



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 8th, 9th, 10th and 11th days of May 2006, and the 22nd day of May 2006, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Patricia Nina George.

The said Court finds that Patricia Nina George aged 81 years, late of Unit 1, 54 Smith-Dorrien Street, Mitcham died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 27th day of July 2002 as a result of aspiration pneumonia, exacerbation of chronic obstructive airways disease (emphysema) and congestive cardiac failure. The said Court finds that the circumstances of her death were as follows:

1. Introduction and reason for Inquest

Patricia Nina George was born on 28 September 1920. She lived alone at Unit 1, 54 Smith-Dorrien Street, Mitcham. She never married. On 27 July 2002 she died in the Royal Adelaide Hospital. Dr Karen Williams gave her cause of death as aspiration pneumonia, exacerbation of chronic obstructive airways disease (emphysema) and congestive cardiac failure. At the time of her death, an order for her detention in an approved treatment centre (RAH – Glenside Campus) was in effect under section 12 of Mental Health Act 1993. Accordingly, her death was a death in custody within the meaning of the Coroners Act 2003 and this Inquest has been held as required by section 21(1)(a) of that Act.

2. Circumstances of hospitalisation

2.1. On Tuesday 16 July 2002 police were called to an incident at Unit 1, 54 Smith-Dorrien Street, Mitcham, having been advised by police communications that an

elderly lady at that address was wandering around outside her unit afraid that it was going to blow up. On arrival, the police located Miss George in a neighbour's unit and she was reluctant to leave. She was persuaded to return to her unit but was agitated and concerned about her safety, apparently believing that the unit was likely to blow up at any time. Contact was made with the Assessment and Crisis Intervention Service (ACIS) and as a result the police were advised to take Miss George to the Flinders Medical Centre for assessment. The attending officers did just that, arriving at the Flinders Medical Centre with Miss George at 9:17 pm that day.

- 2.2. On arrival, a provisional diagnosis was made of paranoid delusions and mild renal impairment.
- 2.3. On 17 July 2002 Miss George was examined by Dr Mark Wadsworth in the Emergency Department at Flinders Medical Centre. Dr Wadsworth formed the opinion that Miss George had a mental illness that required immediate treatment, that the treatment was available at Flinders Medical Centre and that Miss George should be admitted and detained in the centre in the interests of her health and safety. The ground on which he formed his opinion was as follows:

‘Paranoid delusions – receiving messages. Convinced her house has been destroyed by an electrical occurrence.’
(Exhibit C17d)
- 2.4. The following day, Miss George was reviewed Professor Kalucy who confirmed the order for detention on the grounds that he was of the opinion that Miss George was suffering from a mental illness, namely paranoid psychosis, confusion and a degree of renal failure and inability to care for herself.
- 2.5. On 19 July 2002 Professor Kalucy completed a form entitled “Transfer of Detained Patient (S.16)” for the transfer of Miss George to Glenside Campus (Exhibit C17d). On the same form, Professor Kalucy purportedly authorised the transfer of Miss George to Glenside Campus. Section 16 of the Mental Health Act provides:

‘Where a patient is detained in an approved treatment centre and the Director of the centre is satisfied, upon the certificate of a psychiatrist, that another approved treatment centre is better equipped for the care and treatment of that patient, the director--
(a) may authorise the transfer of the patient to that other centre’

- 2.6. In my opinion it is implicit in section 16 that two persons must be involved in a decision to transfer a patient; the Director of the approved treatment centre, and the certifying psychiatrist. I do not consider that it is contemplated by section 16 that the same person, being a psychiatrist and Director an approved treatment centre, can effectively certify (in his or her capacity as a psychiatrist) to himself or herself (in his or her capacity as Director of the centre) that some other approved treatment centre is better equipped for the care and treatment of the patient. The section seems to me to require that there be a check and balance involving the participation of the two mentioned offices. If I am correct in this view, it follows that the transfer of Miss George from Flinders Medical Centre to Glenside Campus, which followed, was not authorised by section 16 of the Mental Health Act 1993. However, I do not consider that this matter affected her status as a person “being detained in any place within the State under any Act or law” as contemplated by the definition of “death in custody” in section 3 of the Coroners Act 2003.
- 2.7. Professor Kalucy stated in the certificate part of the transfer form that the treatment required by Miss George was:
- ‘Involuntary inpatient treatment of paranoid psychosis with anti psychotic medication.’
- 2.8. In the same certificate he expressed the opinion that Glenside Campus was better equipped to provide care and treatment for Miss George because:
- ‘Elderly lady, requires psycho geriatric review and appropriate inpatient environment.’
- 2.9. Miss George was duly transferred to Downey East Ward at Glenside Campus on 19 July 2002 by ambulance. On arrival, she was examined by Dr Hill who noted an extensive history, including chronic renal impairment, ischaemic heart disease, hypothyroidism and emphysema. She was assessed as having a paranoid psychosis.
- 2.10. On 20 July 2002 Miss George was examined by Dr Fielke of Glenside Campus who certified, for the purposes of section 12(5) of the Mental Health Act that he agreed with the initial diagnosis pursuant to which the initial detention order was made and ordered the further detention of Miss George for a period of 21 days commencing on the expiry of the initial detention. He stated that she had:
- ‘Paranoid delusional system remains prominent impacting on her judgement secondary anxiety but not overtly depressed. At risk in the community.’
(Exhibit C17e)
- 2.11. He considered the following treatment to be necessary:

