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 5th, 6th, 7th and 8th of February 2008, the 20th day of March 2008 and the 6th day of June 2008, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Grant Aaron Austin.

The said Court finds that Grant Aaron Austin aged 29 years, late of the the Strathmont Centre, Grand Junction Road, Oakden, South Australia died at the Strathmont Centre, South Australia on the 27th day of April 2005 as a result of aspiration pneumonia complicating acute and chronic Wernicke's encephalopathy and morbid obesity. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

1.1. Mr Austin was born on 25 November 1975 and was 29 years old on 27 April 2005 when he died while detained at the Royal Adelaide Hospital. As at the date of his death Mr Austin was detained under an order made pursuant to Section 12(5) of the Mental Health Act 1993 and accordingly his death was a death in custody as defined by the Coroners Act 2003 and an Inquest was required to be held into his death by virtue of Section 21 of that Act.

1.2. A copy of the order for further detention form (Form 3) dated 24 April 2005 appears in volume 2 of Mr Austin's Royal Adelaide Hospital notes which were admitted as Exhibit C7a in these proceedings. The form was completed by Dr Griffin and relevantly states:

> 'The patient has intellectual impairment and there has been recent concern regarding catatonic like symptoms and refusal to eat and drink. There is a risk of harm to self and

> others by reason of impaired insight and judgement. Inpatient care is necessary to try to preserve life.' [1]

In my opinion, the detention was clearly necessary and lawful.

2. Background

2.1. In addition to his Royal Adelaide Hospital casenotes, Mr Austin's four volumes of notes from the Intellectual Disability Services Council (IDSC) were admitted in evidence[2]. The notes record that Mr Austin had an intellectual impairment. He had been registered with IDSC since he was 3 years of age after being assessed by the Women's and Children's Hospital as having general developmental delay. That assessment was made after he was admitted to hospital with burns to 70% of his body. In the early years of his life behavioural problems became evident and he was hyperactive, aggressive towards his parents, suffered delayed speech, was prone to tantrums and had toileting problems and a dependency on his mother. At the age of 5 Mr Austin attended the Murray Bridge Special School and boarded at the Orana Hostel. Mr Austin's parents lived at Pinnaroo and he returned home on weekends and school holidays. All agencies involved with Mr Austin's care reported continuing difficulties with his behaviour and this continued throughout his schooling. When he attained the age of 18 his parents decided it was best if he returned home to Pinnaroo and it became necessary for IDSC to provide 'day option' support to Mr Austin in his local area. Eventually, Community Lifestyles in Murray Bridge was contracted by IDSC to provide support to Mr Austin at home for two days per week.

2.2. As he grew into his early 20s, this arrangement continued. Mr Austin continued to display challenging and sometimes aggressive behaviour towards his family and his carers. By this time Mr Austin had gained a very great deal of weight. For example, his Royal Adelaide Hospital notes record his weight at 180 kilograms during an admission in February 1997[3].

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[1] Exhibit C7a, page 124
[2] Exhibits C8, C8a, C8b and C8e
[3] Exhibit C7, page 19

3. The events leading up to Mr Austin's death

3.1. Mr Austin's father, Mr Roland Austin, and his sister, Ms Sherry Thompson, gave evidence at the Inquest. They described how Mr Austin's behaviour, which had been reasonably settled, changed on or about Boxing Day 2004. Thereafter, his father became concerned for his welfare. Mr Austin's mother had died approximately twelve months before this and his father, according to the various casenotes to which I have already referred, was finding it increasingly difficult to care for Mr Austin by himself. The evidence during the Inquest focussed on the events in the first part of 2005 leading up to Mr Austin's death on 27 April 2005. The first significant event was Mr Austin's admission to the Royal Adelaide Hospital on 20 January 2005. On that day he was seen in the Emergency Department and a history was gained from his sister who was accompanying him. The notes of the medical officer record that Mr Austin had not been eating for four or five days. I note that the evidence at Inquest suggested that his loss of appetite stemmed from Boxing Day the previous year which would put it at considerably more than four or five days. Unfortunately, it seems that Mr Austin's intellectual disability has resulted in confused and inaccurate histories to medical practitioners at various points during those few months in 2005. I do not think anyone was particularly to blame for this; it seemed that all concerned were doing their very best for Mr Austin's welfare in difficult circumstances. He was an extremely large man and if he decided to be uncooperative, there was little that medical practitioners and carers could do but make the best of difficult circumstances. The casualty doctor examined Mr Austin and noted that he did not cooperate with the complete examination. However, no specific abnormalities on cardiovascular, respiratory, abdominal and neurological examination were determined apart from his pre-existing intellectual impairment and the fact that he was morbidly obese. A urinalysis was performed which suggested a urinary tract infection and Mr Austin was prescribed empirically with Trimethoprim, an antibiotic, to deal with that. He was discharged into the care of his sister with advice to return if his condition deteriorated or if treatment was ineffective[4]. Soon after this he returned to his father's care in Pinnaroo but on 29 January 2005 his father contacted Support Services in relation to Mr Austin. Mr Austin was assessed by a doctor in Murray Bridge and following that assessment he was presented to the Royal Adelaide Hospital on that day. He was admitted to the Royal Adelaide Hospital on 30 January 2005 under the care of Dr

