CORONERS ACT, 2003

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 12th day of July 2005 and the 11th day of August 2005, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Acting State Coroner, into the death of Peter John Begbie.

The said Court finds that Peter John Begbie aged 41 years, late of 4 Clara Street, Murray Bridge, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 30th day of January 2002 as a result of multi-organ failure and staphylococcal septicaemia following pulmonary and aortic valve replacement for staphylococcal endocarditis of the aortic valve. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. The deceased, Peter John Begbie, was born on 30 December 1960. He died on 30 January 2002 at the Royal Adelaide Hospital ('RAH') where he was a patient. He was 41 years of age at the time of his death.

1.2. The deceased was originally admitted to the RAH on 17 January 2002.

1.3. He was re-admitted to the RAH on 19 January 2002 having discharged himself the day before. He remained in the RAH between 19 January 2002 and 30 January 2002, the day of his death. At all material times in that period, the deceased was detained pursuant to the provisions of the Mental Health Act 1993 ('MHA'). As of the day of his death the deceased was subject to a 21 day detention order, pursuant to section 12(5) of the MHA. Although this death had been notified pursuant to the provisions

of the repealed Coroners Act 1975, it was in my view to be regarded as if it were a notification of a reportable death under the Coroners Act 2003 (see Section 25(3) of the Schedule to the 2003 Act). I have therefore taken the view that all of the provisions of the 2003 Act, including those which define the circumstances in which an inquest under the 2003 Act is mandatory, apply to this death. The deceased's death was a death in custody as defined in Section 3 of the 2003 Act.

1.4. Accordingly, an inquest to ascertain the cause or circumstances of the deceased's death was mandatory by virtue of Section 21(1) of the 2003 Act. If I am wrong about that, and the repealed Act still applies, an inquest into the deceased's death was in any event mandatory pursuant to Sections 12(1)(da) and 14(1a) of the repealed Act for the same reasons, namely because the deceased died while he was detained in custody.

2. Cause of death

2.1. I deal with the possible aetiology of the deceased's illness later in these findings, but it is clear that by the time of the deceased's detention and re-admission to the RAH he had developed a severe life threatening staphylococcal aureus septicaemia, very likely associated with an infected heart valve or valves. Septicaemia is essentially blood poisoning caused by bacterial infection. He was extremely unwell and in due course it was medically determined that he required surgery to replace his aortic valve which by then had been afflicted with an infection called endocarditis. An already existing heart valve defect can predispose a person to such an infection. Without that procedure he would certainly have died. This procedure took place on 27 January 2002. In the event, the pulmonary valve of the heart was also replaced as part of the same procedure.

2.2. The surgery was a long and complex procedure. It was technically successful in the sense that both valves were successfully replaced. However, the deceased suffered extensive infarction in the left ventricle of the heart and suffered other complications of cardiac failure and septicaemia including kidney failure, necrosis of the liver and respiratory failure. The deceased does not appear to have regained consciousness following the surgical procedures. In view of his poor progress, treatment was withdrawn on the day of his death.

2.3. A post-mortem examination was performed by Dr John Gilbert, a Forensic Pathologist at the Forensic Science Centre. Although an issue has arisen in this

inquest as to the role that a disease known as Q fever may have played in the deceased's deterioration and death, an issue to which I return, Dr Gilbert expresses the opinion that the cause of death was multi-organ failure and staphylococcal septicaemia following pulmonary and aortic valve replacement for staphylococcal endocarditis of the aortic valve. I accept Dr Gilbert's conclusions in this regard and I find the cause of the deceased's death to be that described by Dr Gilbert.

3. Circumstances of the death

3.1. The deceased resided at Murray Bridge. He was in a defacto relationship with a Deanne Marie Stephens whose affidavit and witness statement I received in evidence (Exhibits C1 and C1a). He had been employed at the local abattoir.

3.2. From time to time, the deceased attended the Bridge Clinic at Murray Bridge as a patient. On 4 January 2002 he had presented to the clinic having suffered a laceration to his left thumb. He had suffered this at work. The laceration had required stitches. Soon after this incident, according to his partner, the deceased became unwell, displaying flu-like symptoms and experiencing dizzy spells.

3.3. At about 7:30am on 13 January 2002 the deceased presented to the Murray Bridge Hospital Accident and Emergency Department and was there seen by Dr Roger Martin, who was also a practitioner in the Bridge Clinic. He was suffering from chest pain and fever. He had been sweating and shivering all night. At that point in time he was diagnosed with a viral infection and sent home.