‘Ongoing inpatient care of mental state – physical problems exploration of community options.’

3. Events at Glenside Campus – Downey East Ward

- 3.1. During the following week Miss George continued to be detained at the Downey East Ward of Glenside Campus. Downey East Ward is a secure ward for the care of patients over the aged of 65 years who are suffering acute mental illnesses.
- 3.2. Nurse Cullen gave evidence at the Inquest. She is a registered mental health nurse and has worked at Glenside for seventeen years. She was on duty on the night shift commencing 26 July and continuing into the early hours of the morning of 27 July 2002 on Downey East Ward. She had two enrolled nurses assisting her until 11:00 pm on 26 July and thereafter she had one enrolled nurse assisting her on her shift. She stated that Downey East is a “locked ward”. Nurse Cullen remembered Miss George as a patient and remembered that night. She stated that she saw Miss George on her rounds at approximately 4:30 am on 27 July 2002. Miss George was awake and stated that she was not feeling well. Nurse Cullen noted that she had a “rattly chest”.
- 3.3. At approximately 5:30 am Nurse Cullen checked on Miss George once again. Her chest was noted to be increasingly rattly and she was short of breath. Nurse Cullen took observations and noted that Miss George had a temperature of 38.5, a pulse of 124 beats per minute, a respiratory rate of 36 breaths per minute and blood pressure of 150 over 70. She paged the duty medical officer for an assessment at 5:45 am.
- 3.4. Nurse Cullen said that the duty medical officer that night was Dr Rhett Bosnich. Dr Bosnich attended within a short time, and examined Miss George and assessed her as having emphysema with secondary chest infection. He decided that she required transfer to the Royal Adelaide Hospital for further assessment. In the meantime she was administered oxygen and placed in a comfortable position.
- 3.5. What occurred thereafter is far from clear as the evidence of Nurse Cullen and other witnesses reveals. Nurse Cullen’s version of events was that she made a call to the admissions officer/switchboard operator to request that person arrange the attendance of an ambulance. She could not recall what she told the switchboard operator but did recall that Dr Bosnich was very concerned about Miss George’s physical condition

and wanted her to go to the Royal Adelaide Hospital. Nurse Cullen could not recall what, if any, directions she gave to the switchboard operator as to the priority designation for the ambulance. She admitted that she might even have left it to the switchboard operator to determine the priority.

- 3.6. Nurse Cullen recalled that she would have been required to contact the night nurse manager, Nurse Edward Bailey, to arrange for Miss George to have an escort to the Royal Adelaide Hospital, as she was under a detention order.
- 3.7. Nurse Cullen was aware at the time of giving evidence that subsequent to the request for the attendance of an ambulance which I have already referred to, a request was in fact made to South Australian Ambulance Service by the switchboard operator at Glenside. However, that request was subsequently cancelled. Nurse Cullen stated that she did not herself have any involvement in cancelling the ambulance and was not aware that it had been cancelled until Dr Bosnich had a telephone conversation in her presence with the night nurse manager Nurse Bailey about the cancellation of the ambulance. She recalled that Dr Bosnich was angry in this telephone conversation which was apparently about a lack of staff to accompany Miss George as her escort to the Royal Adelaide Hospital.
- 3.8. In the hospital notes, Nurse Cullen made an entry at 0725 as follows:

