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 day of February 2009 and the 11th day of March 2010, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Jeong Shin.

The said Court finds that Jeong Shin aged 35 years, late of Banfield Ward, Glenside Campus of the Royal Adelaide Hospital, 226 Fullarton Road, Glenside, South Australia died at Banfield Ward, Glenside, South Australia on the 17th day of April 2007 as a result of pulmonary thrombo-emboli. The said Court finds that the circumstances of her death were as follows:

1. <u>Introduction and reason for Inquest</u>

1.1. Ms Jeong Shin was aged 35 years when she died on 17 April 2007. At the time of her death she was an inpatient within the Banfield closed ward of the Glenside Hospital at Glenside. She had been detained pursuant to the Mental Health Act 1993 (MHA).

1.2. Ms Shin had a complex history of mental illness. Her diagnosis was one of schizophrenia that was resistant to treatment. In the event, Ms Shin died of natural causes that I will describe in a moment. Because her death occurred while she was detained pursuant to the MHA, hers was a death in custody which meant that an Inquest into the cause and circumstances of her death was mandatory pursuant to the provisions of the Coroners Act 2003.

2. Cause of death

2.1. Ms Shin's previous medical history was not material to her cause of death. Ms Shin's death from what turned out to be natural causes was quite unexpected.

2.2. A post-mortem examination was conducted by Dr Allan Cala who at that time was a forensic pathologist employed at Forensic Science South Australia (FSSA). Dr Cala has assigned 'pulmonary thrombo-emboli' as Ms Shin's cause of death. Dr Cala has noted that there were numerous small and large pulmonary thrombo-emboli extending from the hilum of each lung into the periphery of the lungs. There was evidence of infarction of the left upper lobe in two separate areas and there were bilateral pleural effusions.

2.3. Dr Cala's report[1] states that the underlying cause for the development of thrombo-emboli can be one of a number but in this particular case the source of the thrombo-emboli was unknown. Dr Cala identifies risk factors as including smoking, oral contraceptive use, malignant disease, prolonged inactivity and post-operative status. The depot contraceptive Provera had been prescribed for Ms Shin as part of her psychiatric management. There was no suggestion that Ms Shin was sexually active, but she exhibited certain sexualised behaviour as part of her illness and, having regard to her consequent vulnerability, it was considered that a regime of contraception was appropriate and in her best interests. An extract from MIMS[2] states that a thrombo-embolic disorder would be a contraindication to the use of Provera, such that a prescribing doctor should be alert to the earliest manifestations of thrombotic disorders and that if any were detected, the drug should be discontinued immediately. The extract also states that a pulmonary embolism, among other cardiovascular conditions, has been associated with the use of a progesterone derivative such as Depo Provera. The extract does not suggest that this is a frequent side effect of the drug. In all of the circumstances, the possibility that this drug precipitated the development of a pulmonary thrombo-embolus in Ms Shin remains a theoretical one only. I am not satisfied that the drug was the cause or precipitating factor in the development of Ms Shin's pathology. In any event there was nothing to suggest either from Ms Shin's longitudal medical history, nor acutely, that she was developing a thrombotic disorder and so there were no contraindications to the use of the drug Provera in her case.

[1] Exhibit C3a
[2] Exhibit C33b

2.4. Professor Roger Byard, also a forensic pathologist at FSSA, provided further information to the Inquest in the form of a short report[3]. His report discusses causes of pulmonary thromboembolism in more detail than Dr Cala. Professor Byard states that one possible source of blood clots (thrombi) that constitute pulmonary thrombo-embolism, and which may ultimately obstruct blood flow to areas of the lung and cause tissue death (infarction), are the veins of the leg. When clots within the veins fragment, they may travel in the bloodstream to the lungs. This not only results in infarction of lung tissue but can cause acute right heart failure due to the obstruction of pulmonary blood flow, giving rise to sudden death by way of heart arrhythmia. Professor Byard points out that there was an accumulation of fluid in both pleural spaces at autopsy, a feature that may occur with heart failure or pulmonary thrombo-emboli. However, there is no evidence from Dr Cala's examination that there was any indication of clots having been formed in the veins of Ms Shin's leg or, indeed, within the pelvis as is sometimes the case.