3.4. He presented again to the Bridge Clinic four days later on 17 January 2002 and was again see by Dr Martin. The deceased was still acutely unwell, suffering from aching joints, vomiting and diarrhoea. Dr Martin suspected that the deceased was suffering from Q fever or some other virus. He took a blood sample. Q fever is a disease characterised by fever, severe headaches and often pneumonia and is sometimes seen in abattoir workers. It is caused by the organism coxiella burneti. As it transpired, the deceased was later to be diagnosed with this infection. Dr Martin, in his clinical setting, could not make any positive diagnosis at the time. However, he prescribed an antibiotic for the deceased and took a blood sample from him. The deceased declined hospitalisation on this occasion.

3.5. About lunch time of that day, Dr Martin was informed that a blood test had revealed that the deceased's blood platelet count was seriously low, in keeping with a severe infection of a then undetermined cause. Dr Martin was able to contact the deceased. The situation was explained to him and he was persuaded to go to hospital.

3.6. The deceased was conveyed by ambulance to the RAH where he was admitted later that day. Upon his arrival, it was clear that the deceased was unwell with a severe infection, suspected at that stage of being either pneumonia or a blood stream infection from an infected heart valve. It was suspected that the infection may have originated from intravenous amphetamine usage, an activity not unknown to the deceased according to the statement of Deanne Stephens.

3.7. The deceased remained at the hospital until about 10pm the following evening when it is said that he 'absconded', meaning that he informally discharged himself without the knowledge and against the wishes of those treating him. He had not been detained at that stage. Before he left, the existence of the severe infection had been confirmed. Blood cultures had revealed a staphylococcal aureus septicaemia. The deceased was being treated with appropriate antibiotic medication at the time he left.

3.8. What prompted the deceased to leave the RAH is not clear. It is also unclear as to what he did immediately after he left. The hospital notified the police, not because his being at large was unlawful, but in the hope that the deceased might be located with his safety in mind. The next known sighting of the deceased was by his partner, Deanne Stephens, at about 2am the following morning when he turned up on her doorstep at Murray Bridge. She had last spoken to the deceased on the telephone the previous afternoon when he was in the RAH. He had sounded his normal self on that occasion. There was a suggestion in the material before me that the deceased walked from the RAH to Murray Bridge. This can be discounted, of course, because the intervening period was only four hours. In the event, I do not need to address this issue, nor whether this hiatus in treatment exacerbated his condition or led to his death. There is certainly no evidence of the latter.

3.9. When the deceased arrived at Murray Bridge, he is described by Ms Stephens as looking unwell. His legs were swollen and his eyes were sunken. He said that the hospital had let him out. He seemed paranoid to the point where he said that the hospital was trying to kill him and that he had to scale the walls to get away. He

made other bizarre claims, all of which were in keeping with an acute alteration of his mental state caused by the infection. Ultimately, and after considerable difficulty, Ms Stephens was able to persuade the deceased to allow her to take him to the Murray Bridge Hospital. There he saw a Dr David Butler who was also a practitioner at the Bridge Clinic. The time by then was about 7pm which meant that the deceased had been away from the RAH, and a proper regime of treatment, for about 21 hours.

3.10. It was Dr Butler who originally detained the deceased under the MHA. He did so on the basis of his own observations of the deceased in conjunction with information from the RAH. Dr Butler believed that the RAH had diagnosed inter alia staphylococcal septicaemia and a possible heart valve infection which were being treated with intravenous antibiotics. Dr Butler himself formed the same view. Dr Butler found on his own examination that the deceased was delusional, disorientated and paranoid. He believed that it was likely that the deceased was delusional from having a high fever and the septicaemia, although he thought that alcohol withdrawal may have played some role in his presentation. The deceased refused to entertain the notion that he required expert treatment at the RAH. Although Dr Butler did not believe that the deceased had a chronic mental illness, he took the view that his acute mental condition was the product of his serious physical illness. In Dr Butler's own words:

> 'I detained him under the Mental Health Act as I thought he was endangering his health in refusing treatment.'
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> (Statement verified by affidavit of Dr David Andrew Butler dated 8 June 2005, Exhibit C8a)

3.11. I take Dr Butler's statement to mean that he detained the deceased to ensure that he received appropriate treatment for a life threatening physical illness for which the deceased was resisting treatment, the resistance being the product of his acute mental instability.