[4] Transcript, page 169

Newman, a Consultant Physician in General Medicine. Dr Newman gave evidence at the Inquest[5]. Once again, the carers were expressing concerns about Mr Austin's unwillingness to eat or drink. Dr Newman said that on examination Mr Austin revealed no abnormalities apart from the same general health issues which had been observed ten days previously in the Emergency Department. Dr Newman requested the psychiatry staff review Mr Austin because of his behavioural disturbances and the need to provide sedation intermittently either by means of intramuscular injection or oral medications[6]. The relevant medical notes refer to contact with the IDSC and the Public Advocate and the Guardianship Board[7]. Dr Newman noted that Mr Austin's intellectual disability in combination with his obesity created problems with various procedures such as the taking of blood or other specimens. Dr Newman said that from time to time when it was necessary to take blood for testing Mr Austin required restraint as he would otherwise refuse to permit the procedures to be undertaken. Difficulties arose in obtaining venous access because of his morbid obesity[8]. Dr Newman's impression by the end of this admission, 3 February 2005, was that Mr Austin was eating and drinking consistently and reliably[9].

3.2. Between 28 February 2005 and 21 April 2005 Mr Austin was a resident at the Strathmont Centre which is run by IDSC. During the whole of his time at the Strathmont Centre Mr Austin was placed within the infirmary. There he was seen by Dr Nugent on 17 February 2005[10]. On that occasion, Dr Nugent noted that Mr Austin was admitted for assessment with an anticipated short stay at Strathmont involving a full medical and psychiatric workup. Dr Nugent gave evidence at the Inquest and said that when he first saw Mr Austin he seemed to be reasonably well but that in view of the history of unwillingness to eat and drink since Christmas it was decided that he would be fully examined.

3.3. By 3 March 2005, Dr Nugent had determined to refer Mr Austin to Dr Iain Pollard at the Modbury Hospital for an endoscopy to be performed. The letter of referral notes the history of loss of appetite and that Mr Austin was complaining of being 'full'. He had also indicated epigastric discomfort. The letter notes that Mr Austin normally had a big appetite and Dr Nugent questioned whether he had some gastrointestinal

[5] Dr Newman's statement was tendered at the Inquest as Exhibit C12
[6] Transcript, page 170
[7] Transcript, page 170
[8] Transcript, page 171
[9] Transcript, page 170
[10] Exhibit C9a - Computer extract of progress note for Mr Austin by Dr Nugent

pathology that was causing his symptoms. On 11 March 2005, Dr Pollard reported the results of the endoscopy examination. The report stated that Mr Austin's endoscopy showed pylori-duodenal inflammation, and superficial duodenal erosions. Although it was not possible to obtain gastric biopsies, Dr Pollard believed that Mr Austin almost certainly had Helicobacter and suggested a course of eradication therapy. He suggested that if the eradication of Helicobacter did not improve Mr Austin's discomfort with meals it might be worth giving him a two week trial of a proton pump inhibitor such as Nexium on the basis of possible non-ulcer dyspepsia. Dr Nugent said that he gave consideration to the endoscopy results and that although he thought they were worth treating, he believed there was something else going on, of a psychiatric nature, that was the main cause of Mr Austin's illness. He elaborated that Mr Austin should be prescribed oral medication. However, he did not think that, in the event that Mr Austin was uncooperative or non-compliant with the oral medications, that it would be worth putting him in hospital, restraining him and subjecting him to intravenous treatment for the administration of the necessary medications[11].

