



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 15th, 16th, 17th, 18th and 21st days of February 2011 and the 3rd day of November 2011, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Margaret Dawn Ballard.

The said Court finds that Margaret Dawn Ballard aged 76 years, late of Rose Court Aged Care Facility, 3 Grant Avenue, Gilles Plains, South Australia died at the Glenside Campus of the Royal Adelaide Hospital, 226 Fullarton Road, Eastwood, South Australia on the 2nd day of January 2009 as a result of aspiration of gastro-intestinal contents as a result of small bowel obstruction due to small bowel torsion. The said Court finds that the circumstances of her death were as follows:

1. Introduction and cause of death

1.1. Mrs Ballard was a 76 year old lady who was admitted to Glenside Hospital in November 2008 with Alzheimer's dementia. She died on 2 January 2009 at Glenside Hospital. An autopsy was carried out by Drs Dodd and Chia who found the cause of death to be aspiration of gastro-intestinal contents as a result of small bowel obstruction due to small bowel torsion¹, and I so find. It should be noted that Mrs Ballard was not detained at the time of her death and, accordingly, this was not a death in custody within the meaning of the Coroners Act 2003.

2. Background

2.1. Mrs Ballard had a past history of major depression requiring electro-convulsive therapy and she had been admitted on a number of times to various hospitals over the 3 years prior to her death. In the weeks prior to her death she was experiencing

¹ See Exhibit C1a

hallucinations which were difficult to control and a number of alterations in her medication were made towards the end of 2008 in an effort to address these symptoms.

3. The circumstances leading to Mrs Ballard's death

- 3.1. On 1 January 2009 at approximately midnight, Mrs Ballard was found unconscious on the floor by her bed. She was examined by the duty doctor, Dr Buenviaje, who noted that she was hypotensive and clammy. She complained of right-sided abdominal pain and, after discussions with the emergency registrar at the Royal Adelaide Hospital, Dr Buenviaje transferred Mrs Ballard to the Royal Adelaide Hospital for assessment. Dr Buenviaje prepared a transfer letter stating that his impression was:

'Unconscious collapse, ? vaso vagal syncope, ?TIA, ?MI'

- 3.2. Mrs Ballard arrived in the Emergency Department at 0141 hours and was triaged as a category 3. Her observations were recorded as BP ¹¹⁶/₈₅, pulse 65, respiratory rate 18, temperature 36.2° and GCS 14, in that she was confused as to time and place. The triage nurse recorded that she had a soft abdomen with no pain. At this time an ECG was recorded that showed normal sinus rhythm with no acute changes. At 0307 hours she was reviewed by Dr Peter Bruce who was a resident medical officer and an emergency medicine trainee in the Emergency Department.
- 3.3. Dr Bruce later recorded that² Mrs Ballard was able to give a 'clear history' of feeling light headed and weak immediately prior to collapsing. During the fall she did not hit her head or sustain any other injuries. She denied any chest pain or shortness of breath and had no headache or neck stiffness. In the preceding 48 hours she told Dr Bruce that she had experienced some diarrhoea and vomiting but no abdominal pain. She had not received any analgesia or antiemetics during this time and her regular laxatives had continued to be administered.
- 3.4. Dr Bruce noted her past medical history to include Alzheimer's dementia, hypothyroidism and hearing impairment. He noted her regular medications were listed as sorbitol, sodium valproate, venlafaxine, temazepam, quetiapine, stelazine, oxazepam, thyroxine, ostelin and coloxyl with senna.
- 3.5. On examination Dr Bruce found that Mrs Ballard had heart sounds I and II with no audible murmurs. Her chest had good air entry bilaterally with no added sounds, her abdomen was not distended and was soft and non tender with normal bowel sounds.

² Exhibit C14a

The power in all four of her limbs was 5/5 with normal sensation and normal reflexes and cranial nerves II to XII were clinically intact.

