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 4th and 14th days of December 2006, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Elemer Petter.

The said Court finds that Elemer Petter aged 79 years, late of 74/24 Lady Grenfell Place, Klemzig, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 3rd day of February 2005 as a result of myocardial infarction. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

1.1. Mr Elemer Petter was a 79 year old man with a significant medical history at the time of his death in the Royal Adelaide Hospital at about 9:20pm on Thursday, 3 February 2005. At about 5:55pm on Wednesday, 2 February 2005, Mr Petter was detained under section 12(1) of the Mental Health Act 1993 by Dr Benjamin Williams. At the time of his death he was still detained pursuant to that section, and accordingly his was a death in custody within the meaning of that expression under the Coroners Act 2003, and this Inquest has been held pursuant to section 21(1)(a) of the Coroners Act 2003.

2. Background

2.1. Prior to his death and the period of hospitalisation that preceded it, Mr Petter lived with a close friend Erzsebet Berta. In a statement given by Ms Berta to Senior

Constable Lange which was admitted as Exhibit C1a in these proceedings, Ms Berta states that she has known Mr Petter for about twelve years. She stated:

> 'We were very close and I would say Elemer was "more than family" to me.'[1]

2.2. Mr Petter had his own home at Klemzig but, as already stated, was living for some period before his hospitalisation with Ms Berta at her house in Marden.

2.3. Ms Berta stated in Exhibit C1a that for some weeks Mr Petter had been ill and as a result he had been living in her house since some time in December 2004.

2.4. According to a statement of Dr Forsyth which was admitted as Exhibit C4a in these proceedings, she had been Mr Petter's general practitioner for some ten years prior to his death. She stated that he had a very significant history of ischaemic heart disease, congestive cardiac failure, mitral regurgitation, pulmonary hypertension, insulin dependent diabetes, peripheral vascular disease and glaucoma. His severe peripheral vascular disease had caused him to develop what she described as 'painful black toes'. According to a statement of Dr Williams, an intern at the Royal Adelaide Hospital who treated Mr Petter, his toes were in fact gangrenous.

2.5. In Exhibit C4a Dr Forsyth stated that Mr Petter was estranged from his family but he was cared for by his friend Ms Berta in her unit at Marden. She stated that during the last few months of his life Mr Petter had spent most of his time lying in the back bedroom of Ms Berta's unit in a darkened room refusing to eat. Dr Forsyth stated that she visited Mr Petter at Ms Berta's home on 10 December 2004. At that time he was convinced that he was about to die from a melanoma on his right arm. Dr Forsyth stated that this turned out to be a much less serious basal cell carcinoma. Mr Petter was refusing to eat and had no appetite and Dr Forsyth arranged for him to be admitted to the Royal Adelaide Hospital for investigation of anorexia and weight loss. An ultrasound and CT scan of his abdomen found no cause for the anorexia and weight loss. After leaving hospital the anorexia returned and he complained of increasing pain from his toes. Mr Petter was depressed and Dr Forsyth started him on an antidepressant on 29 December 2004. On 12 January 2005 she arranged for a full blood examination, liver function test and analysis to investigate his anorexia and weight loss and these were normal. She arranged a barium swallow for Mr Petter on

[1] Exhibit C1a, page 1

20 January 2005 which was normal. She last saw Mr Petter on 20 January 2005 at which time she informed him that she was unable to find a physical explanation for his loss of appetite and weight loss. She recommended that he be hospitalised but he refused. The following day she received a telephone call from Dr Michael Page from the Glenside Campus to advise her that Mr Petter had been admitted to a medical ward at that hospital.

2.6. Dr Forsyth gave some further insight into the relationship between Mr Petter and Ms Berta. She stated that Ms Berta was present during the surgery consultation she had with Mr Petter on 20 January 2005 and also on many other occasions when Dr Forsyth was consulting to Mr Petter. From this I infer that Ms Berta's description of herself as 'more than family' was, indeed, a good description.

3. Glenside Campus admission

Exhibit C8a is a statement of Dr Michael Page, Psychiatry Registrar at Glenside Campus. He states that Mr Petter was admitted to the Glenside Campus after first presenting to the Royal Adelaide Hospital on 21 January 2005. The circumstances in which Mr Petter was initially transferred from the Royal Adelaide Hospital to the Glenside Campus are not clear. There are no records in the Royal Adelaide Hospital casenotes to explain how this came about. In any event, I do not consider it is necessary to explore this further. Dr Page said that the team at Glenside Campus decided to manage Mr Petter by making modifications to his antidepressive therapy and paying close attention to his medical conditions. Dr Georgette Michail oversaw his medical management. Over the course of his admission it became apparent that his medical issues were his primary problem and it was necessary that he be transferred to the Royal Adelaide Hospital on 28 January 2005 for continued management. Mr Petter was a voluntary patient for the duration of his admission at the Glenside Campus.