‘Ambulance was originally contacted at approximately 0550, but due to lack of staff to accompany Patricia (re – being detained), duty MO had to cancel ambulance. It was then rebooked, at 0620 due to increased concern re patient’s deteriorating physical condition. Still awaiting ambulance. Patient’s vital signs have worsened T 37.8, P 160, R 40, BP 200/90.’
- 3.9. Nurse Cullen did not recall who made arrangements to rebook the ambulance. She stated that she did not recall Dr Bosnich actually making the cancellation of the first booking, but acknowledged that she noted it in the hospital records. She clearly recalled Dr Bosnich being annoyed after the call from night nurse manager Bailey.
- 3.10. Nurse Cullen could not recall whether the ambulance had already been cancelled at the time of the telephone conversation between night nurse manager Bailey and Dr Bosnich.
- 3.11. Dr Bosnich gave evidence at the Inquest. He obtained his medical qualification in 1994 and stated that he held the position of night career medical officer at Glenside

Campus in 2002. His duties were to attend to the acute medical and psychiatric assessment of patients overnight. He did not recall Miss George but was able to identify a notation he made in the hospital notes at 6:10 am on 27 July 2002 in which he recorded that Miss George's chest was hyper resonant with extreme moist airway noise and formed the view that she had emphysema with secondary chest infection and required transfer to the Royal Adelaide Hospital for further assessment.

- 3.12. He stated that he could not recall if he called the switchboard operator to arrange the attendance of an ambulance but was aware that this had happened. He had no independent recollection of the events of 27 July 2002. He was only aware of the fact that the ambulance had been cancelled after speaking to the investigating officer in this case, Senior Constable Della Sala. He had no recollection of the telephone conversation recalled by Nurse Cullen as having taken place between himself and night nurse manager Bailey. He stated that the medical priorities of the patient for transport by ambulance to the Royal Adelaide Hospital would have outweighed any staffing considerations in any event. He stated that he should have been called if the ambulance was delayed because he could have taken further steps to arrange for its attendance.
- 3.13. Dr Bosnich could not recall if he had the hospital notes with him when Senior Constable Della Sala took a statement from him on 30 July 2002. Nor could he recall if he had the hospital notes with him when Senior Constable Della Sala took a second statement from him on 14 December 2005. He did recall that Senior Constable Della Sala did not have the first statement with him at the time of interviewing Dr Bosnich for the second statement.
- 3.14. Dr Bosnich stated that the ambulance priority would be determined by the treating doctor. He stated that he would have given a priority two for either of the calls for the ambulance if he could recall anything. Dr Bosnich stated that he understood priority one to apply to situations where the patient required immediate ambulance attendance due to impending death. Dr Bosnich stated that Miss George could have been transferred without an escort. Dr Bosnich stated that he certainly would not have cancelled the ambulance call as asserted in the notes by Nurse Cullen as he regarded the transfer as essential.

- 3.15. Dr Bosnich was one of the handful of witnesses to be interviewed at an early time in the investigation; the bulk were not interviewed for three years or more after the event. Dr Bosnich's early interview failed to cover important issues that were not dealt with by the investigating officer until some three and a half years later when a thorough interview was finally conducted. If the conversation recalled by Nurse Cullen as having transpired between Dr Bosnich and nurse manager Bailey did occur (and it should be noted that she made a contemporaneous note of it), it is surprising that Dr Bosnich made no mention of it in that interview which took place only days later, particularly bearing in mind the fact of Miss George's death, and the dispute (on Nurse Cullen's version) about the cancellation of the ambulance only hours before her death. The fact is that there was no mention of it in the statement taken by Senior Constable Della Sala. Unfortunately, in the face of the vehement denials of the likelihood of such a conversation having taken place by both protagonists, I am reluctant to make any findings as to its existence.
- 3.16. Denise Mahlo is a clerical assistant. She was, in July 2002, the admission clerk on duty overnight at Glenside Campus. She provided a statement to Senior Constable Della Sala on 5 December 2005.
- 3.17. She stated that the arrangements for summoning an ambulance could occur in either of two ways. The switchboard operator might receive a telephone call on the "emergency phone" which is apparently a telephone designated for emergency ambulance calls which will all be designated priority one. She stated that if the call was not to be a high priority, the switchboard operator would be requested to make the booking by a telephone call made on another telephone.
- 3.18. A telephone recording of three telephone calls between Ms Mahlo and the South Australian Ambulance Service on 27 July 2002 was played during Ms Mahlo's evidence. She acknowledged that the recording was authentic and identified her voice and recalled the conversations. A transcript of the recordings was admitted in evidence as Exhibit C14a. Ms Mahlo accepted the accuracy of the transcript so far as it related to the telephone conversations she had made. In the first conversation the transcript shows Ms Mahlo calling the ambulance service and informing the operator that an ambulance was required because a person had emphysema. The ambulance service operator asked how bad the patient's breathing was and Ms Mahlo stated "they said it needs to be urgent but probably not priority one". The ambulance

operator repeated that it needed to be urgent and then said that they would arrange for an ambulance straight away.