2.5. There is insufficient evidence to identify the mechanism by which the fatal pulmonary thrombo-emboli in Ms Shin's case occurred. Equally, there is nothing to suggest that the development of thrombo-emboli in Ms Shin ought to have been predicted or anticipated. However, prior to her collapse Ms Shin had complained of pain in respect of a leg and as well, on one interpretation of the evidence, chest pain. I deal with this in a little more detail within, but complicating Ms Shin's physical presentation was her psychiatric difficulty, her at times lack of amenability to physical examination and a lack of proficiency in expressing herself in English. In any event, as will be seen, none of any such symptoms could reasonably have been expected to be associated with the development of a pulmonary embolus in Ms Shin's case.

2.6. The other relevant feature relating to Ms Shin's post-mortem examination is the identification in her bloodstream of various medications including Clozapine, Chlorpromazine and Lorazepam, all of which were prescribed for her. Although the presence of these drugs is a not unexpected finding, a feature of Ms Shin's toxicology worthy of discussion is the fact that there was a concentration of approximately 6mg of Clozapine per litre, which is described in the toxicology report of Mr Timothy Scott, a forensic scientist at FSSA[4], as a potentially lethal concentration. It has to be borne in mind, however, that Ms Shin's toxicology is complicated by the fact that her

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[3] Exhibit C33
[4] Exhibit C4a

autopsy and sampling for toxicology purposes was conducted three days after her death on 20 April 2007. In his report Dr Cala suggests that the very high blood level of Clozapine may be explained by post-mortem redistribution. Professor Byard in his short report states that he has also considered the abnormal concentration of Clozapine and has also discussed the matter with Dr John Gilbert, another forensic pathologist at FSSA. The conclusion that both pathologists have reached is that the level could have been an artefact of post-mortem redistribution and that the level of Clozapine within Ms Shin's bloodstream may have been lower prior to her death. This scenario is supported by the fact there was no clinical manifestation of a lethal concentration of Clozapine in Ms Shin's bloodstream prior to death. In addition, Professor Byard states that he is unaware of Clozapine presenting any risk in terms of the development of a pulmonary thrombo-emboli, although I note from a MIMS extract regarding Clozapine that was also tendered to the Inquest[5] that, very rarely, cases of thromboembolism have been reported following use of Clozapine. However, there is no evidence in this case that Ms Shin was administered anything other than a therapeutic dose of Clozapine. At the time of her death Ms Shin was prescribed 900mg per day which MIMS regards as the maximum permissible dosage. As at the date of her death this drug was being administered to her at the rate of 200mg in the morning and 700mg in the evening. She had been given both doses on the day of her death, the second larger dosage having been given to her within the two hour period prior to her collapse. There is no reason to believe that this regime, administered as it was daily, would have given rise to a lethal concentration of Clozapine in her bloodstream. In my view, the very high level of Clozapine detected in the post-mortem sample is probably due to post-mortem redistribution. In any event there is a perfectly viable cause of death in her case that is not normally associated with Clozapine usage.

2.7. I find that the cause of Ms Shin's death was as stated by Dr Cala, namely pulmonary thrombo-emboli.

2.8. In all of the circumstances, I am unable to identify the cause of Ms Shin's pulmonary thrombo-emboli.

[5] Exhibit C33a

3. The relevant provisions of the Mental Health Act 1993

3.1. Before discussing the circumstances of Ms Shin's hospitalisation and death, I should briefly explain the regime of detention that the MHA provides for. Section 12(1) of the MHA enables a medical practitioner to make an order for the immediate admission and detention of a person in an approved treatment centre where the medical practitioner is satisfied of a number of matters: firstly that a person has a mental illness that requires immediate treatment, secondly that such treatment is available in an approved treatment centre and thirdly that the person should be admitted as a patient and detained in an approved treatment centre in the interests of his or her own health and safety or for the protection of other persons. Section 12(2) of the Act provides that such a detention order expires 3 days after the day it is made unless it is earlier revoked. A person so detained must be examined by a psychiatrist within 24 hours of the patient's admission to the approved treatment centre or, where that is not practicable, as soon as is practicable after that admission. The examining psychiatrist must consider whether the continued detention of the patient is justified or not. If the psychiatrist is not satisfied that the continued detention of the patient is justified, the psychiatrist must revoke the order. Otherwise, the psychiatrist will confirm the order. If the psychiatrist confirms the order, this has the effect of continuing the 3-day period that had been activated by the original detention order. Before the expiry of that 3-day period, a further order for detention for another period of up to 21 days may be imposed. A second 21-day order may be imposed upon the expiry of the first such order.