4. Royal Adelaide Hospital admission

4.1. Exhibit C2a is a statement of Dr Williams who was an intern working in Ward A7 at the Royal Adelaide Hospital in January 2005. Dr Williams states that he was a treating doctor for Mr Petter during his hospitalisation at the Royal Adelaide Hospital. He first saw Mr Petter in the mid afternoon of 28 January 2005. According to

Dr Williams, Mr Petter was also seen by the Senior Vascular Registrar, Dr Morrow that day. Mr Petter had ischaemia to his feet and his toes were gangrenous. Dr Williams stated that a female person who he assumed was Mrs Petter was present. I infer that this was in fact Ms Berta. Dr Williams on examination of Mr Petter found that he had poor pulses in his legs. He decided that Mr Petter either had to have the blood supply improved to his feet with a bypass or an amputation. Dr Williams contacted Dr Michail from Glenside Campus[2]. According to Dr Williams, Dr Michail informed him that psychiatrically she believed Mr Petter was well, however she thought he needed medical management for his toes. It was arranged that an arteriogram or femoral angiogram would be performed on Mr Petter and this was to take place on 31 January 2005. According to Exhibit C12a which is a statement of Dr Daniel Alcorn, Radiology Registrar at the Royal Adelaide Hospital, when Mr Petter arrived in the Radiology Department that day Dr Alcorn explained the arteriogram procedure to him while he was in the barouche bay and Mr Petter consented to having the procedure done. He was then wheeled into the angiography suite. At that point, according to Dr Alcorn, Mr Petter withdrew his consent. He asked for the consent form back. The vascular intern (Dr Benjamin Williams) was called to explain the situation to Mr Petter. Dr Williams came down to the Radiography Department for that purpose. After attempts to explain the procedure by Drs Alcorn and Williams, Mr Petter maintained his refusal. An entry by Dr Alcorn in the Royal Adelaide Hospital notes at 11:45am that day states:

> 'For femoral angiogram – procedure explained and consent signed. Patient then refused procedure when taken in to Angio Suite. Despite further explanations, still refused. Vascular team informed.' [3]

A further entry appears in the notes at 1645 hours that day by Dr Morrow, Vascular Registrar, in the following terms:

> 'I have discussed with Mr Petter. He realises he has gangrene in the leg. He refuses angiography. He understands that this means we cannot attempt revascularisation thus leading to amputation. He stated that he wishes to be left alone to die. I have asked him to reconsider.'

4.2. The Royal Adelaide Hospital notes show that the Psychiatric Registrar Dr Goel was asked to see Mr Petter the same day in relation to his refusal to have the angiogram.

[2] Exhibit C9a
[3] Exhibit C22

A very detailed history was taken by Dr Goel together with a detailed description of Dr Goel's explanations to Mr Petter about the consequences of not having the angiography. It is interesting to note that the history taken by Dr Goel records that Mr Petter stated that he never wanted anything that included 'pricks and prods' and that he made the decision not to have an invasive procedure 'a long time ago'. When he was asked why he had signed the consent initially for the angiography, he stated that 'they talked me into it but now I've changed my mind'[4]. Dr Goel records that Mr Petter was made aware of the risks and benefits of having the procedure. He was informed that the risks of not having the angiogram/bypass included:

1) Higher amputation risk including bilateral amputation;
2) Increased pain;
3) Further hospital admissions;
4) Septicaemia;
5) Death.

On the other hand, he understood that the benefits included not having to have an invasive procedure thus avoiding the risks associated with operations. Dr Goel conducted a mental state examination and decided that Mr Petter was not for detention at that point.

4.3. On 1 February 2005 Mr Petter was reviewed by Senior Psychiatrist Sinjini Gray. Dr Gray assessed Mr Petter as being confused with some underlying persecutory beliefs regarding the angiography procedure. Although Dr Gray did not believe he was competent to give consent, she did not consider him to require detention because he was happy to remain as an inpatient. However, she wrote in his notes that if he were to decide to leave the hospital then he should be reviewed with a view to detention. She suggested that social workers needed to be involved in relation to applications to the Guardianship Board with a view to obtaining consent for the medical problems being faced by Mr Petter.

4.4. Later the same day he was reviewed again by the vascular team comprising Doctors Morrow, Loh and Williams. The note of that review records that Mr Petter was still stating that he was happy not to have any treatment, that he refused operative

[4] Exhibit C22

treatment and understood that his refusal may lead to sepsis and possible death. The plan at that stage was to review him further in relation to his mental state and to consider detention if he wished to leave and to monitor him for signs of sepsis.