- 3.19. The transcript of the second conversation records Ms Mahlo as contacting the ambulance service referring to the ambulance booking which had previously been made and simply stating “can we cancel that please”, and the ambulance service acknowledging the cancellation.
- 3.20. The third transcription shows Ms Mahlo calling the ambulance service once again, and asking “can we rebook that ambulance”, the ambulance service agreeing to this and asking what priority is needed on it this time. Ms Mahlo replies, “It’s not urgent so priority two or something.” The ambulance service responded “priority two, within half an hour or within the hour or?”. Ms Mahlo replied “yeah that will be fine”. And the conversation ended. I find that Ms Mahlo’s rather casual words could have been construed by the ambulance service as acceptance of a priority lower than priority two.
- 3.21. Ms Mahlo stated that the information as to the priority to be placed upon the ambulance would have come from the ward. She understood that a priority one designation was for an immediate attendance by the ambulance, and that a priority two designation was for an attendance within approximately half an hour.
- 3.22. Ms Mahlo stated that she would have cancelled the first booking on advice from the ward or from the nurse manager. Nurse Cullen accepted that there could have been confusion between herself and the ambulance service as to the priority for the second booking because of her use of the expression “priority two or something”. Ms Mahlo stated that she would have filled out documentation on a form entitled “Ambulance Request”. However, the Court was informed by counsel for the ambulance service and the hospital that all of the ambulance request documentation was lost or destroyed at the time of Inquest. I note that it was not obtained at any earlier time by the investigating officer Senior Constable Della Sala.
- 3.23. Registered Nurse Edward Bailey gave evidence at the Inquest. Nurse Bailey stated that he was employed at Glenside in July 2002 as a nurse manager. He was interviewed by Senior Constable Della Sala on 12 December 2005. He stated that he was the nightshift nurse manager on the night of 26-27 July 2002. He stated that his

duties in that capacity were to assume responsibility for overnight staffing at Glenside Campus.

- 3.24. Nurse Bailey stated that he did not recall having any conversation with Dr Bosnich about the need for an escort for Miss George. He did not recall any conversation about the cancellation of the first ambulance booking. He stated that the lack of an escort would certainly not have been a reason for the cancellation of the ambulance booking.
- 3.25. Nurse Bailey stated that he would have been responsible for obtaining an escort to accompany Miss George to the Royal Adelaide Hospital. He stated that he would have gone about this by seeking the “least busy ward” within the hospital at the time to spare a nurse who could accompany Miss George as an escort.
- 3.26. Nurse Bailey stated that he did not recall cancelling the ambulance. He stated that he would not have done it and that he was at a loss to say who would have done it. He stated that he certainly would not have cancelled the ambulance without first speaking to Nurse Cullen or Dr Bosnich. He stated that when he was interviewed by Senior Constable Della Sala on 12 December 2005 he had no recollection of any of the events of July 2002 and the night in question beyond the vaguest and haziest of recollections. He recalled no more at the hearing.
- 3.27. Nurse Tasma Rodda is a clinical nurse employed at the Glenside Campus. She was a clinical nurse at Downey House East in July 2002. She was not interviewed by Senior Constable Della Sala until 8 December 2005 by which time her memory of events had also been eroded. She gave evidence that she commenced duty on dayshift on Downey East Ward at 7:00 am on 27 July and was made aware that an ambulance had been requested to transfer Miss George to the Royal Adelaide Hospital and that all preparations had been made. She assigned another nurse to monitor Miss George and in addition she contacted the nursing manager (dayshift) to arrange a backfill nurse to assist on the ward.
- 3.28. Nurse Rodda was not made aware of the priority applied to the ambulance booking, however an entry made by her in the medical records at 0810 reveals that she contacted Dr Bosnich about the delay in the ambulance attendance, although that contact was clearly not made at the time of the note, but earlier. She stated that she

believed she would also have contacted the admissions clerk asking her to follow-up the ambulance.