3.4. On 21 March 2005 a note of Dr Lasath Hattotuwa in the IDSC infirmary notes records that Mr Austin had been refusing food, fluid and medication and that he appeared to be suffering from depression and may benefit from ECT[12]. The note records that a letter was written to the Emergency Department at the Modbury Public Hospital. A copy of the letter to the Modbury Hospital Accident and Emergency Department appears in the notes[13]. The note is dated 21 March 2005. The letter records that Mr Austin's oral intake, both solids and fluids, had been very poor for several weeks. It recorded his having been seen in the Royal Adelaide Hospital in January 2005 and the endoscopy. It referred to the fact that Mr Austin had refused oral medication for eradication of Helicobacter pylori. The letter stated Mr Austin had been commenced on Sertraline Hydrochloride (an antidepressant) as depression was suspected but that he refused to take the antidepressant medication. The letter states:

> 'I wonder whether there is a role for ECT therapy given that he is refusing food and fluid now.'

[11] Transcript, pages 57 and 58
[12] Electro-Convulsive Therapy
[13] Exhibit C8c

The letter concludes:

> 'Please assess him with a view to admission. Thank you.'

The notes contain a record of Dr Hattotuwa dated 22 March 2005 recording that Mr Austin was assessed at the Modbury Public Hospital the previous day but that he was not admitted and a recommendation was made to discuss his case with Psychiatrist, Dr Les Koopowitz.

3.5. A letter of referral was then prepared for Dr Koopowitz on 24 March 2005. The letter records the history and requests Dr Koopowitz's assessment. The letter notes:

> 'Blood tests and endoscopy have revealed no physical cause for his symptoms and although he does have a resistant case of oral thrush, we believe he is severely depressed.'

3.6. Dr Nugent acknowledged that his letter to Dr Koopowitz omitted to mention that the endoscopy had shown some mild changes of disease and that in that sense Dr Koopowitz was not fully informed[14]. Dr Nugent stated that it was his opinion that a psychiatric illness was the primary cause for what he understood to be a 'startling difference' in Mr Austin between March 2005 and his normal condition and that Dr Nugent thought that depression was likely to be the main reason for this dramatic change rather than a possibly significant but relatively mild physical pathology[15].

3.7. Dr Koopowitz saw Mr Austin and recommended that he be placed on daily intramuscular Clonazepam which was prescribed as an appetite stimulant. It was successful in that regard for a short time although after a while it did not seem to help with Mr Austin's appetite[16]. Dr Nugent discussed the case with Dr Koopowitz. The latter expressed the view that he thought that Mr Austin's diagnosis was a negative catatonia rather than depression[17]. Around this time, a CT scan of Mr Austin's head was arranged and it did not report any acute changes but according to Dr Nugent it showed 'a small area that may have represented previous or long-standing damage'[18]. By early April, according to Dr Nugent, the infirmary staff were at their 'wits end' trying to get Mr Austin to take fluid. He said that they had had intermittent success with banana smoothies, yoghurt and water but that nothing was really consistently

[14] Transcript, page 62
[15] Transcript, page 63
[16] Transcript, page 67
[17] Transcript, page 67
[18] Transcript, page 67

being taken[19]. According to Dr Nugent, he did not recall vomiting being part of the initial presentation. The medical notes of 18 April 2005 refer to ongoing vomiting and the administration of a Maxalon injection to assist with this. Dr Nugent said that this indicated that Mr Austin's condition was going downhill and that he was just getting worse[20]. Mr Austin's IDSC notes refer to an application to the Guardianship Board that was heard on 12 April 2005 seeking consent for ECT at the request of Dr Koopowitz. The Board that day granted its authorisation for the administration of up to twelve ECT treatments for Mr Austin. Dr Nugent gave evidence that once Dr Koopowitz had advised that approval had been given by the Guardianship Board for ECT treatment, Dr Nugent had discussions with Glenside Hospital about transfer to Glenside for the ECT. However, he was informed by the staff at the Glenside Hospital that it was their view that because of Mr Austin's obesity they were unable to accept him for ECT treatment because of the anaesthetic risk that he posed. Dr Nugent described in his evidence his frustration at that point because of the worsening situation and his feeling that ECT treatment would be Mr Austin's last chance to turn around[21]. Dr Koopowitz said that when Glenside refused to take Mr Austin, the only other place at which ECT could be performed was the Royal Adelaide Hospital where intensive care support was available in view of his anaesthetic risks. Thus, on 22 April 2005, Mr Austin was sent to the Royal Adelaide Hospital where he was accepted for treatment by Dr Skinner.