4.5. The nursing notes record that from approximately 1800 hours that day Mr Petter became progressively confused. The notes record that he was hallucinating and speaking inappropriately.

4.6. At 0800 hours on 2 February 2005 Dr Lam[5] saw Mr Petter. Dr Lam was asked to see Mr Petter in relation to chest pain. This is the first reference to chest pain that appears in the notes. Dr Lam considered that Mr Petter was suffering from unstable angina. Dr Lam discussed with Mr Petter the possibility of a coronary angiogram but Mr Petter refused saying that he preferred medical management. Dr Lam made a note suggesting that the Cardiology Department review Mr Petter if he had further chest pain or prolonged chest pain.

4.7. Later that day Mr Petter was reviewed by Dr Symon, a Consultant Psychiatrist at the Royal Adelaide Hospital. It was his opinion that Mr Petter was unable to make informed decisions regarding his treatment. He advised the vascular team that one of two options would need to be pursued to obtain consent for any required treatment. The options he suggested were either to apply to the Guardianship Board for consent to do a medical procedure or to apply to the Guardianship Board for a Guardianship Order. He noted that the fluctuation of Mr Petter's mental state lent support to a diagnosis of delirium (an acute disturbance of cognitive function and perception often seen in the context of physical illness).

4.8. A note made during the evening on 2 February 2005 by Dr Williams records that he saw Mr Petter. He noted that Mr Petter had some chest pain during the day and that an ECG showed some ischaemic changes to his heart. He had refused an angiogram and it was therefore necessary to manage him by optimising his medication. He was taking all appropriate medications as a preventative measure to reduce the chances of a myocardial infarction. Of particular significance is the fact that during the course of the evening, according to the notes, Mr Petter again became acutely confused. According to Exhibit C2a, Dr Williams' statement, Mr Petter started yelling and

[5] Dr Lam was the night RMO on Ward A7

screaming in the late afternoon that day. Mr Petter was saying that he had called a taxi and he walked into the nurses bay, sat down and stated that he was waiting for the taxi. He was yelling and shouting and he pulled out some of his intravenous access jelcos. Mr Petter had not in fact called a taxi – he was in no position or condition to do so. At this point, at approximately 5:50pm on 2 February 2005, Dr Williams made the decision to detain Mr Petter pursuant to the Mental Health Act 1993. A Form 1 was completed by Dr Williams at 5:55pm stating that the grounds upon which he had decided to detain Mr Petter were 'acute delirium – lack of insight – requiring medical treatment for ischaemic feet'. A copy of that Form 1 was admitted as Exhibit C21c in these proceedings. At that point Mr Petter was placed in a posey, which is a form of restraint, and was given an intramuscular injection of Haloperidol. He was reviewed as was required by the Mental Health Act 1993 by Dr Symon the following morning. Dr Symon completed a Form 2 pursuant to the Mental Health Act 1993 confirming the initial detention order of Dr Williams. In that form he stated that Mr Petter was suffering from cognitive impairments and delirium. A copy of that form was admitted as Exhibit C21e in these proceedings.

4.9. Later on the evening of 2 February 2005, following the making of the detention order, Mr Petter was reviewed by the Cardiology Registrar. The result of that consultation was that Mr Petter was transferred to the Cardiology Ward A6 for cardiac monitoring at 2230 hours on 2 February 2005. During the ensuing night he was very unsettled and agitated. I note that Dr Williams in his statement Exhibit C2a, refers to serial blood enzymes demonstrating a rise in troponin which is indicative of a heart attack. No doubt this is a further explanation for the transfer to the Cardiology Ward.

4.10. This narrative brings me to the day of Mr Petter's death on 3 February 2005. For an account of the pivotal events of that day I turn to the evidence of Dr Leong who was a Cardiology Registrar at the Royal Adelaide Hospital in February 2005. Dr Leong was the only witness to give evidence at the Inquest. He also provided statements which were admitted in these proceedings as Exhibit C13. Dr Leong stated that the first time he became aware of Mr Petter as a patient was when he was on the Cardiology Ward at approximately 1:50pm on 3 February 2005. He was with a junior Resident Medical Officer, Dr Wong. Together they were doing a ward round when they heard what Dr Leong described as a 'commotion' at the other end of the ward. They went to see