- 3.29. There is no way of checking whether the admissions clerk was contacted, as the communications book and ambulance request forms are no longer available, and as already noted were not seized by Senior Constable Della Sala.
- 3.30. Steven Cameron, Programme Director, South Australian Ambulance Service gave evidence at the Inquest, and made an affidavit dated 4 May 2006 which was admitted in evidence as Exhibit C21. He stated that in July 2002 he was the Metropolitan Coordinator with South Australian Ambulance Service and was responsible for ambulance coordination in the metropolitan area. His evidence revealed that the ambulance crew were not despatched until 7:22 am, despite the fact that the second call came through at 6:20 am.
- 3.31. Mr Cameron listened to the tape recorded telephone conversations between Ms Mahlo and the South Australian Ambulance Service operator on the morning of 27 July 2002 which have already been referred to. He stated that it was his belief that the exchange between Ms Mahlo and the operator when the ambulance was rebooked was such that the ambulance operator would have regarded Ms Mahlo as accepting a timeframe of an hour as acceptable and therefore assigned the call a priority three rating. He stated that in fact, a priority three rating was assigned to the call and accordingly the ambulance should have arrived at the scene within an hour. He was asked to explain why the ambulance took, instead, an hour and twenty two minutes from the time of the booking.
- 3.32. His evidence was that in July 2002, if a priority three rating was assigned to a particular callout and the callout was close to a shift changeover, the South Australian Ambulance Service had a policy that the assigned crew not go into overtime in order to achieve the response target of one hour. Accordingly, the call would not be allocated until a new crew had commenced duty following the change of shift. In this case, the day crew commenced its shift at 7:00 am. As noted, the ambulance arrived at Glenside Campus at 7:41 am. Miss George was assessed and reclassified as a priority one conveyance by the ambulance crew, the ambulance departing Glenside Campus at 7:54 am and arriving at the Royal Adelaide Hospital at 8:02 am.

3.33. I am concerned about the delay in the ambulance service despatching the ambulance to Glenside Campus. Mr Cameron gave me to understand that since July 2002 the South Australian Ambulance Service has undergone a number of changes and that the policy of not booking priority three calls in a way which would result in crews taking overtime has been altered in a way that requires the operator to contact the person booking the call, to ascertain whether the call can wait until after the change of shift or whether it should be reprioritised to ensure that the change of shift does not affect the response time. Having regard to Mr Cameron's assurances in this regard, I do not propose to make any recommendations in relation to the ambulance service practice. However, I emphasise that in the absence of Mr Cameron's assurances, I would most certainly have made a recommendation that the ambulance service takes steps to modify the policy. It is, to say the least, regrettable that an ambulance booked forty minutes before a change of shift on the understanding that the attendance would take place within an hour of the booking, is not even despatched until twenty minutes after the change of shift merely to preclude the risk that, were it despatched prior to the change of shift, the particular personnel would go into overtime.

4. Events at the Royal Adelaide Hospital and Miss George's death

4.1. Dr Karen Williams gave evidence at the Inquest. Dr Williams was working at the Royal Adelaide Hospital as an emergency registrar on the morning of 27 July 2002. When the ambulance crew which finally attended to pick up Miss George at Glenside Campus assessed her condition and reprioritised the ambulance to a priority one, the crew made arrangements to contact Royal Adelaide Hospital and warn staff of the imminent arrival of Miss George. Consequently Dr Williams was awaiting the arrival of Miss George. Miss George presented in a decreased conscious state with respiratory distress, she was verbally non-responsive and when breathing, she emitted gurgling sounds. Miss George had an increased respiratory rate and increased pulse. X-rays revealed that she had cardiac failure with possible right side mid lobe consolidation. She was treated with Ventolin, GTN infusion, frusemide and morphine.

4.2. Dr Williams said that Miss George improved to the extent that she became responsive to short questions and obeyed physical motion commands. However, at approximately 11:00 am she started to deteriorate and antibiotics were administered in an attempt to improve her condition. In accordance with the wishes of her brother,

Miss George was given comfort care thereafter. At 11:20 am Miss George died. Dr Williams concluded as a result of Miss George's medical condition and following a review of her medical notes, that she died as a result of aspiration pneumonia, exacerbation of chronic obstructive airways disease/emphysema and congestive cardiac failure. I accept her opinion as to cause of death.