4. Mr Austin's final admission to the Royal Adelaide Hospital

4.1. Dr Newman gave evidence at the Inquest. He said that on 22 April 2005 Mr Austin was referred to his care by the psychiatric staff in view of Mr Austin's presentation to the Royal Adelaide Hospital and the fact that Dr Newman had previously seen him in late January/early February[22]. Dr Newman said that he was suspicious that Mr Austin may have had either cholecystitis or pancreatitis in view of abdominal pain which he was experiencing[23]. Dr Newman requested amylase and a lipase blood examinations to test for these conditions. A chest x-ray was planned and intravenous therapy commenced in view of Mr Austin's dehydration. Some time after Mr Austin's admission, Dr Newman became aware that he had undergone an endoscopy in March

[19] Transcript, page 69
[20] Transcript, page 72
[21] Transcript, page 73
[22] Transcript, page 174
[23] Cholecystitis is inflammation of the gallbladder; Pancreatitis is inflammation of the pancreas

2005. The amylase and lipase tests, combined with the CT scan of the abdomen, led Dr Newman to conclude that pancreatitis and cholecystitis were unlikely to account for Mr Austin's presentation.

4.2. Dr Newman gave evidence that the treatment of Mr Austin's dehydration was very difficult because he had an aversion to all intravenous cannulae. A combination of encouraging oral intake and the administration of intravenous and subcutaneous fluid was resorted to[24].

4.3. Dr Newman said that in the early stages of Mr Austin's final admission to the Royal Adelaide Hospital he was considering possible medical reasons for Mr Austin's abdominal pain. He said that progressively they had eliminated one possibility after the other, to the point where the team had satisfied themselves that there was no major pathology to be dealt with below Mr Austin's diaphragm[25]. Dr Newman remained in consultation with the psychiatry team and it was agreed that a medical cause be pursued first, but on the understanding that there was likely to be a psychiatric diagnosis underlying Mr Austin's presentation[26]. By the day of Mr Austin's death on 27 April 2005, Dr Newman was becoming increasingly concerned to deliver some form of nutrition to Mr Austin. He said that delivery of nutrition through an intravenous drip would have been very difficult to manage given Mr Austin's propensity to remove intravenous cannulae. This left the possibility of inserting a nasoenteric feeding tube but this had its own difficulties in that it would have required a restraint team to insert the tube. However on the balance of the risks this was regarded as the best way to proceed[27]. Also when Dr Newman saw Mr Austin at 9am on the morning of 27 April 2005 he noted that a further CT scan of the head should be considered.

4.4. Dr Newman said that he was present on the ward when Mr Austin was found collapsed. He said that the emergency team had arrived by the time that he reached Mr Austin and that there were numerous staff attempting various resuscitative manoeuvres. Attempts at getting central venous access were being made and an attempt was being made to intubate Mr Austin. However he was pulseless and

[24] Transcript, page 178
[25] Transcript, page 182
[26] Transcript, page 183
[27] Transcript, page 185

without spontaneous respirations. He and his bed were covered in copious bile stained vomit. Resuscitative efforts were in vain.

4.5. Dr Newman said that it was apparent that Mr Austin had vomited and aspirated and this was at odds with his review of Mr Austin earlier in the day when he had a spontaneous cough, was able to roll on the bed and seemed able to protect his airway adequately.

4.6. Dr Newman was questioned about the autopsy finding that Mr Austin was suffering from Wernicke's encephalopathy. Dr Newman said that condition is a result of sustained and prolonged deficiency of Thiamine, vitamin B1[28]. He said that the demographic of the patient who presents with Wernicke's encephalopathy is, in the vast majority of cases, the alcoholic population who have poor nutrition and are wasted. He said that a small number of other patients fit within the different demographic of anorexia or patients with hyperemesis in pregnancy[29]. Dr Newman did not suspect that Mr Austin was suffering from Wernicke's encephalopathy because his morbid obesity told against such a condition[30]. Dr Newman said that Wernicke's encephalopathy is a diagnosis that relies on neurological examination including particular eye signs such as nystagmus, jerking movements of the eyes on natural gaze, ophthalmoplegia (an inability to move one or other eye beyond the midline with direct requesting) and incoordination of the limbs and confusion[31]. Dr Newman commented that it would have been very difficult in Mr Austin's case, in view of his intellectual disability, to have elicited many of these symptoms. He referred in particular to the opthala signs, the unsteadiness of gait and confusion which would have all been masked by Mr Austin's other problems[32]. Dr Newman commented that Mr Austin had presented at the hospital with a diagnosis of catatonic depression and was referred for ECT to the psychiatry service. This was sufficient to explain any confusion that he might have together with his profound intellectual impairment and the fact that he had been placed in a strange environment[33]. Mr Austin's lack of movement was also more than likely attributable to his intellectual impairment. As far as neurological signs were concerned Dr Newman said that they were typically very subtle and required a high level of cooperation from the patient to

[28] Transcript, page 187
[29] Transcript, page 188
[30] Transcript, page 188
[31] Transcript, page 188
[32] Transcript, page 189
[33] Transcript, page 215

elicit[34]. Dr Newman concluded by saying that he could not see how it would have been possible to make a diagnosis of Wernicke's encephalopathy in the circumstances with which he was presented[35].

