

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 20th and 30th days of July 2004, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Nikola Novakovic.

I, the said Coroner, find that Nikola Novakovic aged 64 years, late of 3 Sheriff Street, Salisbury East, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 11th day of May 2003 as a result of hypoxic encephalopathy, secondary to cardiac arrest, secondary to myocardial infarction.

1. Reason for inquest

- 1.1. On 30 April 2003 Dr Colin McLeay, General Practitioner, made an order pursuant to Section 12(1) of the Act ('the Act') detaining Mr Novakovic to the Lyell McEwin Hospital on the basis that he was suffering from a delusional illness, was refusing to be examined, and that he was showing signs of breathlessness, distended abdomen and legs, and was suffering from uncontrolled diabetes.
- 1.2. Mr Novakovic was admitted to the Lyell McEwin Hospital after being transported there by ambulance.
- 1.3. On 1 May 2003 Dr R P Nagesh, Psychiatrist, made an order pursuant to Section 12(4) of the Act confirming Dr McLeay's detention order. On 2 May 2001 Mr Novakovic was transferred to the Royal Adelaide Hospital.
- 1.4. On 3 May 2003, Mr Novakovic was examined by Dr Julian Kent, Psychiatrist, who made an order pursuant to Section 12(5) of the Act detaining Mr Novakovic at the Royal Adelaide Hospital for a period of 21 days. The grounds for Dr Kent's order

were that he was suffering from paranoid psychosis, and that he required further inpatient care.

- 1.5. Accordingly, at the time of his death on 11 May 2003, Mr Novakovic 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. Dr McLeay states that he has been treating Mr Novakovic since February 1982. He said:

'From the time I have known him he suffered from a delusional disorder and had diabetes and certainly in 1995 where it was more apparent as he was unwell with those problems. It has been difficult from time to time to get him to comply with his medication and his diabetes. He had associated symptoms of his diabetes such as ulcerations on his legs and I felt that the poor management of his diabetes probably contributed to his death.

The last time I saw him was on the 30th of April 2003, at his home where as I mentioned he refused to let me examine him. I referred him to the Lyell McEwin Health Service and he was taken there by ambulance. I also completed an Order for Admission and Detention under the Mental Health Regulations.

There was nothing else in his medical history that was striking or needing such attention, it was purely his mental state and how it was impacting on his own personal management of his diabetes.'

(Exhibit C4a, p2)

- 2.2. Detective Senior Constable Kranz, who investigated this matter on my behalf, made the following comment in relation to Dr McLeay's treatment of Mr Novakovic:

'During my investigation it appeared obvious that the care provided to Mr Novakovic by his General Practitioner, Dr Colin McLeay, was highlighted as he displayed a high degree of professionalism, compassion, sensitivity, concern and comfort to him and his immediate family under difficult circumstances.'

(Exhibit C5a, p26)

It is appropriate that I record Detective Kranz's comments in these findings as a public record.

- 2.3. After Mr Novakovic was transferred to the Royal Adelaide Hospital, he obviously presented a number of difficulties in relation to treatment. He refused all oral medications including treatment for congestive cardiac failure and atrial fibrillation secondary to ischaemic heart disease, as well as end stage chronic obstructive airways

disease and very poorly controlled diabetes with associated complications including kidney disease.

- 2.4. The statement of Dr V M Hamilton who was working in the Intensive Care Unit at the Royal Adelaide Hospital on 10 May 2003 records the following:

'At about 8:00pm on 10th May 2003, he complained of chest pain and became very agitated.

ECG showed atrial fibrillation with ST and T wave changes, in the lateral leads, consistent with Ischaemia.

He refused all medications. He was given 10ml of Haloperidol intramuscularly, and settled in bed.

At approximately 9:30pm on 10th May 2003, he had a cardiac arrest. Cardiac pulmonary resuscitation was started. He required 30 minutes of advanced cardiac life support to obtain a spontaneous cardiac output. He was then transferred to Intensive Care - intubated and ventilated, requiring 100 mls per hour of adrenalin infusion to maintain his blood pressure.

He was noted to have no gag, no cough. His pupils were unreactive, and he had no spontaneous respiratory effort consistent with hypoxic encephalopathy.

On the basis of these findings, brain death tests were performed at about 9:30am and 12:30pm on 11/5/03.

I pronounced Nikola Novakovic dead at 12:30pm on 11th May 2003.'

(Exhibit C2a, p2)

3. Cause of death

- 3.1. Dr Hamilton stated that in her opinion, the cause of Mr Novakovic's death was hypoxic encephalopathy, secondary to cardiac arrest, secondary to myocardial infarction. I accept Dr Hamilton's conclusion and find that the cause of Mr Novakovic's death was as she has stated.

4. Issues arising at inquest

- 4.1. As I have already mentioned, Mr Novakovic's death was investigated by Detective Senior Constable R W Kranz on my behalf. Detective Kranz has prepared a very thorough and well-presented report detailing the results of his investigation. I summarise his conclusions as follows:

- Mr Novakovic's detention at the Royal Adelaide Hospital at the time of his death was lawful;

- The treatment Mr Novakovic received for his psychiatric condition over the years was appropriate;
- The treatment Mr Novakovic received for his diabetes and other health issues was appropriate even though treatment was difficult because of his uncooperative attitude and inability to care for himself;
- All proper emergency procedures were undertaken after Mr Novakovic's collapse on 10 May 2003;
- Mr Novakovic's death was not preventable.

4.2. I am content to adopt Detective Senior Constable Kranz's conclusions for the purpose of these findings.

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 30th day of July, 2004.

Coroner