- 4.3. Dr Williams was asked whether in her opinion the delay in transfer by ambulance from Glenside Campus to the Royal Adelaide Hospital contributed to Miss George's death. Dr Williams gave a guarded response to the effect that she believed that Miss George was in an extremely perilous position in any event and would probably have died regardless. With all due respect to Dr Williams, I take little comfort from this, although I am unable to find that the delay in her transfer did contribute to Miss George's death.
- 4.4. I note that Dr Williams was interviewed by Detective Senior Constable Simon Bell on 27 July 2002 making her one of only three witnesses interviewed within a relatively short period after Miss George's death.
- 4.5. I have already referred to the fact this was an Inquest held pursuant to section 21(1)(a) of the Coroners Act 2003. A death in custody is by definition a "reportable death" within the meaning of that expression in the Act. Of all of the categories of reportable death in the Act, and of the other matters which may be the subject of an inquest under the Act, a death in custody is the only category of event that must be the subject of an inquest. In all other cases, the matter is left to the discretion of the State Coroner or, should he choose to exercise his power of direction, the Attorney General. The Parliament has placed special significance on deaths in custody. The public policy reasons why the Parliament has taken this stance need hardly be stated. Since the Royal Commission into Aboriginal Deaths in Custody it is universally accepted that persons in custody are in a special position of vulnerability such that there should be an external independent review of the circumstances leading to their death. In the Royal Commission into Aboriginal Deaths in Custody the following passage appears at page 109, volume 1 by Commissioner Elliott Johnston QC:

'The tragedy of a death in custody is experienced most deeply by the family of the deceased. It occurs out of sight within the structure of confinement under the control of police or prison officers. Death occurs in circumstances where the deceased is totally dependent on his or her custodians for proper care and adequate medical attention. The anguish and anger of the relatives, their fear and suspicion as to what may have happened

inside a police or prison cell, demands an assurance that the circumstances of death will be thoroughly and fairly investigated.

This need for assurance is not limited to the family of the deceased. A death in custody is a public matter. Police and prison officers perform their services on behalf of the community. They must be accountable for the proper performance of their duties. Justice requires that both the individual interests of the deceased's family and general interest of the community be served by the conduct of thorough, competent and impartial investigations into all deaths in custody.'

- 4.6. These comments were made about a distinct racial group, namely Aboriginal people. Furthermore, they were made in the context of correctional facilities. However, the principles expressed in the passage quoted are clearly applicable to persons in custody under any law of the State or Commonwealth. The Mental Health Act 1993 is clearly such a law. The fact that the comments expressed by Commissioner Johnston were made in the context of Aboriginal deaths in custody in a correctional or police setting does not lessen their application to a death of a person held against his or her will in an approved treatment centre such as Glenside Campus. It is the mark of a civilised society that a death in custody be thoroughly and independently investigated. As Commissioner Johnston said, such a death is a public matter.
- 4.7. The present Inquest has been hampered by the extremely long delay between Miss George's death and the submission of a final report to me by Senior Constable Della Sala. Miss George died in late July 2002, and a report was not provided to me until January 2006. To make matters worse, most of the witnesses, including some crucial witnesses, were not interview sufficiently soon after Miss George's death to enable them to recall events clearly enough, or at all. I set out hereunder a list of witnesses interviewed by Senior Constable Della Sala, and dates of interview:

Witness	Date
Dr Karen Williams	27 July 2002
Mr Peter George (Id statement)	29 July 2002
Dr Rhett Bosnich	30 July 2002
Dr Kenneth Fielke	7 October 2003
Dr Joanne Hill	2 February 2004
Professor Ross Kalucy	26 November 2004
Dr Andrew Pearce	17 February 2005
Senior Constable Simone Roche	4 May 2005
Ms Marilyn Jellett	27 May 2005
Nurse Maureen Cullen	30 May 2005
Mr Simon Walter	15 June 2005

Mr Adrian Vanderklis (statement re 000 call tape extract)	23 August 2005
Ms Denise Mahlo	5 December 2005
Ms Judith Morrison	6 December 2005
Nurse Maureen Cullen (second statement)	7 December 2005
Nurse Tasma Rodda	8 December 2005
Nurse Bronte Mackereth	8 December 2005
Nurse Edward Bailey	12 December 2005
Dr Rhett Bosnich (second statement)	14 December 2005
Mr Paul Sullivan	14 December 2005

