

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 18th and 27th days of January 2005, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Ronald Thomas Robjohns.

I, the said Coroner, find that Ronald Thomas Robjohns aged 89 years, late of Patterson East Ward, Glenside Campus of the Royal Adelaide Hospital, 226 Fullarton Road, Eastwood, South Australia died at Eastwood, South Australia on the 19th day of November 2003 as a result of congestive cardiac failure due to ischaemic heart disease and aortic valve stenosis. I find that the circumstances of his death were as follows:

1. Reason for inquest

- 1.1. On 15 November 2003 Dr John Litt, Consultant Psychiatrist, made an order pursuant to Section 12(5) of the Mental Health Act 1993 ('the Act') for the detention of Mr Robjohns for a period of 21 days. This order followed orders made by Dr Raymond Behrens pursuant to Section 12(1) of the Act on 12 November 2003 detaining Mr Robjohns to Glenside Hospital, and by Dr Saro Hapuarachchi pursuant to Section 12(4) of the Act on 13 November 2003, confirming the initial detention order.
- 1.2. Accordingly, Mr Robjohns 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. Mr Robjohns had been a patient at the Hughes Clinic in Unley for 25 years. Dr Neil Brice from that clinic advises that his relevant medical history included non-insulin dependent diabetes mellitus, ischaemic heart disease, aortic stenosis and hypertension (Exhibit C13a).
- 2.2. Dr Brice commented:

'Mr Robjohns' health had essentially been deteriorating since the death of his wife Gwen from pancreatic carcinoma during 2002. This event, compounded by the subsequent death in 2003 of his son and daughter-in-law in a motor vehicle accident, led to Mr Robjohns becoming depressed as evidenced by depressed mood, irritability, declining motivation and self care. He did not acknowledge that he was depressed.'

(Exhibit C13a, p1)
- 2.3. During 2003 it was also felt that Mr Robjohns may have suffered a mild left-sided stroke as he was suffering some right-sided clumsiness. This was causing him to fall, and he was admitted to Ashford Hospital on a number of occasions, most recently in July and October 2003.
- 2.4. During the last admission, Mr Robjohns was reviewed by Dr Philip Popplewell, Geriatrician, who felt that Mr Robjohns was severely depressed (Exhibit C14a). Dr Geoffrey Seidel, Psycho-Geriatrician, was asked to review Mr Robjohns and he agreed (Exhibit C15a).
- 2.5. Mr Robjohns was discharged from Ashford Hospital on 11 November 2003 and his case was referred to the Community Outreach Services of Repatriation General Hospital Mental Health Services for Older People.
- 2.6. On 12 November 2003, Mr Robjohns was visited by Dr Raymond Behrens, Consultant Psychiatrist, in company with Mr Kevin Jane, a Social Worker and Mr Robjohns' son Peter. Dr Behrens found that Mr Robjohns was gaunt and emaciated, his ankles were swollen indicating a significant degree of congestive cardiac failure, and he also had symptoms of severe depression. Despite his family's extensive efforts to support him, providing him with meals daily, and assisting him to bathe and helping him to bed at night, Mr Robjohns had steadily lost weight and his health continued to decline. Mr Peter Robjohns reported that he was very concerned about his father because he had been having falls, and that there was a risk that he might be

left injured and without attention all day or overnight. Mr Robjohns reported that his father had also contemplated suicide (Exhibit C9a, p2).

- 2.7. Dr Behrens concluded that Mr Robjohns was suffering from severe depression. However, Mr Robjohns refused hospital admission or any other form of psychiatric treatment. Dr Behrens felt that if he was left at home, Mr Robjohns was at risk of suicide, or that he would die from self-neglect either from an untreated infection, complications of his physical illness, an accidental fall or from dehydration or malnutrition.
- 2.8. As he could not be persuaded to voluntarily undertake treatment, Dr Behrens exercised his discretion pursuant to Section 12(1) of the Act and detained him to Glenside Hospital. Mr Robjohns was admitted to Glenside Hospital that day.
- 2.9. As I have already mentioned, Dr Behrens' order was reviewed on 13 November and again on 15 November 2003 and the order was confirmed and extended for 21 days.
- 2.10. Unfortunately, Mr Robjohns failed to come to terms with his admission to Glenside Hospital. A number of the statements before me indicate that he was unhappy about being admitted to hospital. On the evidence before me, however, it is apparent that his detention to the hospital was appropriate in the circumstances.
- 2.11. On 18 November 2003, Mr Robjohns suffered a fall. He was found by the nursing staff sitting on the floor with blood on his clothes and on the floor. He reported that another patient had pushed him over. This other patient was an elderly woman who was suffering from dementia.
- 2.12. Upon examination, Mr Robjohns had lacerated his left hand and had a bruise on his right forearm. These injuries were treated and Mr Robjohns was put to bed.
- 2.13. At about 11am, Mr Robjohns was reviewed by Dr Hussain, the Night Medical Officer who found that he was asleep and that his vital signs were stable (Exhibit C2a).
- 2.14. The nurses continued to check on Mr Robjohns visually every 10 to 15 minutes for the following two hours and there was no change in his condition.
- 2.15. At about 2am Mr Robjohns was checked by Registered Psychiatric Nurse ('RPN') Elizabeth Kiroff, who woke him and took his observations which were normal

(Exhibit C7a, p4). At 4am, RPN Ray Cornell also checked Mr Robjohns and he appeared comfortable.