3.2. The regime of detention that I have described only permits the imposition of two 21-day orders. These orders may be imposed by psychiatrists. Any further detention under the MHA beyond the total of the 45 days that I have described requires an order of the Guardianship Board of South Australia. The Guardianship Board may impose a continuing detention order under the MHA in the interests of the patient's own health and safety or for the protection of other persons.

4. Ms Shin's detention

4.1. Ms Shin migrated with her family from South Korea in 1989 when she was 18 years of age. She had married in 1998 and was divorced in 2005. There were no children of the union. Ms Shin's psychiatric difficulties manifested themselves some years before her death.

4.2. On 21 December 2005 Ms Shin was detained pursuant to Section 12(1) of the MHA on the basis that she had been suffering from a mental illness that had involved overt psychosis with auditory hallucinations and no insight. Save and except for two days of voluntary admission in March of 2007, Ms Shin remained under Mental Health Act detention until her death in April 2007. The initial detention was confirmed and extended until a continuing detention order was ultimately granted by the Guardianship Board of South Australia until 1 May 2006. A further continuing detention order was made by the Guardianship Board that extended the detention to 29 September 2006 and then a further order was granted by the Board until 20 March 2007. Ms Shin was accommodated in various mental health institutions. On 2 January 2007 Ms Shin had been transferred to the Glenside campus where she remained until her death.

4.3. Between 20 and 22 March 2007 Ms Shin was a voluntary patient at Glenside campus, but on 22 March 2007 she was again detained pursuant to Section 12(1) of the MHA. This detention was effected by Dr Sophie Cameron on the basis that Ms Shin was believed to be suffering from a mental illness, namely chronic psychotic illness with poor insight and judgment with disorganised behaviour. This detention was confirmed by a psychiatrist, Dr Julie Connor. On 25 March 2007 Ms Shin was detained pursuant to a 21-day order under Section 12(5) of the MHA. On Saturday 14 April 2007 Doctors Stephan and Mosler, psychiatrists, made a further order for Ms Shin's detention pursuant to Section 12(6) of the MHA. This order was made on the basis that Ms Shin had continued to exhibit behaviour consistent with psychosis with long-term documentation of active and chronic severe psychosis with ongoing treatment difficulties that included unpredictable behaviour involving aggression that was irrational. As well, the order was made by virtue of evidence of a severe psychotic disorder, characterised by blunted, perplexed affect, distraction relating to internal stimuli and bizarre, possibly catatonic, behaviour. Tendered to the Inquest were statements verified by affidavit from both Dr Stephan[6] and Dr Mosler[7]. I need not recite the details of their examination which, according to their statements, was made on 15 April 2007. Suffice it to say, in the light of Ms Shin's lengthy psychiatric history and her presentation on that day as evaluated by Drs Stephan and Mosler, the detention was both appropriate and lawful. I note that the examination was not

[6] Exhibit C21a
[7] Exhibit C20a

conducted with the use of a Korean interpreter but I am satisfied from the statements of both psychiatrists that this did not in any way diminish their evaluation of Ms Shin, particularly in the light of her history and her presentation that day that included an observation by Dr Mosler of bizarre posturing and catatonic features and by Dr Stephan of Ms Shin talking loudly to herself and waving her hand in admonishment towards a non-existent person. I note that a further application for a continuing detention order was scheduled to be heard by the Guardianship Board on 18 April 2007, the day after her death. The grounds for the application, as made by Dr Cameron of the Glenside Campus, were that Ms Shin suffered from chronic disorganised schizophrenia with behaviour disturbance, poor insight and judgment and that she should be detained to enable consolidation of her treatment in a secure setting. It was also envisaged that she would be granted leave to spend time with her family with a view to discharging her home in the near future if she could tolerate it, and if appropriate supports could be put in place. I note, however, that Ms Shin had recently been granted short periods of leave that were spent with family members. Unfortunately it appears that these leave periods had thus far not been particularly successful.

4.4. In short, Ms Shin was deeply psychotic at all material times and her detention from beginning to end was lawful and appropriate.

4.5. My finding that Ms Shin's detention was both lawful and appropriate is reinforced by the observations of the investigating police officer, Senior Constable Benjamin Everett of the Adelaide Criminal Investigation Branch, who after a thorough investigation expresses the conclusion in his very helpful report[8] that the detention of Ms Shin was lawful at all material times.

4.6. Ms Shin's detention and her psychiatric history, both longitudinal and acute as it was in April 2007, were reviewed by an independent forensic psychiatrist, Dr Craig Raeside. I here set out Dr Raeside's conclusions in this regard:

> 'Finally, from my review of Ms Shin's case, it would appear that throughout her various psychiatric admissions and hospitalisations she received appropriate care. I was particularly impressed about the regularity and frequency of psychiatric review of Ms Shin's mental state, utilising an interpreter frequently, which might otherwise have been overlooked or less than frequent given the extended care status and the chronic psychotic symptoms.