- 4.8. From the above summary it can be seen that limited enquiries were made at around the time of Miss George's death in July 2002. The identification statement was brief, the statement from Dr Williams was quite brief as was the statement from Dr Bosnich. I have already noted that there was no mention in the statement from Dr Bosnich of the cancellation of the first ambulance booking. That issue was simply not covered at that time. By the time it was eventually raised with Dr Bosnich when he was interviewed for a second time in December 2005, his recollection, so he said, had evaporated. Even if one were reluctant to accept an assertion by a witness that they had no recollection of an event, one can hardly press the matter at a remove of three and a half years from the event in question.
- 4.9. On 29 July 2002 a number of warrants were issued for hospital notes held by Glenside Campus, Flinders Medical Centre and Royal Adelaide Hospital, by the Coroner at the request of Senior Constable Della Sala. Senior Constable Della Sala executed all of the warrants personally. He executed the Glenside Campus warrant on 30 July 2002, the Flinders Medical Centre warrant on 19 August 2002 and the Royal Adelaide Hospital warrant on 27 August 2002. It is apparent from this chronology that the Glenside Campus notes were at hand when Senior Constable Della Sala obtained the first statement from Dr Bosnich. Indeed, Senior Constable Della Sala gave evidence that he provided the Glenside Campus notes to Dr Bosnich at the time of taking the statement to assist Dr Bosnich's recollection. However, Senior Constable Della Sala stated that he did not review the Glenside Campus notes prior to or during his interview with Dr Bosnich. He was not therefore aware of the cancellation of the first ambulance call at that time. Even a cursory review of the notes for the date of Miss George's death would have alerted Senior Constable Della Sala to this issue. It was clearly a relevant issue to any enquiry about the cause and circumstances of Miss George's death. I cannot image that any competent investigator, aware of the reference to the cancellation of the ambulance purportedly by reason of staff

shortages, would have failed to question Dr Bosnich about his recollection of the issue. Thus, from a very early stage, flaws emerged in the investigation in this matter.

- 4.10. Indeed, Senior Constable Della Sala gave evidence that he did not become aware of the issue of the cancellation of the first ambulance until August 2005 when he sought copies of documents from the South Australian Ambulance Service which contained a reference to the cancellation. He admitted that he had not looked at the hospital notes before that time sufficiently closely to have observed Nurse Cullen's note about the ambulance cancellation which has been set out previously in these findings. By that stage more than three years had passed since Miss George's death.
- 4.11. From the list set out above, it will be apparent that no witness was interviewed between July 2002 and October 2003 when Senior Constable Della Sala interviewed Dr Fielke. Senior Constable Della Sala was asked if he could explain this particular delay. He replied that coronial enquiries are complex investigations and that investigations at Adelaide CIB are done on a priority basis. He stated that investigations of offences against the person take precedence over deaths in custody enquiries (T107-108, T132) and that state of affairs is apparently acceptable to those in line of command above Senior Constable Della Sala (T132). Senior Constable Della Sala was asked whether he had considered passing this investigation over to another investigator if he was unable to do it by virtue of the pressure of other investigations. He stated that he did not consider that course (T132). However, he stated that his superiors were at all times aware of the fact that this death in custody was part of his workload. It seems to me that none of his supervisors made effective arrangements or took any steps to enable him to complete this investigation in a timely fashion (T133). I regard this as completely unacceptable.
- 4.12. As stated above, deaths in custody are the only category of event in which an inquest is mandatory, and rightly so. In my opinion, it is appropriate for the State Coroner, when exercising a discretion whether or not to hold an inquest, to consider the state of the evidence available for consideration at the inquest, and in the event that the evidence, by virtue of the effluxion of time, or other considerations, is such that the issues in consideration in the matter the subject of a possible inquest would not be elucidated sufficiently because of lack of evidence, it is appropriate that the State Coroner exercise a discretion not to hold an inquest. That discretion is not available in the case of deaths in custody. Had it been available in this case, I would have had

to have given serious consideration to the question of whether or not it was appropriate to hold an inquest having regard to the state of the investigation.

- 4.13. The next witness to be interviewed after October 2003, was not interviewed until February 2004.
- 4.14. The next witness to be interviewed after February 2004 was not interviewed until November 2004, and the next witness after that, not until February 2005.
- 4.15. Further witnesses were interviewed in May and June 2005 following which a report was forwarded to the State Coroner by Senior Constable Della Sala in August 2005. The report was examined by Counsel Assisting me who, not surprisingly, identified serious deficiencies in the report. As a result the investigation was referred back to Senior Constable Della Sala for further enquiries. These were eventually carried out in December 2005, and the final report submitted to me in January 2006. Amongst the witnesses not interviewed until December 2005 were:
 - Ms Mahlo – a party to all relevant conversations about the cancellation of the ambulance.
 - Nurse Rodda – a person who by her own account in the notes had information about the cancellation of the ambulance.
 - Nurse Cullen – a person who by a cursory glance at the Glenside Campus notes for the date of death reveals had information about the lateness of the ambulance.
 - Nurse Bailey – a person who clearly had pertinent evidence to give about the cancellation of the ambulance.
 - Dr Bosnich (second interview) – questioned for the first time on the crucial question of the delay in the arrival of the ambulance.