- 2.16. At about 5:40am on 19 November 2003, RPN Kiroff found that Mr Robjohns was no longer breathing. RPNs Kiroff and Cornell attempted resuscitation but it was apparent that further attempts would be futile.
- 2.17. At 6am on 19 November 2003, Dr Hussain attended and checked Mr Robjohns' vital signs but it was apparent that he was deceased.

3. Cause of death

- 3.1. A post-mortem examination of the body of the deceased was performed by Dr J D Gilbert, Forensic Pathologist, on 20 November 2003.
- 3.2. Dr Gilbert concluded that the cause of Mr Robjohns' death was 'congestive cardiac failure due to ischaemic heart disease and aortic valve stenosis'. He commented:

- '1. The deceased had a history of ischaemic heart disease, hypertension, aortic stenosis, congestive cardiac failure and non-insulin dependent diabetes. He had had recent hospital admissions for congestive cardiac failure and a urinary tract infection. He was unsteady on his feet and subject to falls.

The deceased was admitted to Glenside Hospital under a 21-day detention order on the 12th of November 2003. This was because of a depressive illness with inability to cope apparently resulting from multiple recent deaths in the deceased's family. On the 6th day of the admission the deceased had an unwitnessed fall. He claimed to have been pushed over by another patient. The fall resulted in lacerations to the palm of the left hand and the right forearm. There were no signs or symptoms of a head injury and the deceased's observations were normal. He was found dead in bed approximately 10 hours later.

At autopsy, the lungs were markedly oedematous and congested. The aortic valve was moderately stenosed due to degenerative fibrosis and calcification of its cusps and there was significant narrowing of each of the three main coronary arteries.

Death has been attributed to congestive cardiac failure due to ischaemic heart disease and aortic valve stenosis.

An unexpected finding was the presence of areas of old organising subdural haematomas in the left parietal region and on the floor of the left anterior cranial fossa. The brain was submitted for neuropathological examination to assess the age of the subdural haemorrhages, to determine the possible presence of other signs of traumatic brain injury and any underlying dementing illness and/or cerebrovascular disease. The final microscopic brain report was not to hand at the time of this report but it appears quite unlikely that the brain abnormalities contributed to the death.

The lacerations to the left hand and right forearm were relatively minor and did not appear to have contributed to the death. Discomfort from the injuries and the circumstances in which they reportedly occurred may, however, have caused stress and anxiety that could have caused an increase in heart rate and blood pressure thus placing added demands on the heart. It is a possibility that these factors precipitated the cardiac decompensation that led to death.

2. Analysis of a specimen of blood obtained at autopsy reportedly showed a blood alcohol concentration of nil. The blood contained therapeutic concentrations of sertraline, diltiazem and glipizide. The blood level of ramipril could not be assessed due to lack of an analytical method in our laboratory at present. No other common drugs were identified.'

(Exhibit C3, p5)

- 3.3. A neuropathological examination was performed by Dr Grace Scott, and Dr Scott found evidence of head injury from an apparent fall in the form of chronic left subdural haemorrhage, some axonal abnormalities in the white matter, tauopathy consistent with Progressive Supranuclear Palsy and cerebral amyloid angiopathy (Exhibit C4b, p6). In further correspondence, Dr Gilbert commented:

'The macro and micro neuropath reports provide no evidence of any acute brain process that had any bearing on the cause of death. The subdurals were old. There were no changes indicative of significant recent brain injury attributable to recent falls. There was some evidence of axonal injury that could have resulted from a recent fall but the extent of these changes, the absence of associated brain swelling and the lack of a history of loss of consciousness after any of the recent falls were all consistent with the injury (or injuries) being old and/or trivial.

The cerebral amyloid angiopathy and tauopathy consistent with progressive supranuclear palsy were incidental findings with the latter being a possible explanation for his frequent falls.

On the other hand, the deceased had significant coronary artery disease with old and recent ischaemic changes in the myocardium, moderate aortic valve stenosis due to age-related degenerative changes and signs of terminal congestive cardiac failure (pulmonary oedema, pleural effusions, liver congestion, leg oedema).

I see no reason to modify the cause of death.'

(Exhibit C3b)

4. Conclusions

- 4.1. On the basis of the above evidence I find:

- That the cause of Mr Robjohns' death was congestive cardiac failure due to ischaemic heart disease and aortic valve stenosis;

- The evidence before me suggests that Mr Robjohns was lawfully and appropriately detained pursuant to the Mental Health Act 1993 at the time of his death, and that his care at the Glenside Hospital was appropriate and in no way contributed to the causation of his death.

5. Recommendations

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

Key Words: Death in Custody; Psychiatric/Mental Illness; Natural Causes

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

Seal the 27th day of January, 2005.

Coroner