

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 13th days of February 2004, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Kevin Charles White.

I, the said Coroner, find that, Kevin Charles White aged 57 years, late of Glenside Hospital, 226 Fullarton Road, Eastwood, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 11th day of July 2003 as a result of aspiration pneumonia secondary to small bowel obstruction.

1. **Reason for Inquest**

- 1.1. On 30 October 2002, the Guardianship Board of South Australia made an order pursuant to section 13 of the Mental Health Act, 1973 that Mr White be detained for treatment for a period of 12 months (the order is contained in Exhibit C9c, Volume 6).
- 1.2. Accordingly, on 11 July 2003 Mr White 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. **Introduction**

- 2.1. Mr White was born on 21 October 1946. He had resided at Glenside Hospital for many years, and had done so continuously since 1991.

- 2.2. On Thursday 10 July 2003 Mr White complained of feeling unwell. While being escorted to his room by a nurse, he vomited and the vomitus appeared to contain faecal material.
- 2.3. The nurse contacted the medical officer, an ambulance was called and Mr White was transferred to the Royal Adelaide Hospital arriving at about 1:42pm.
- 2.4. At about 2:20pm Dr Thomas Soulsby was called by nursing staff to see Mr White as he had very low blood pressure and appeared very unwell. Dr Soulsby thought that he was shocked and it was likely that he had suffered a bowel obstruction. He was treated with fluids and oxygen.
- 2.5. After undergoing an x-ray, Mr White's blood pressure deteriorated even further.
- 2.6. Mr White was seen by Dr James Kollias, Surgeon, who also thought he had suffered a bowel obstruction. He recommended further resuscitation, naso-gastric suction and observation. Similar treatment was recommended by Dr David Hetzel, a Gastroenterologist who saw Mr White at about 7:30pm.
- 2.7. Mr White's condition deteriorated again at about 8:30pm in that he had developed pulmonary oedema. He was intubated and ventilated and given adrenaline. He was transferred to the Intensive Care Unit at about 9:20pm.
- 2.8. By this time it was thought that Mr White had pneumonia and multi-organ failure as well as a bowel obstruction. His condition deteriorated further overnight, with multi-organ failure developing despite maximum supportive therapy. A conference of senior medical advisors considered that his position was hopeless and, in consultation with his family and a representative of the Guardianship Board, aggressive treatment was withdrawn.
- 2.9. Dr Michael Sweeney pronounced life extinct at 2:25pm on 11 July 2003 (Exhibit C1a, p2).

3. **Cause of Death**

- 3.1. Dr Kollias offered the opinion that the cause of Mr White's death was massive aspiration pneumonia secondary to small bowel obstruction (Exhibit C8a, p3).
- 3.2. I accept Dr Kollias' opinion and find that the cause of Mr White's death was as he described.

4. **Background**

- 4.1. Mr White was seen by a psychologist at the Adelaide Children's Hospital at the age of six for behavioural problems. He was assessed as having suffered 'borderline' intellectual retardation. He attended a special school until he was 14, when his family moved to Mannum.
- 4.2. Mr White's earliest contact with Glenside Hospital appears to have been in 1971 when he was admitted to hospital suffering confusion, disorientation and delusions. He was transferred to the Royal Adelaide Hospital because of an allergic reaction to the drug Chlorpromazine.
- 4.3. Mr White had many admissions to Glenside Hospital after that. In 1986 he suffered a 'twisted bowel' and underwent surgery including a colostomy following which he wore a colostomy bag. A number of admissions to the Royal Adelaide Hospital since that time are recorded in the case notes where gastro-intestinal problems were evident.
- 4.4. Mr White's psychiatric diagnosis was unclear until 1993. Since that time it has been accepted that he suffered from schizophrenia, and he was treated for that illness with medication ever since.
- 4.5. The Guardianship Board made successive 12-month detention and treatment orders for Mr White since 1995 in order that the illness could be treated.
- 4.6. In a 'Discharge Summary' written after Mr White's death, Dr Georgette Michail wrote:

'57 y.o. long term resident of Karingai Wd on account of Borderline intellect, Chronic schizophrenia due to delusional beliefs, such as 'the joker' who sits on his shoulder who tells him what to do, but is easily brushed off. He also spoke to his dead mother by telephone where he would hold the receiver and carry on with his mumbling for prolonged time. He had a low IQ of 50 or below that is mentally retarded on neuropsychological and IQ testing that was repeated on several occasions since his admission in 1993.