Of all of the above witnesses, the only one to have any recollection of events was Nurse Cullen. It will be recalled that Nurse Cullen had made a contemporaneous note. This may be the reason for her being able to recall events more clearly than other witnesses. However, her recollection is at odds with the vehement testimony given by Dr Bosnich and Nurse Bailey of what their positions would have been had they had any recollection. It was absolutely crucial that these witnesses be interviewed at a time when they could not credibly have denied recalling events. It is

self evident that someone must have cancelled the ambulance. It is clear that no one is now admitting to it. Dr Bosnich states that he would not have done it having ordered it in the first place. Nurse Bailey states that he would not have done it without consulting with Dr Bosnich and, in any event, that lack of escort staff would never be sufficient reason to put a patient's health at risk. Nurse Cullen was a witness to one side of a telephone conversation who was not properly interviewed until more than three years after the event. While her contemporaneous file note might have served to jog her memory, one could hardly rely on her evidence as a basis for finding that one or other of Dr Bosnich or Nurse Bailey had cancelled the ambulance. Furthermore, the relevant records which might have cast light on the identity of the person who had made the decision to cancel the ambulance had been lost, misplaced or destroyed by the time Senior Constable Della Sala belatedly realised that it was an issue.

- 4.16. It need hardly be stated that this state of affairs is completely unsatisfactory. The object of the Coroners Act 2003, so far as it relates to deaths in custody, has been thwarted in this case and my inquiry has been hampered. Furthermore, the amount of time which has passed has rendered meaningless any recommendations which might have been made; applicable systems at both Glenside Campus and South Australian Ambulance Service having been reviewed, modified and replaced in the meantime.
- 4.17. Senior Constable Della Sala made certain recommendations as to system improvements which could be made to avoid a recurrence of the episode with the ambulance. Both Glenside Campus and South Australian Ambulance Service had long since instituted other measures such that these recommendations were no longer relevant at the time of the Inquest (or for that matter, at the time when they were first written by Senior Constable Della Sala in August 2005). I do not believe any point would be served by referring to these recommendations; suffice to say that the alterations to shift arrangements by the South Australian Ambulance Service and the way in which priority three calls will be dealt with have attended to the matter as far as that organisation is concerned.
- 4.18. Glenside Campus has put in place a procedure by which all calls to the ambulance service are patched straight through to the relevant ward or clinician. This will avoid the extremely undesirable situation of a receptionist in the position of Ms Mahlo, who is not medically qualified and who is not even present at the scene of the relevant

event, being required to convey crucial information to the ambulance service – information which is then used by the ambulance service to arrive at a priority for the despatch of the ambulance.

4.19. At page 110 of Volume 1 of the Royal Commission into Aboriginal Deaths in Custody, Commissioner Johnston stated:

‘Not only are full police investigations and coronial inquiries essential for the reasons given but also for the prevention of further deaths in custody.’

4.20. It is this element of prevention in the case of deaths in custody which mean that investigations and inquests into such events should be conducted expeditiously. Only by this means can the object of section 25(2) of the Act be given proper meaning. That section provides:

‘The Court may add to its findings any recommendation 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 the inquest.’

4.21. While I am not in a position to make a recommendation which might prevent or reduce the likelihood of a recurrence of the problems of communication which occurred in the case of Miss George, steps having already been taken by the relevant agencies, I can make a recommendation which is intended to ensure that enquiries into deaths in custody take place at a sufficiently proximate time to the relevant death to give meaning to section 25(2) of the Act.

4.22. Accordingly, I recommend pursuant to section 25(2) of the Act, that the Commissioner of Police review the operations of Adelaide CIB, with a view to determining why Senior Constable Della Sala’s investigation took three years to complete; that this review be conducted by an officer of sufficient senior rank to ensure a thorough outcome; and further that the Commissioner of Police take steps to ensure that investigations into deaths in custody are conducted in a timely fashion and in any event that such investigations are completed within twelve months of the date of death.

Key Words: Death in custody; Detention Order; Psychiatric/Mental illness; Reportable death

*In witness whereof the said Coroner has hereunto set and subscribed his hand and
Seal the 22nd day of May, 2006.*

State Coroner

Inquest Number 19/2006 (2040/2002)