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[8] Exhibit C32a

> Unfortunately, Ms Shin appears to have had a particularly aggressive and severe psychotic illness, which proved essentially treatment resistant despite considerable efforts. Further, she appears to have had adequate medical and nursing review when she became more unwell shortly before her death.' [9]

Dr Raeside has commented favourably upon a number of aspects of Ms Shin's care including the regularity of follow-up, attempts at regular physical examination and the utilisation of an interpreter. Dr Raeside believes that those and other interventions appear to have been of a relatively high standard. Upon an examination of the large amount of material that was tendered to me during the course of the Inquest, I have no reason to conclude otherwise.

5. The circumstances preceding and surrounding Ms Shin's death

5.1. Ms Shin's physical well being in the days leading up to her death became a matter of concern. During the afternoon of Sunday 15 April 2007, which was two days before her death, Ms Shin was observed to have been sitting down in the television room leaning over, holding her stomach and saying 'I sick' and making yelling noises which resulted in her being given some sedative medication[10]. At about 4pm she was escorted to her bedroom. At that stage she was noted to be showing the effects of the medication. However, she still voiced complaints in English that she was 'sick'. When asked what was wrong, that was all she could reply.

5.2. This episode had been preceded by a visit that afternoon by Ms Shin's sister, Ms Melissa Yungyoung Shin, who provided a statement to the Inquest[11]. Ms Shin and her sister Melissa had attended at the canteen where some food and beverages were purchased. In her statement Ms Melissa Shin states that Ms Shin complained of feeling sick and told her sister to go home. Ms Shin apparently did not eat any of the food at that time but took the food with her into the ward. In her statement Melissa Shin describes noticing that her sister's stomach was enlarged and made a point of asking whether she was pregnant. Ms Shin reacted angrily to that. Melissa Shin states that apart from that, her sister did not look any different and it appears that Melissa Shin that afternoon did not draw anything of note about her sister to the attention of nursing or medical staff. Indeed, nursing staff did not appear to have been unduly concerned at Ms Shin's condition that afternoon.

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[9] Exhibit C23a, page 11

[10] Statement of Alexander Natziuk, Exhibit C19a

[11] Exhibit C5a

5.3. Melissa Shin did not see Ms Shin again until the following Tuesday afternoon which was the day of her sister's death.

5.4. In the intervening period nursing staff and the psychiatric registrar, Dr Sophie Cameron, had become increasingly concerned about Ms Shin's physical health.

5.5. According to the statement of Dr Cameron[12], at 10:45am on Monday 16 April 2007 she together with a registered nurse by the name of Yvette Moseley attempted to examine Ms Shin. Dr Cameron noted that Ms Shin was shouting out or wailing and was difficult to assess as she could not communicate the reason for her distress. She pointed to her leg and said 'pain' and specifically indicated her right knee. She permitted Dr Cameron to examine the knee only very briefly but Dr Cameron was able to observe that Ms Shin had a bruise on the medial aspect of her knee. Ms Shin pushed Dr Cameron away and refused to allow any further examination. Dr Cameron estimated the bruise to be a couple of days old. She could see no other sign of injury. Nor could she identify any other significant physical symptoms.

5.6. Ms Moseley who gave a statement to the Inquest[13] describes Ms Shin's leg as being quite bruised and swollen. Ms Moseley in her statement confirms that Ms Shin did not want the doctor to examine her beyond merely looking at her knee. Ms Moseley states that Ms Shin was saying things like 'no' and 'tomorrow' and making hand gestures. Ms Moseley offered her Panadol and Ms Shin took two tablets. With that Ms Moseley questioned Ms Shin as to whether she was 'okay' and Ms Shin responded in the affirmative.

5.7. There is an unsubstantiated suggestion on the evidence that Ms Shin may have recently fallen from her bed and that this might account for the injury to the knee.

5.8. Dr Cameron believed that in the light of her presentation and the injury to her knee, Ms Shin warranted further assessment. To this end Dr Cameron arranged for an interpreter to attend the following afternoon. The interpreter was a woman by the name of Sabina Chang who had been involved in a number of previous interviews with Ms Shin. In the meantime it was planned that nursing staff would monitor Ms Shin and advise the on-duty doctor if there were any significant changes.