He had a list of behavioural problems that warranted his ongoing care in a locked ward accommodation and also ongoing Mental Health Orders of Custody and Treatment which were:

- verbal aggression
- physical aggression without provocation
- stealing
- poor self care and poor hygiene

Kevin has also a colostomy and was dysphasic. His speech was incoherent and rather very difficult to interpret.

Kevin had been very difficult to manage and hence required the above listed number of psychotropic medications to help contain his behaviour.'

(Exhibit C9c, Volume 9)

- 4.7. The 'above listed number of psychotropic medications' referred to by Dr Michail were Seroquel, Pericyazine, Sodium Valproate, Clonazepam and Multivitamins.

5. Events leading to admission to Royal Adelaide Hospital

- 5.1. The first indication that Mr White was unwell was given during the night shift of 9 July 2003. Registered Psychiatric Nurse Wendy Houston said that Mr White had vomited down the front of his pyjamas. She helped him to the shower and then saw a large amount of vomit in a nearby toilet. He had also vomited on his bed so RN Houston remade it and Mr White returned to sleep.

- 5.2. At 3:00am, Mr White got up and had a drink and then returned to bed. RN Houston said that Mr White did not appear unwell at that stage.

- 5.3. RN Houston noted the incident in the case notes and mentioned it to the day staff at the handover at about 7:00am (Exhibit C3a, p4).

- 5.4. The next day, 10 July 2003, Mr White complained to Mental Health Nurse Lorraine Hall that he felt sick, indicating his stomach. Ms Hall and another nurse took him to his room where he vomited. Ms Hall said that the vomit was 'faecal in origin' (Exhibit C4a, p2).

- 5.5. The nurses called Dr Michail who attended quickly. Dr Michail's statement records:

'On the 10th of July 2003 I was working at the Cedars Medical Centre and at about 12:30 pm I was called to attend Karingai Lodge to see Kevin White as he had just had a vomit, containing faeces. I went across and examined the patient, straight away.

As usual, Kevin White was being a difficult patient because of his mental incapacity, making it difficult to do anything with him. It was quite impossible to get any history from him or examine him. I got a temperature from him, the recording was 36.2 degrees Centigrade. The pulse was quite feeble, recorded at 80 beats per minute, his BP (blood pressure) was just made at 50 systolic and I could not get a diastolic reading. Although he usually had a low blood pressure, this was much lower than normal. He was obviously clinically dehydrated as he had a dry tongue and a skin pinch indicating it was quite evident that he was quite low in fluids.

The most outstanding feature was the patient complaining about pain when I was palpating his abdomen. The patient had a colostomy bag, it had some faecal matter in it and he was obviously guarding when I was examining his abdomen.

I had to deal with inserting an IV (intravenous) line to help his dehydrated state. I reached out for a set and attempted to insert an IV line two or three times. I tried at least once in each arm, and when I failed, I did not want to delay the situation any longer, so I abandoned further attempts at inserting the IV and started making arrangements for a transfer to the RAH.

It was difficult to get the IV line in because his veins are very hard to find and he was resisting the medical treatment. In the past, to give Kevin White medical treatment, he has had to be very sick or had to be on a stretcher, to examine him, as he was a very difficult patient.' (Exhibit C5a)

5.6. An ambulance was called and Mr White was transferred to the Royal Adelaide Hospital. Ms Hall accompanied him in the ambulance.

5.7. Mr White's treatment at the Royal Adelaide Hospital was as I have already outlined. Dr Soulsby explained the treatment in the Emergency Department as follows:

'I initiated some blood tests and x-rays, and made a note that he should have a nasogastric tube if he did not improve. His blood pressure and oxygen saturation improved, although his pulse remained fast at 124.

At that point he went round for a x-ray of his chest and abdomen. He returned from x-ray at about 1615 hours. At this point his blood pressure had dropped again and was 57 over 41. He was given further fluids and at this point, his care was taken over by Dr. Robert DUNN and Dr. Michael DAVEY, who are both consultants in Emergency Medicine at the RAH.

The abdomen x-ray confirmed a bowel obstruction and the chest x-ray indicated he may have aspirated and had pneumonia. He was given another five litres of normal saline, two units of gelofusine and oxygen while under Dr.'s DUNN and DAVEY. The General Surgeons and Intensive Care Unit (ICU) staff reviewed him at about 1730 hours, and it was determined he would be transferred to a ICU bed. He was also reviewed by a Gastroenterology Registrar. His blood pressure returned to normal by about 1800 hours.