3.12. Dr Butler detained the deceased under Section 12(1) of the MHA which reads as follows:

> 12(1) If, after examining a person, a medical practitioner is satisfied:
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> (a) that the person has a mental illness that requires immediate treatment; and
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> (b) that such treatment is available in an approved treatment centre; and

(c) that the person should be admitted as a patient and detained in an approved treatment centre in the interests of his or her own health and safety or for the protection of other persons,

the medical practitioner may make an order for the immediate admission and detention of the person in an approved treatment centre.

3.13. Although the primary focus was on treatment for the deceased's physical illness, in my view the detention was authorised under Section 12(1) of the MHA. His delirium and general confused state could be characterised as an 'illness or disorder of the mind' in accordance with the definition of mental illness in Section 3 of the MHA. That mental illness did require immediate treatment because it was the very reason the deceased was refusing treatment for his life threatening physical illness. His detention was therefore necessary in the interests of his health and safety. It is to be observed that the MHA is not solely confined to the compulsory treatment of mental illness. Section 18 authorises the treatment of a detained patient in an approved treatment centre not only for the mental illness that is the catalyst for the detention, but for any other illness. Such treatment may be given notwithstanding the absence of refusal of consent of the detained person or any other person. In my view therefore, the deceased was detainable, notwithstanding that the primary motivation of the person detaining him was the treatment of a physical illness.

3.14. In any event, it is plain that if the deceased had not been detained, he would not have undergone treatment of his own volition and inevitably would have died.

3.15. As a result of his detention, the deceased was again conveyed to the RAH on the evening of 19 January 2002. The detention order was reviewed and confirmed the following day under Section 12(3) of the MHA by a psychiatrist, Dr Shane Gill, whose statement verified by affidavit I received in evidence (Exhibits C5 and C5a). Dr Gill confirmed the order based on a diagnosis of delirium related to septicaemia. Dr Gill explained that the deceased did not need any specific psychiatric treatment as the reversal of the septicaemia could resolve his delirium, but that the detention order was a way of managing the risk of him absconding due to the acute confusion brought about by the seriousness of his infectious disease. In addition, it could also be inferred that the deceased's capacity to understand the nature of medical procedures would also have been impaired. In all of these circumstances, in my view the deceased's further detention was lawful and appropriate.

3.16. As it happened, the deceased was treated for his acute mental disturbance. He was prescribed 5mg of olanzapine twice daily from 20 January 2002 to 25 January 2002 by which time such treatment was considered to be no longer appropriate. Olanzapine is a drug indicated for the management of the manifestation of psychotic disorders.

3.17. Physically, the deceased deteriorated after his re-admission. It was determined that the infection was destroying his heart valve. He had a severe endocarditis of the aortic valve with an associated dysfunction of that valve. He remained relatively stable over the next few days but a new regime of antibiotics was not sufficient to control the infection.

3.18. The deceased remained confused and agitated and had to be sedated. On 22 January 2002, the 3-day detention order under the MHA was reviewed by another psychiatrist, Dr Helen Marmanidis whose statement verified by affidavit I received in evidence (Exhibits C6 and C6a). She refers to the deceased's mental condition as an Acute Organic Brain Syndrome secondary to the endocarditis. He was confused and she concluded that his health was severely jeopardised by a medical condition that warranted further treatment. Dr Marmanidis made an order under Section 12(5) of the MHA for the further detention of the deceased for a period of 21 days. As observed earlier, it was during the currency of this detention order that the deceased died. Again, in my view, the further detention order was in the circumstances lawful and appropriate.

3.19. By 25 January 2002, the deceased's clinical state had deteriorated. He had developed heart failure because the aortic valve was rapidly disintegrating from the presence of the infection. He was reviewed by Cardiothoracic Surgeon, Mr Cullen. The opinion of senior physicians was that the deceased would certainly die without aortic valve replacement. There was also a risk that he would die from the operation or its sequelae, but this risk was considered to be significantly less than the absolute risk that existed if the operation was not performed. These risks and benefits were explained to him.