4.7. Dr Newman said that on 23 April 2005 he endorsed Mr Austin as requiring one on one special nursing. He said that his intention was that there would be a nurse dedicated simply to the task of looking after Mr Austin and that that would continue 24 hours per day so that there would be a closer degree of observation for him than would normally be the case. Dr Newman said that with special nursing there should be no periods of the patient being unattended[36]. Dr Newman was not aware when he reviewed Mr Austin at 9am on 27 April 2005 that the nursing special had been ceased. When asked whether he thought it might have made any difference to Mr Austin's outcome had the nurse been present when he became seriously unwell at some time between 11:20am and 11:50am that day he responded that it may have made a difference[37]. As I have noted, Mr Austin had been 'specialled' in his nursing care since 23 April 2005. However, for reasons which could not be fully explained at Inquest, the specialling was not carried over into the day shift of 27 April 2005 (his date of death). Certainly he was specialled during the afternoon shift of the previous day and the night shift which immediately preceded that day. I heard evidence from four nursing staff in an effort to ascertain how it came to pass that Mr Austin's special nursing regime did not continue during 27 April 2005. The best explanation was that the matter was most probably overlooked by more than one person[38]. The evidence from the four nursing staff leads me to believe that there is a need for a formalisation of the practices and procedures within the Royal Adelaide Hospital in relation to the ordering of nurse specials and the circumstances in which a decision so made can be revoked, whether the original decision was made by medical staff or not. It is my intention to recommend that the Royal Adelaide Hospital review this matter.

5. Conclusions

5.1. It is clear to me on a consideration of the whole of the evidence that Mr Austin's profound intellectual impairment created a number of difficulties for medical staff in treating his prolonged failure to eat. Those difficulties included his inability to

[34] Transcript, page 215
[35] Transcript, page 216
[36] Transcript, page 202
[37] Transcript, page 203
[38] Transcript, page 297

communicate his symptoms, to follow simple instructions to provide neurological observations, his refusal to cooperate with oral medications and his obesity which made it difficult to obtain intravenous access. His propensity to remove cannulae was another significant impediment to proper medical treatment. The hospital environment would have been a very challenging and hostile environment for Mr Austin who had for many years lived in the quiet, small country town of Pinnaroo. In the final months of his life he had two admissions to the Royal Adelaide Hospital in January 2005, an admission to the infirmary at the Strathmont Centre punctuated by referrals to the Modbury Hospital, and then finally his last admission to the Royal Adelaide Hospital. Throughout all of this he was unwell and unhappy. In the circumstances it is not surprising that medical staff were unable to elicit the subtle information required to arrive at a diagnosis of Wernicke's encephalopathy, particularly bearing in mind that Mr Austin did not fit any of the known demographic groups at risk of that condition. Dr Koopowitz suggested that in hindsight the diagnosis should have been made. He went on to say that the staff involved in Mr Austin's treatment were going to be very hard on themselves, and he suggested that he would be very hard on himself. In my view, Dr Koopowitz should not be unnecessarily self critical. The clear view of Dr Newman was that even in retrospect it was impossible to see how he could have made the diagnosis. In my view, that is a reasonable position, and even Dr Koopowitz acknowledged that Wernicke's encephalopathy is a diagnosis which can only safely be made with the patient's cooperation.

6. Recommendations

6.1. As I suggested at the outset, the evidence in this Inquest showed that there were some deficiencies in the flow of information between medical staff. For example, information regarding the endoscopy results was not clearly communicated between Dr Nugent and Dr Koopowitz. Dr Newman commented that it was not entirely clear on the various histories taken how long Mr Austin had been refusing to eat[39]. This case shows that the health system needs to recognise that with patients who suffer from an intellectual disability the system itself needs to ensure that there is an adequate flow of relevant information from practitioner to practitioner. I recommend that the Department of Health consider the options available to ensure that

[39] Transcript, page 198

information is accurately and faithfully disseminated between the various medical practitioners involved in the care of the intellectually disabled.

6.2. I further recommend that the Royal Adelaide Hospital conduct a review of the system of nursing specials, with particular reference to the circumstances in which specials can be revoked and by whom, and the documentation required to authorise such revocations including a system for recording such documentation upon the patient's medical records.

Key Words: Intellectually Disabled; Wernicke's Encephalopathy; Hospital Treatment

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 6th day of June, 2008.

State Coroner

Inquest Number 4/2008 (1245/2005)