensive Care Paramedic Stacey Solomou states that they arrived at 11:23am having been summoned at 11:17am. This was a very good response time.
- 2.11. The paramedics intubated Mr Curnow and ventilated him using a bag. Cardio-pulmonary resuscitation was continued and further adrenaline and atropine were administered. They were unable to achieve cardiac output and, at 11:45am due to the lack of response, Ms Solomou pronounced life extinct (see Exhibit C2a, pp1-2).

### **3. Cause of death**

- 3.1. Dr Symon reported that the cause of Mr Curnow's death was a myocardial infarction. I accept Dr Symon's opinion and find that the cause of Mr Curnow's death was as she described.

### **4. Issues arising at inquest**

- 4.1. Mr Curnow's death was investigated by Senior Constable Talei Bentley of Adelaide Criminal Investigation Branch. Senior Constable Bentley has presented a very

thorough and thoughtful investigation report which has been particularly helpful in assessing the issues in this case.

4.2. Senior Constable Bentley has formed the following conclusions as a result of her investigation:

- The various orders detaining Mr Curnow were lawful and justified in the circumstances;
- Mr Curnow's death was not preventable;
- There is no evidence to suggest that Mr Curnow received other than appropriate treatment.

I am content to adopt these conclusions for the purpose of these findings.

4.3. Allergy to Neulactil

Prior to Mr Curnow's final admission to hospital, an issue arose about his reaction to the medication Neulactil (pericyazine). Mr Curnow's General Practitioner, Dr Geoffrey Symons, discontinued the medication on 13 August 2002 because Mr Curnow's level of agitation had increased. The discontinuance of the medication did not have immediate effect, and the agitation was not eased until Tegretol, an anti-convulsant medication, was prescribed on 20 August 2002 (see Dr Symons' affidavit and casenotes, Exhibits C13a and C13b).

4.4. Mr Curnow was subsequently admitted to the Winchester Nursing Home on 13 September 2002, and his reaction to Neulactil was noted clearly by nursing staff at the time.

4.5. Mr Curnow was subsequently admitted to the Royal Adelaide Hospital on 18 September 2002 where, again, Mr Curnow's reaction to Neulactil was noted (see the casenotes, Exhibit C20).

4.6. Mr Curnow was discharged from the Royal Adelaide Hospital on 27 September 2002 into the care of his family and was not admitted to Glenside Hospital until 11 October 2002.

4.7. On admission to Glenside Hospital, Dr Jacqueline Symon noted:

'Epileptic seizures which commenced 8/52 - same time as he was commenced on medication (pericyazine)'

(Exhibit C20)

4.8. Mr Curnow did not receive Neulactil (pericyazine) during his admission at Glenside Hospital.

4.9. Although Senior Constable Bentley drew attention to the fact that Mr Curnow's reaction to Neulactil was not communicated by the Royal Adelaide Hospital to Glenside Hospital staff, she was quick to point out that this issue is in no way linked with Mr Curnow's death, and clearly, she has drawn attention to the issue out of thoroughness.

4.10. Having regard to the fact that Neulactil was not prescribed to Mr Curnow during his stay at Glenside Hospital, I agree with the submission of Mr Bonig, Counsel for the Department of Health, that no criticism of staff at either the Royal Adelaide Hospital or Winchester Nursing Home is called for in relation to this issue.

## 5. **Recommendations**

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

*Key Words: Death in Custody; Mental/Psychiatric Illness*

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

*Seal the 30<sup>th</sup> day of July, 2004.*

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*Coroner*