3.20. The deceased was transferred to the Intensive Care Unit on 25 January 2002. The deceased's clinical record (Exhibit C9i) reveals that his partner, Deanne Stephens, was contacted that evening and informed of that fact. The deceased is recorded as being lucid and orientated (sic) that evening. He stated that he wanted his surgery

delayed until Sunday 27 January 2002 so he could see his partner and children. The clinical record reveals that on 26 January 2002 the deceased formally consented to the necessary surgical procedures.

3.21. The deceased underwent surgery on 27 January 2002. Extensive infection and abscesses were discovered not only in the aortic valve but in other parts of the heart. The pulmonary valve also required replacement. It was an extremely difficult surgical procedure.

3.22. In the days following surgery, the deceased deteriorated. At one point he suffered a cardiac arrest. He developed renal (kidney) failure which worsened. Other organs failed. He ultimately died at 10:38am on 30 January 2002.

4. The post-mortem examination

4.1. The post-mortem examination was conducted by Forensic Pathologist, Dr John Gilbert. His reports verified by affidavit are Exhibits C2, C2a, C2b, C2c and C2d. None of Dr Gilbert's conclusions in any way conflict with any of the observations contained in the statements of those responsible for the deceased's treatment. I accept Dr Gilbert's conclusions in their entirety. Dr Gilbert concluded that even after surgery, the deceased's situation was irretrievable due to extensive infarction associated with the heart, necrosis of the liver due to cardiac failure, respiratory failure due to septic infarct and Adult Respiratory Distress Syndrome.

4.2. I have already referred to the possible role of Q fever in the deceased's heart valve infection. It is to be observed that before his death, both Q fever and a staphylococcus aureus infection were diagnosed. Dr Gilbert raises the possibility that Q fever may have infected the aortic valve first. Such an infection would increase the likelihood that other organisms, such as staphylococcus aureus, would then secondarily have attacked and infected the valve. However, he expresses the view, which I accept, that Q fever endocarditis was not in itself responsible for the death. The cause of death was the overwhelming staphylococcal infection. Importantly, however, Dr Gilbert states that it is entirely possible, if not probable, that an initial Q fever infection in conjunction with a pre-existing aortic valve abnormality set the stage for the staphylococcal infection of the valve and that the progression of that staphylococcal infection led to death.

4.3. The exact origin of the infection cannot be known for certain. As seen, the deceased had presented with a cut finger only a matter of days before he became unwell. An infection could have been introduced at that stage. There is also speculation that he indulged in intravenous drug use, again a possible source of infection. The Q fever may have been a chronic condition, but the coincidence of that diagnosis, his previous occupation as an abattoir worker and the possible role it had played in the aortic valve infection, cannot be overlooked. It raises a question as to the desirability of abattoir workers, especially those with a known cardiac valve irregularity, receiving immunisation against the disease.

5. Conclusions

5.1. The deceased died on 31 January 2002 at the Royal Adelaide Hospital from multi-organ failure and staphylococcal septicaemia following pulmonary and aortic valve replacement for staphylococcal endocarditis of the aortic valve.

5.2. The source of the infection leading to the endocarditis is undetermined.

5.3. The deceased died while he was in custody. I find in all of the circumstances that it was lawful custody.

5.4. There is no suggestion other than that at all times, the deceased received an appropriate level of psychiatric, medical and surgical care.

6. Recommendations

6.1. By virtue of Section 25(2) of the Coroners Act 2003, I am empowered to make recommendations that might, in the opinion of the Court, prevent or reduce the likelihood of a recurrence of an event similar to the event that was the subject of this inquest.

6.2. There is in existence a National Q Fever Management Program that was commenced in 2001. It is designed to provide vaccination to workers at risk of contracting Q fever, such as abattoir workers, shearers, farmers and like occupations. In South Australia the program has been extended to mid 2006. According to information promulgated by the South Australian Department of Health, vaccination is strongly recommended for employees of meat processors, certain other occupations and others

who have animal contact (refer to the Department of Health website, http://www.dh.sa.gov.au/pehs/qfever.htm).

6.3. These findings reinforce the desirability of the immunisation of persons who have animal contact in the course of their occupations. The complications of the disease can in some circumstances be fatal. I recommend that the South Australian Department of Health reinforce its already existing recommendations in the case of persons who have a known existing cardiac valve irregularity.

Key Words: Death in Custody; Staphylococcal Septicaemia; Q Fever; Abattoir Workers

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 11th day of August, 2005.

Acting State Coroner