[12] Exhibit C10a
[13] Exhibit C12a

5.9. Neither Dr Cameron nor Ms Moseley describe any complaint of chest pain on the part of Ms Shin during the course of their examination.

5.10. On the morning of Tuesday 17 April 2007 Ms Moseley offered and gave Ms Shin some further paracetamol as she assumed that she was still suffering from some discomfort in the knee. However, Ms Moseley formed the view that Ms Shin seemed better. She was out of her room. Ms Moseley considered that Ms Shin may have been improving because she was vocalising and had come out for breakfast and morning tea and was interacting with other patients and staff. Nevertheless, at one point Ms Shin returned to her room. She received a brief visit from her sister Melissa during the course of that day. Melissa Shin observed her sister to be in distress and in pain. Melissa Shin states that she asked Ms Shin in the Korean language what the source of the pain was and Ms Shin indicated her chest. Later Ms Shin was heard to be crying and in distress. She was given some PRN medication at 1:20pm in the form of 50mg of Chlorpromazine and 2.5mg of Lorazepam that were designed to settle her down.

5.11. The examination that Dr Cameron had organised with the interpreter took place at 3pm on the afternoon of 17 April 2007. The examination was conducted by Dr Julie Connor, who is a consultant psychiatrist, together with Dr Cameron. According to Dr Connor's statement[14] Ms Shin was resistant to the examination. Nevertheless, Dr Connor describes an informal survey and examination that she conducted during the course of a conversation that she had with Ms Shin. Dr Connor noted that Ms Shin was afebrile to touch and not clammy but appeared to be sleepy which was consistent with her earlier medication. Her pulse was approximately 80 beats per minute. Her breathing was unremarkable and there was no cyanosis (blueness) around her mouth. Her ankles were not swollen. There was no suggestion of malaise and she did not look unwell, notwithstanding earlier complaints that had been made in the previous two days that she had been feeling sick. When Dr Connor asked Ms Shin to come to the dining room she agreed at first but on the way decided to return to her bed. When Dr Connor took her hand Ms Shin said 'no, tomorrow'. Dr Connor describes Ms Shin as giving her a kiss on the cheek and saying 'thank you'.

5.12. Dr Cameron in her statement describes Ms Shin as being increasingly distressed during the examination and was wailing. She conducted the interview at first and the

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[14] Exhibit C9a

response from Ms Shin was that she was feeling sick but wanted to talk about it 'tomorrow'. When Dr Connor attempted to interview Ms Shin she stated several times that she should come back tomorrow and did not want to talk at that time. She declined to be examined. Ms Shin evinced her unwillingness to be examined by pushing the doctors away. Dr Cameron states that there did not appear to be any obvious pain, breathing difficulties or any alteration in consciousness nor colour. Other more in-depth examination would not have been possible without restraint. Dr Cameron believed that restraint was not appropriate. Ms Shin's clinical impression was that there was no physical symptomatology significant enough to warrant traumatising her by restraint. Dr Cameron indicates that they were with Ms Shin for approximately 45 minutes that afternoon.

5.13. Registered Nurse Leona Gonis, who gave a statement to the Inquest[15], was also present during the examination and interview. She confirms in her statement that Ms Shin was not interested in the examination because she said that she wanted to be examined 'tomorrow'. During the interview Ms Shin was gesturing with her hands and getting on and off her bed. According to Ms Gonis, at one point there was an indication through the interpreter that Ms Shin was not experiencing any pain.

5.14. A statement from the interpreter, Ms Sabina Chang, was tendered to the Inquest[16]. Ms Chang is a professional interpreter in the Korean language. She has interpreted in many different scenarios including for police, hospitals, schools and Court. She was first used as an interpreter for Ms Shin in December 2005. Ms Chang expresses the view that Ms Shin could understand requests by staff in English and could also make herself understood and speak sentences in English which were, although not fluent, comprehensible. Ms Chang also states that Ms Shin had a strong tendency to become impatient during conversations with psychiatrists and nurses. She said that Ms Shin would simply stand up and leave, or become impatient and complain and attempt to delay any further communication until 'tomorrow' or at another time. Ms Chang suggested that Ms Shin had a general propensity to be uncooperative. Ms Chang confirms that at the 3pm meeting on 17 April 2007 the doctors were endeavouring to find out what, if anything, was wrong with Ms Shin. Ms Shin did not say there was anything wrong with her, only that she was tired and wanted to sleep. Ms Chang confirms that there was an attempt to get Ms Shin to go to the dining room to further

[15] Exhibit C13a
[16] Exhibit C22a

facilitate the examination but she was uncooperative in that regard and wanted to go back to bed because she said that she needed to sleep. Ms Chang confirms that the doctors tried to examine Ms Shin but that she refused to let them touch her.