what was occurring and realised that a MET (medical emergency team) call had been made in relation to Mr Petter. Mr Petter's casenotes record the MET call as having been made at 1:56pm. As Dr Leong was one of the two most senior doctors present including the members of the MET, he assumed the management of the situation. He was informed that Mr Petter had been transferred to the ward the night before after a small myocardial infarction. He was informed by nurses that Mr Petter had been hospitalised for a while, had gangrene as a result of diabetes, had been offered an angiogram but had refused and was detained. Dr Leong was informed that Mr Petter's close friend Ms Berta was thought to be in the process of obtaining a Power of Guardianship in relation to his affairs. Dr Leong examined Mr Petter and could not obtain any history from him directly. Mr Petter was being monitored by an ECG and on examining the ECG traces, Dr Leong concluded that he was having an acute myocardial infarction which was extensive and had been in process for some time at that point. He said that in his opinion there were few management alternatives given Mr Petter's age and comorbidities and reluctance for invasive treatment. His likelihood of survival was very poor. The options were that he could have an urgent coronary angiogram which would have been a difficult procedure given his low blood pressure and peripheral vascular disease. Even if he survived this process there would still be the issue of his ischaemic feet and the likelihood that he would have to undergo a leg amputation. The second option would have been to admit him to the Intensive Care Unit where he would be intubated and ventilated and supported by inotropic fluids. This would prolong an outcome which was going to be poor. The third option was to continue to manage him in Ward A6 and to keep him pain free. Dr Leong decided to approach Ms Berta as Mr Petter's close friend and discuss the matter with her.

4.11. Ms Berta was with a social worker in a side room. Dr Leong introduced himself to Ms Berta and advised her that he needed to speak to her urgently. He explained the treatment options already described by me to Ms Berta and asked her what Mr Petter's wishes would be if he could express them. Dr Leong said Ms Berta was tearful. She said that Mr Petter should not be aggressively managed but should be kept comfortable. Dr Leong advised her that in his opinion that was an appropriate approach and assured her that the team would keep Mr Petter pain free but would refrain from undertaking invasive procedures.

4.12. Dr Leong then returned to the MET at Mr Petter's bedside and related the conversation and sought the view of the other clinicians. The other clinicians were in agreement. Dr Leong then prescribed Midazolam on an 'as needed' basis along with IV fluids to support Mr Petter's blood pressure and advised that it would be the extent of his management. Dr Leong also paged Dr Steele, a Consultant Cardiologist, and related the events that had occurred and asked Dr Steele if he agreed with the proposed course of management. Dr Steele advised that he did agree.

4.13. After this Dr Leong had no further involvement with Mr Petter's management.

4.14. In the course of his evidence Dr Leong was asked whether he was familiar with the Royal Adelaide Hospital Medical Procedures Manual Guidelines entitled 'Guidelines for No Cardio Pulmonary Resuscitation'. Dr Leong was not familiar with this protocol. However, it became apparent in the course of submissions from counsel from the Royal Adelaide Hospital, who led Dr Leong's evidence in chief, that Dr Leong had been shown the relevant guideline in his solicitor's offices, but had not previously seen them. This information was provided by counsel for the Royal Adelaide Hospital but was not elicited in either examination in chief or cross examination of Dr Leong. Dr Leong acknowledged that the note of these events, which was made in the Royal Adelaide Hospital notes on his behalf by Dr Wong, was not as comprehensive as the protocol required. He explained that he was extremely busy at the time.

4.15. Following the events surrounding the MET call which have been described through the evidence of Dr Leong, Mr Petter remained sedated. At approximately 9:20pm, Ms Berta, who remained with him until his death, alerted staff that he required attention. The staff then noted that he was in distress and that his respirations were laboured. He ceased respirations at 9:45pm and was certified deceased at that time.

5. Conclusions

5.1. In my opinion, Mr Petter was lawfully detained at the time of his death. The circumstances surrounding his detention were quite appropriate and in my opinion the decision to detain him was an entirely appropriate decision. In my opinion the treatment provided to Mr Petter while he was in the Royal Adelaide Hospital was of an extremely high standard. A great deal of effort was taken by all staff concerned to

explain to him the benefits of the treatment options which were available to him, and the risks associated with his persistent refusal to permit such treatment. I consider that all measures were taken by the staff consistent with the limitations which were imposed by Mr Petter's own unwillingness to undergo the necessary treatment. By the time of his detention, his heart condition had become the primary problem, and he was in no condition at any time after his detention for aggressive treatment of the kind that might have prolonged his life in a condition that would have been comfortable for him.

5.2. I note the inadequacy of the notes regarding the decision by Dr Leong, in conjunction with Ms Berta and the MET that Mr Petter would be 'not for resuscitation'. However, I do acknowledge that the medical notes, read as a whole, provide evidence of this decision, and the circumstances leading up to it amply justified it. It is a matter of concern that Dr Leong was not aware of the relevant protocol. However, I do not doubt that he will familiarise himself with it at an early opportunity. Dr Leong was otherwise an impressive witness.

6. Recommendations

6.1. I make no recommendations in relation to this matter.

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

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 14th day of December, 2006.

State Coroner