- 3.6. Intravenous access with a cannula was obtained and blood tests taken. These blood tests returned the following results:

'Haemoglobin, white cell count and platelets within normal ranges; sodium 130 and chloride 95 both slightly below normal limits but with remaining electrolytes within the normal ranges; bicarbonate and anion gap within normal limits; normal liver function tests. Troponin at 3hrs post collapse was negative.'³

- 3.7. Dr Bruce said that his impression after taking a history and examining Mrs Ballard was that the transient bradycardia and hypotension recorded following her collapse, in the context of a normal ECG and essentially normal blood tests, were consistent with a vaso vagal syncopal episode. He said that he thought her recent symptoms of diarrhoea and vomiting without abdominal pain or distension were consistent with gastroenteritis and were likely to have resulted in mild dehydration and hypovolaemia which may have potentiated the vaso vagal collapse.
- 3.8. Dr Bruce directed that she be given two litres of intravenous normal saline over the next 2 hours to rehydrate her. He directed that she be given an antiemetic in the form of 2mg of tropisetron IV and to resolve any vomiting associated gastritis, she was given 40mg IV pantoprazole.
- 3.9. Mrs Ballard remained in the Emergency Department for 4 hours following her admission and did not complain of any abdominal pain and did not vomit. She was connected to an alarmed monitor that recorded ECG output, oxygen saturations and blood pressure and all of these remained within normal limits. Dr Bruce returned to review her and she stated that her light headedness had resolved and that she felt much improved. Mrs Ballard wished to use the commode to urinate and Dr Bruce assisted a nurse with her mobilisation which he reported as being satisfactory.
- 3.10. An ambulance was arranged to transfer Mrs Ballard back to Glenside Hospital with advice that she increase her oral fluid intake while her gastrointestinal symptoms persisted. She left the Emergency Department at 0541 hours.
- 3.11. Mrs Ballard's Glenside Hospital notes for 1 January 2009 state that she felt cold, slept most of the day and refused breakfast and lunch, although she had a very small amount of dinner. She was unsteady on her feet and vomited three times overnight. However, she mobilised and wandered into other patients' rooms and had to be

³ Exhibit C14a

redirected to her own room. On the morning of 2 January 2009 Mrs Ballard was seen at 10:30am by the psychiatric registrar, Dr Lawrence. Dr Lawrence noted the history of the previous few days and noted that Mrs Ballard was not getting any better and, in fact, appeared to be getting worse. She had already vomited three times that day when seen by Dr Lawrence and she looked ill and stated that she felt sick. Dr Lawrence noted that Mrs Ballard's observations were stable and she said there were no loose stools or abdominal pain. Dr Lawrence arranged for rehydration fluid Gastrolyte to be organised and that a medical doctor should be called if Mrs Ballard's condition deteriorated further.

- 3.12. Mrs Ballard vomited again at 11am and 5pm that day. No action was taken to arrange a medical review. During the evening of 2 January 2009 Mrs Ballard vomited again at 8pm and 9pm and the vomitus was reported to have smelt of faecal matter. Still medical review was not sought.
- 3.13. At around 10pm Mrs Ballard was found collapsed in the corridor outside her room. She was conscious and was able to be helped back to her bed. Once in bed she quickly became unresponsive and then vomited copious amounts of brown liquid from her mouth and nose. CPR and suction were performed but Mrs Ballard had aspirated gastric contents and suffered a cardiac arrest.
- 3.14. An expert overview was conducted for the Court by Professor Robert Fraser, the Director of the Investigations and Procedures Unit and Head of Gastroenterology and General Medicine 2 at the Repatriation General Hospital in Daw Park, South Australia⁴. Professor Fraser commented that Mrs Ballard's was a complex case⁵, largely as a result of her mental illnesses⁶. He said that in patients with mental illnesses, clinicians have to be very careful about history taking, particularly with a background of dementia. He commented that history is very important in reaching a diagnosis⁷.
- 3.15. It would appear that although Mrs Ballard told Dr Bruce that she had been suffering from diarrhoea, this was not true. As a result, Dr Bruce reached a diagnosis of gastroenteritis. Unfortunately, Dr Bruce placed undue reliance on Mrs Ballard's ability to give an accurate history.
- 3.16. Professor Fraser also considered that Dr Bruce accorded insufficient weight to the severity of Mrs Ballard's collapse that precipitated the admission to the Royal