5.15. There is no evidence that at the 3pm examination that Ms Shin complained of any pain, discomfort and in particular any pain in the leg or chest. At no time did she complain specifically of pain in her chest. Her complaints to her sister in that regard were simply not verbalised by Ms Shin or in any other way communicated to clinical staff either directly or through an interpreter. She exhibited no physical symptoms other than those consistent with sedation.

5.16. Dr Cameron nevertheless decided that she should perform some further investigations including serum levels for her medication, haematology, biochemistry and an ECG as a way to screen for any underlying physical difficulties. She also considered splitting the Clozapine dose as Ms Shin's recent behavioural deterioration might have been related to her current regime of distribution. She recommended a more even dose such that the 200mg in the morning and the 700mg in the evening might be adjusted to 400mg and 500mg respectively. Dr Cameron altered the dosage on the drug chart to take effect the following day. Dr Cameron decided that in the light of Ms Shin's lack of cooperation during the course of the afternoon examination, the tests she had in mind should be performed at the earliest possible opportunity and when Ms Shin was more cooperative. Dr Cameron said:

> 'It didn't seem a matter of urgency that it be done soon and that she should be monitored overnight for any deterioration.'

5.17. The next contact between nursing staff and Ms Shin of any significance occurred at approximately 5:15pm when Ms Moseley checked on her. According to Ms Moseley's statement she stroked Ms Shin's hair to see if she was alright and held her hand. She also attempted to take Ms Shin's blood pressure and pulse. She was unable to record blood pressure because Ms Shin was 'combative'. At that time Ms Shin had a rash on her left arm and she did not want nursing staff to take blood from that particular arm. When Ms Moseley attempted to put the blood pressure cuff on that arm Ms Shin became upset, possibly thinking that Ms Moseley was trying to obtain blood. Although Ms Moseley managed to get the cuff on and inflate it once, she was unable to obtain a reading because the machine had battery difficulties. The second attempt involved Ms Shin becoming upset so Ms Moseley abandoned all

further attempts. Ms Moseley states that she did manage to palpate Ms Shin's left radial pulse and discovered that it was regular and at about 93 beats per minute. Ms Moseley observed no respiratory distress at this time and Ms Shin was verbalising. At this time Mr Adrian Harris, also a registered nurse at Glenside and who provided a statement[17], decided to administer Ms Shin's evening medication. This included the second part of Ms Shin's daily dosage of Clozapine, a quantity of 700mg, consisting of 7 x 100mg tablets. Mr Harris reveals in his statement that Ms Shin was lying down on her bed when he walked in. She sat up when he said that he had her medication and she put her hand out for it. She took the medication without difficulty. Mr Harris states that Ms Shin looked the same as she always had done, nothing different.

5.18. At approximately 6:30pm Enrolled Nurse Charlotte Kerr[18] noticed that Ms Shin's bedroom door was open. She looked inside and saw Ms Shin lying on a blanket on the floor. She drew this to the attention of other nursing staff. Nursing staff attended at Ms Shin's room and lifted her from the floor onto her bed. Ms Kerr indicates that at that point Ms Shin did not look right and they became concerned. A number of attempts were made to detect a pulse and none of the nursing staff were able to do so, except that at one point a carotid pulse of approximately 60 beats per minute was detected. Attempts to measure Ms Shin's blood pressure were met with Ms Shin pushing nursing staff away. Mr Harris confirms in his statement that after they placed Ms Shin on the bed she had become resistive by waving her arms around and verbalising in Korean. A radial pulse could not be obtained. Both electronic and manual attempts at obtaining her blood pressure resulted in no blood pressure being registered.

5.19. Ms Gonis also confirms the inability to obtain a pulse and blood pressure reading. Ms Gonis described Ms Shin as very uncooperative when attempts were made to take her pulse and blood pressure. She continued to struggle.

5.20. Registered Nurse Peter Lovell, who provided a statement to the Inquest[19], also entered Ms Shin's room. He too was unable to detect a pulse. Mr Lovell said that Ms Shin was not cyanosed but he did note that she had poor periphery responses in her fingertips and that her breathing was slightly laboured. Mr Lovell believed that Ms

[17] Exhibit C16a
[18] Exhibit C15a
[19] Exhibit C32b

Shin's presentation involved a matter of some urgency and that there was a need to obtain a doctor.