At about 2030 hours, observations showed he had deteriorated while waiting for an ICU bed and he became very distressed and agitated. He developed some signs of pulmonary oedema and was intubated and ventilated. He was subsequently transferred to ICU, leaving ED probably about 2120 hours, when the last observations were taken. He was commenced on adrenaline infusion before leaving ED.' (Exhibit C6a)

5.8. Dr Michael Farr was an Anaesthetic Registrar who was working in the Intensive Care Unit at the Royal Adelaide Hospital at the time. He said:

'In my assessment, there was a small bowel obstruction and right and left lower lobe pneumonia (+/- aspiration). Given his fever, raised white cell count, cardiovascular instability and evidence of multi-organ failure, he appeared to be in septic shock.

The plan was to 1) Provide medications as charted, including the antibiotics Timentin and Ciprofloxacin, 2) Place a central venous catheter to monitor fluid status, which I put in to his internal jugular vein to just outside his heart, 3) To repeat his chest x-rays and blood tests in the morning and 4) Conservative management of his small bowel obstruction (as per the surgical team). The surgeons were to review in the morning.

Mr. White remained in the ICU with a one on one nurse, and I had no further involvement with the patient, as the doctor looking after patients in that part of ICU returned from another ward to which he had been called. I completed work at 8:30 am.

Looking at the notes of an entry apparently made by Peter Sharley, an ICU consultant, noted on the 11th of July 2003 at 0930 hours. I am able to say that Mr. White's condition deteriorated overnight with worsening multi-organ failure despite almost maximal supportive therapy (100 micrograms a minute of adrenalin). Given the multiple problems and multi organ failure, his outlook was very grim and his prognosis was extremely poor.' (Exhibit C7a)

5.9. Dr Kollias, the Surgical Consultant who reviewed Mr White initially, said:

'Initial investigations, including abdominal x-ray, suggested the likelihood of a small bowel obstruction. My initial recommendation was for resuscitation, naso-gastric suction and observation. If deterioration occurred then laparotomy should be considered.

These measures were instituted and he was subsequently reviewed by the Gastroenterologist, Dr. Hetzel at 7:30 pm, who recommended similar measures.

At 9:20 pm his clinical state deteriorated while waiting for an Intensive Care (IC) bed. The overall features suggested the likelihood of aspiration pneumonia. The emergency Physician, Dr. Dunn, intubated the patient and commenced further resuscitation measures including the use of adrenaline and intravenous antibiotics. He was subsequently transferred to the IC ward for further stabilisation.

At 3:30 am (11th July 2003) the Surgical Registrar, Dr. Shilbi, again reviewed the patient and he was noted to have significantly deteriorated. It was at this time that I was again contacted and recommended laparotomy.

Dr. Shilbi then discussed this recommendation with the Anaesthetist and IC Consultant, who felt that the patient was too unstable to leave the IC department and would not survive surgery.

It was felt that he had suffered massive aspiration pneumonia secondary to small bowel obstruction. He was closely observed in the IC ward, with aggressive resuscitation measures overnight, but failed to respond to treatment.

At about 9:30 am on the 11th July 2003 a case conference was conducted with Dr. Peter Sharley IC Consultant, Professor Runciman IC Consultant, Dr. Peter Malycha Surgeon, myself, the patient's sister and the Guardianship Board representative. The final decision was to withdraw aggressive treatment due to the poor prognosis. The oxygen requirements were reduced at 1:45 pm and inotrope support withdrawn. The patient subsequently died at 2:25 pm on the 11th of July 2003 and the Coroner's Office was advised.' (Exhibit C8a)

6. Issues Arising at Inquest

6.1. Medical Treatment provided

The nursing staff at Glenside responded quickly to Mr White's presentation on 10 July 2003, and he was quickly and appropriately transferred to the Royal Adelaide Hospital by Dr Michail.

6.2. At the Royal Adelaide Hospital, the decision was made by a number of consultants to treat Mr White conservatively, and his condition did improve initially when his blood pressure returned to normal.

6.3. However, after he aspirated, Mr White's condition deteriorated rapidly to the extent that surgical intervention would not have assisted. The decision was taken, in consultation with all the appropriate people, not to proceed with aggressive treatment because the situation was hopeless.

6.4. In all those circumstances, I have no criticism of Mr White's treatment.

7. Recommendations

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

Key Words: Death in Custody; Hospital Treatment; Psychiatric/Mental Illness

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

Seal the 13th day of February, 2004.

Coroner