⁴ Exhibit C17a

⁵ Transcript, page 252

⁶ Transcript, page 262

⁷ Transcript, page 237

Adelaide Hospital on 1 January 2009. He said that there were a number of possible diagnoses that were not given sufficient weight or were not given sufficient time to develop⁸ and that Mrs Ballard should have come in for a period of observation⁹. Professor Fraser was not unduly critical of the subsequent treatment at Glenside Hospital and the failure to obtain a medical review. His comment was that the psychiatric team at Glenside Hospital had sent Mrs Ballard in for an opinion and had received it and therefore they carried on in the light of that opinion.

- 3.17. It was Professor Fraser's opinion that vulnerable patients from mental institutions should be seen by reasonably senior clinical staff and have a consultant level review¹⁰. He summed his views up in the following passage:

'I guess patients who have mental illness are complex and that you have to have a much higher ... clinical index of suspicion ... I mean Mrs Ballard was in and out in under four hours ... I think again patients who come from a psychiatric institution probably need to be outside that, they need to be thought a little bit more differently, they're the vulnerable ones, the ones who do not - who it's hard to get back into the system. I think there should be a mechanism for having them reviewed by a more senior clinician ... that someone who has what is effectively a MET call at Glenside, I think probably should be observed for at least 24 hours and with a senior input.'¹¹

- 3.18. I was informed by counsel for the Royal Adelaide Hospital and Glenside Hospital that a Root Cause Analysis was conducted into Mrs Ballard's case¹². As a result of that Root Cause Analysis the following recommendations were made:

- 1) All consumers admitted into a mental health bed must have a comprehensive medical examination documented on a standard examination form by the mental health treating team within 48 hours of admission.
- 2) A project (Clinical Practice Improvement style) is undertaken to address sub-optimal medical review in a consumer with physical illness in the mental health setting. the project would be led by a senior consultant, and include psychiatry registrars.
- 3) The Mental Health Directorate (MHD) consider the Australian Commission of Safety and Quality in Healthcare's current work on recognising and responding to clinical deterioration, found on the following website (<http://www.health.gov.au/internet/safety/publishing.nsf/Content/prog-patientsrisk-lp>) and implement the recommendations from this work, including implementing a criterion for calling a rapid response team for medical emergencies, or, where the team is not available, a priority one ambulance, and put into practice the listed essential elements for systems of care to improve recognition and response to clinical deterioration.

⁸ Transcript, page 245

⁹ Transcript, page 245

¹⁰ Transcript, page 260

¹¹ Transcript, page 262

¹² Exhibit C19

- 4) The MHD Executive discuss the concerns raised in this aggregate RCA review regarding the Emergency Department's sub-optimal medical assessments with the appropriate leadership at the hospital.
- 5) Under the guidance of a senior Medical Consultant lead, regularly audit medical assessment of consumers as part of documentation review across the MHD, with analysis and action planning to promote improved practices. Reports are to be provided to the MHD Clinical Governance Committee and the Safety and Quality Unit for monitoring.
- 6) N/A
- 7) N/A
- 8) All new registrars to the Directorate receive documented clear guidelines of their responsibilities in admitting a consumer, including medical assessment, and their role in responding to clinical deterioration.'¹³

4. Recommendations

- 4.1. Pursuant to Section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.
- 4.2. It would appear that the Mental Health Directorate has recognised the lessons to be learnt from, not only Mrs Ballard's case, but those other cases which were the subject of the Root Cause Analysis. I recommend that the Minister for Health note this Finding and endorse the recommendations of the Root Cause Analysis, Exhibit C19.

Key Words: Alzheimers Disease; Hospital Treatment

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

Seal the 3rd day of November, 2011.

State Coroner

Inquest Number 4/2011 (0015/2009)

¹³ Exhibit C19