5.21. Notwithstanding the inability to detect a pulse, Ms Shin was not totally unresponsive. It is apparent that Ms Shin was agitated, resistant and was also verbalising. An attempt to take her blood pressure was made both electronically and manually with the result being that no blood pressure could be registered. Ms Shin appeared to be active but her presentation was of obvious concern to the nursing staff.

5.22. At approximately 6:45pm the on-call doctor at Glenside Campus, Dr Billakota who provided a statement to the Inquest[20], was called to attend the scene. He was advised that a patient in Banfield Closed Ward was uncooperative and that her blood pressure and pulse was not recordable. He immediately attended the ward and confirmed Ms Shin's presentation as precisely that. Her peripheral pulses were not palpable although Dr Billakota detected a carotid pulse of 55 beats per minute. Nevertheless Ms Shin was conscious, alert and responsive to verbal stimuli. She was not cooperative in respect of any examination. Dr Billakota described her as shouting, pushing people and kicking. Dr Billakota thought a possible diagnosis of cardiac arrhythmia was involved in her presentation. A decision was made to call the South Australian Ambulance Service (SAAS). In the meantime Ms Shin was administered oxygen by mask and an IV access was attempted but she remained, according to Dr Billakota, physically uncooperative and was, for example, getting up off the bed and pulling at the oxygen mask. Attempts to check blood pressure were met with Ms Shin pushing their hand away.

5.23. In the event, two SAAS crews were despatched. The SAAS record in relation to the crew that attended first[21] reveals that the call was received by SAAS at 7pm and that this crew was despatched at 7:01pm. The crew arrived at the Banfield Closed Ward at 7:07pm and was with the patient at 7:09pm. Statements were provided by the members of both crews. The first crew was staffed by Intensive Care Paramedic Wayne Le Clercq[22] and Ambulance Officer Catherine Howland[23]. According to Mr Le Clercq's statement Ms Shin was thrashing around with both arms, her legs and her torso. She was physically resisting and uncooperative. She was not responding to

[20] Exhibit C32c
[21] Exhibit C32v
[22] Exhibit C2a
[23] Exhibit C6a

verbal requests. His attempts to obtain Ms Shin's blood pressure by cuff and stethoscope were unsuccessful as a result. Ms Shin was on her bed. Ms Shin did calm down for a period and an oxygen mask was able to be applied. Ms Shin resisted further attempts to take her pulse and blood pressure.

5.24. Ms Shin's presentation as described by Mr Le Clercq is confirmed by Ms Howland. Ms Howland describes Ms Shin as combative. Ms Howland asserts that, notwithstanding the absence of or inability to detect vital signs, there was no cyanosis observed to begin with and Ms Shin's lips were quite pink and her skin colour was normal in its appearance. Ms Howland also asserts that when the heart monitor was placed on the patient it revealed a sinus rhythm at a rate she believed was 66 beats per minute.

5.25. According to the statement of Mr Le Clercq, ambulance personnel had, for the purposes of transport, wanted to sedate Ms Shin while she was in her agitated and responsive state, but this was resisted by the Glenside staff, both medical and nursing, on the grounds that she had already been administered sedative medication. A decision was therefore made that the police would be called to provide an escort. A police patrol eventually did attend but not before Ms Shin had gone into cardiopulmonary arrest.

5.26. It was while discussion was taking place about how Ms Shin would be transported by ambulance that Mr Le Clercq observed her head slump to one side with a slow rate of breathing. Mr Le Clercq observed her respiratory rate drop further and there was no palpable pulse and so CPR was administered, on the bed to begin with and then on the floor. IV access was attempted but there were difficulties with that. An endotracheal tube was inserted in Ms Shin's airway and CPR was continued. Ms Shin was administered adrenalin, at one point through the endotracheal tube itself and then into a jugular IV line. Atropine was also administered.

5.27. Notwithstanding an extremely slow non-pulsatile heart beat at various points in time, there was no further cardiac output after Ms Shin's cardiac arrest despite the attempts at resuscitation that I have described. At 7:50pm a decision was made to cease further CPR as it was considered futile and Ms Shin's death was declared at 8:10pm.

5.28. The second ambulance crew arrived on the scene after Ms Shin had gone into cardiopulmonary arrest. They also assisted in Ms Shin's attempted resuscitation.

