CORONERS ACT, 1975 AS AMENDED

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 10th day of March and the 7th day of April 2005, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Margret Lillian Harris.

I, the said Coroner, find that Margret Lillian Harris aged 48 years, late of 46 Wilpena Avenue, Klemzig, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 1st day of October 2002 as a result of Chronic Obstructive Airway Disease. I find that the circumstances of her death were as follows:

1. <u>Reason for inquest</u>

1.1. On 9 July 2002 Mrs Harris was conveyed to the Royal Adelaide Hospital by Police Constables Elisabeth MacPherson and Sonia Wellings. They had been tasked to a phone booth on OG Road at Klemzig in relation to a female person who had called '000'. She gave the officers several false names and gave them the distinct impression that she was delusional.

1.2. At the Royal Adelaide Hospital, Mrs Harris was examined by Dr J Holmes in the Emergency Department. Dr Holmes noted the presence of thought disorder, irritability and hostility and questioned whether she may have been psychotic. Accordingly he made an order pursuant to Section 12(1) of the Mental Health Act 1993 ('the Act') detaining Mrs Harris to the Royal Adelaide Hospital (Exhibit C5b).

1.3. On 10 July 2002 Mrs Harris was examined by Dr A T Davis, Consultant Psychiatrist, who found that she was suffering from florid thought disorder, delusions and

cognitive impairment, and he confirmed the detention order pursuant to Section 12(4) of the Act (Exhibit C5c).

1.4. On 12 July 2002, Dr L Koopowitz, Consultant Psychiatrist, examined Mrs Harris and found her to be suffering from a ‘chronic psychotic process’, and that she was unable to care for herself on a consistent basis. Dr Koopowitz detained her pursuant to Section 13(5) of the Act for a period of 21 days (Exhibit C5d).

1.5. A further order for the detention of Mrs Harris pursuant to Section 12(6) of the Act was made on 2 August 2002 by Drs Beckwith and Kent, Consultant Psychiatrists (Exhibit C5e).

1.6. On 20 August 2002, the Guardianship Board of South Australia made an order pursuant to Section 13 of the Act for the continuing detention of Mrs Harris for the period up to and including 20 August 2003.

1.7. Accordingly, on the date of her death on 1 October 2002, Mrs Harris 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 her death was therefore mandatory by virtue of Section 14(1a) of the said Act.

2. <u>Background</u>

2.1. Mrs Harris had been a patient at the Royal Adelaide Hospital for many years. Dr Julia Hanna, Psychiatric Registrar, treated her on her final admission. She said:

> 'The history of the deceased is well documented in six volumes of medical notes and is generalised as her suffering from chronic medical and psychiatric illnesses. Her presentations at the Hospital were similar in nature on almost all occasions, particularly the most recent ones.
>
> Her medical conditions included that she suffered from Chronic Obstructive Airways Disease (COAD) and right heart failure along with being chronically hypoxic. Her COAD appeared to be the causal factor in all of her medical problems which may have been exacerbated by her chronic cigarette smoking habit. In turn the right heart failure also led to her suffering from fluid retention to her legs and neck. As a result she was on diuretic medication. Her COAD and hypoxic condition left her with cyanosis to the entirety of her body. This is suggestive of chronic heart or lung disease, but more specifically, in the case of the deceased, I purport that it was more indicative of her COAD.
>
> Her psychiatric conditions included that she suffered from chronic schizophrenia and psychosis often leaving her delusional and therefore unable to self control her medical conditions as described above or to even understand her need to control these medical conditions.

> She last presented to the Hospital on the 9th of July 2002 and was assessed by both the Psychiatric and Medical Registrars on duty. It was considered that the deceased was not able to take proper care of herself medically due to her advanced psychosis. As a result, she was admitted into Ward C3 as an inpatient. It was on this day that I began treating the deceased.
>
> I found the deceased to be delusional with disorganised thought processes and to suffer from shortness of breath and oedema. This was in line with previous presentations to the Hospital and with the medical history as described above. Her condition was such that she was considered to have no real chance of recovery, and, that she would need to remain within a hospital or care facility that could provide constant monitoring of her. Treatment of the deceased included monitoring and limiting her cigarette intake and her fluid intake. This was required to prevent worsening of her present medical conditions, particularly her COAD. These restrictions were sometimes difficult to maintain as the deceased would sometimes be found scrounging cigarette butts from the ground when outside and smoking these or drinking in excess of her fluid limit. Her prognosis for recovery was very poor.
>
> Due to her poor physical and mental condition, the deceased was placed on a Continuing Detention Order by the Guardianship Board.'
>
> (Exhibit C1a, pp1-3)

2.2. Dr Hanna said that during mid August 2002, Mrs Harris' condition deteriorated further, and in particular her cigarette smoking and fluid intake were restricted.

2.3. On 1 October 2002, Dr Hanna examined Mrs Harris and found her to be unresponsive to stimuli, and her condition was rapidly deteriorating. Her husband and other relatives were contacted and palliative measures were taken to ease her discomfort.

2.4. At 4:55pm on 1 October 2002, Dr Hanna found that Mrs Harris was not breathing, her pupils were fixed and unreactive, there were no heart sounds, no respirations, no pulse and no response to stimuli. She certified life extinct at that time.

2.5. Dr Hanna certified that the cause of Mrs Harris' death was Chronic Obstructive Airway Disease. I accept her opinion in that regard and find accordingly.

3. <u>Investigation</u>

3.1. Mrs Harris' death was investigated by Detective Senior Constable Christopher Walkley of Adelaide Criminal Investigation Branch of South Australia Police. In his undated investigation report which was received by this office in September 2004. Detective Senior Constable Walkley concluded:

> 'Harris was lawfully and necessarily detained both prior to and at the time of her death. Harris was terminally ill and received appropriate medical care whilst under detention.'
>
> (Exhibit C5a, p14)

3.2. I agree with those conclusions for the purpose of these findings.

3.3. Delays

The investigation was forwarded to Detective Senior Constable Walkley on 2 October 2002. Despite several inquiries made about the lack of progress (on 4 July 2003, 3 February 2004 and 19 May 2004), the investigation report was not received until September 2004. Further delays were experienced when certain medical records went missing, so that preparations for the inquest could not commence until February 2005.

3.4. These are unacceptable delays. This was an uncomplicated investigation. The family of the deceased should not have had to wait 2½ years for the inquest to be finalised. I understand that police officers are busy, but Detective Senior Constable Walkley seems to have given this matter such a low priority that his supervisors should either have reallocated it or at least counselled him about the delays. Despite several approaches, this has not occurred.

3.5. In the vast majority of cases, officers of South Australia Police provide careful, thorough and detailed investigations of coronial cases, and exhibit a professional approach which is a credit to the organisation. Regrettably, this case is an exception. I draw the matter to the attention of the Commissioner of Police.

4. Recommendations

4.1. In view of the conclusions expressed above, it is not necessary for me to make recommendations pursuant to Section 25(2) of the Coroners Act 1975.

Key Words: Death in Custody; Psychiatric/Mental Illness

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

Seal the 7th day of April, 2005.

Coroner

Inquest Number 11/2005 (2761/2002)