There is no question but that the SAAS ambulance crews, consisting of Mr Le Clercq, Ms Howland and Intensive Care Paramedic Trevor Matthews and Ambulance Officer Amy Seymour-Walsh did everything that they could to resuscitate Ms Shin.

6. **Issues at Inquest**

6.1. I have already referred to the report of Dr Craig Raeside, forensic psychiatrist, in another context. Dr Raeside was also invited to comment upon the final days of Ms Shin's life. In his view, during the course of those few days Ms Shin appeared to have experienced an appropriate level of increased nursing and medical intervention. Dr Raeside believes that the treatment plan was appropriate in that there did not appear to be any indication that Ms Shin would have needed more aggressive physical examination, which clearly would have been a source of distress to her, requiring extreme sedation and possibly restraint. Dr Raeside expresses the view that given Ms Shin's history, and having regard to the lack of any obvious distress until shortly before her death, he did not believe that more urgent medical investigations had been warranted. Further, he does not believe that any alternative action would have made a difference to the outcome or that Ms Shin's death was otherwise preventable. Dr Raeside also expresses the view that the medical response to Ms Shin's injuries had been appropriate. In this regard he refers to the injury to Ms Shin's leg and to her complaints of pain. Dr Raeside refers to the possibility that the contraceptive Provera may have been associated with the thrombo-embolism following the injury to Ms Shin's leg and that ideally in retrospect there may have been some heightened awareness of the possibility of a deep vein thrombosis which can of course increase the risk of pulmonary embolus. However, given the clinical situation in reality, Dr Raeside believed that taking extreme measures for further, more invasive examination was probably not indicated upon the information available at the time. He believes that other more extensive and invasive investigations such as those that might have led to appropriate blood thinning agents being introduced would have been an unrealistic expectation in the circumstances of this case. In any event, I would observe that there is really insufficient evidence from which it can be concluded that there was a deep vein thrombosis in Ms Shin's leg or legs or that the Depo Provera was otherwise involved in Ms Shin's pathology. There is nothing revealed at autopsy to that effect and the source of her pulmonary embolus is unknown.

6.2. I am compelled to agree with Dr Raeside's observations regarding the appropriateness of the management of Ms Shin's physical well being.

6.3. Naturally this matter was investigated by the police. The investigation was conducted by Senior Constable Benjamin Everett of the Adelaide Criminal Investigation Branch. The only issue of substance that Senior Constable Everett raises following his thorough investigation was whether the medical response to Ms Shin's collapse had been appropriate having regard to the apparent time lapse between various events associated with Ms Shin's presentation and attempted resuscitation. He points out that there appears to have been an approximate 30 minute delay between discovering Ms Shin on the floor of her room and the calling of an ambulance at 7pm. I would observe, however, that Ms Shin's eventual cardio-respiratory arrest could not in any sense have been predicted from her presentation. However, that said, without meaning to criticise any individual or clinical staff collectively, it probably would have been better if an ambulance had been called earlier, given the ongoing inability to detect a pulse or blood pressure. The difficulty confronting clinical staff, however, was the fact that, despite the inability to detect vital signs, there was every indication that Ms Shin was nevertheless active and responsive. In any event there is no evidence to suggest that any earlier intervention on the part of the SAAS would have made any difference to the outcome having regard to the fact that Ms Shin's presentation when the first ambulance crew arrived was much as it had been since 6:30pm. It will be remembered that her cardio-respiratory arrest occurred after the arrival of the ambulance service and that active cardio-pulmonary resuscitation was not indicated before that event. When the arrest occurred, everything that could have been done was done. It is difficult to see how any delay to secure the attendance of SAAS affected the outcome. I agree with Senior Constable Everett's observation that the death of Ms Shin was probably not preventable.

6.4. Senior Constable Everett's report contains a recommendation in the following terms:

> 'Recommendation: Training and protocols are implemented where SA Ambulance Service is called immediately in circumstances where a patient is located without a pulse.'

I have given consideration to that recommendation myself. The suggestion contained within the recommendation has obvious prima facie attraction. However, I am mindful of the fact that there is no evidence that the calling of an ambulance would be the universal and invariable practice in circumstances where clinical staff are simply unable to detect a pulse in a patient who was already in a hospital or another clinical setting, especially where the patient is otherwise conscious and responsive. I say no more than that I draw the recommendation to the attention of the Chief Executive of the Department of Health for his consideration and action if deemed necessary.

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

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

Seal the 11th day of March, 2010.

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Deputy State Coroner

Inquest Number 4/2009 (0497/2007)