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, 5th and 19th days of September 2012, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Kenneth Alfred Stead.

The said Court finds that Kenneth Alfred Stead aged 79 years, late of 11 Zephyr Court, Surrey Downs, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 24th day of November 2010 as a result of delirium due to aspiration pneumonia complicating advanced metastatic non-small cell lung cancer (stage 4). The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

1.1. Kenneth Alfred Stead was 79 years of when he died on 24 November 2010 in the Royal Adelaide Hospital. At the time of his death he was subject to detention under the Mental Health Act and accordingly his was a death in custody as defined under the Coroner's Act 2003 and this Inquest was held as required by section 21(1)(a) of that Act.

2. Cause of death

2.1. A pathology review was conducted by Dr McIntyre of Forensic Science South Australia and he gave the cause of death as delirium due to aspiration pneumonia complicating advanced metastatic non-small cell lung cancer (stage 4)[1], and I so find.

[1] Exhibit C3a

3. Background and the events leading to Mr Stead's death

3.1. Mr Stead was diagnosed with metastatic non small cell lung cancer in December 2009. He was treated by a consultant medical oncologist, Dr Healy, between January and October 2010. Chemotherapy treatment was very successful during that period and Mr Stead tolerated it well. Up until 31 October 2010 he was living independently at home with his wife and was reasonably fit and well. He was able to carry out such activities as mowing the lawns.

3.2. On 31 October 2010 he was admitted to Calvary Hospital at North Adelaide complaining of nausea, vomiting, headaches and rapidly increasing confusion. Dr Healy reviewed him the following day and was struck by his marked confusion. A CT scan of his brain was organised and it revealed multiple lesions, more consistent with strokes than with metastases. An MRI scan was arranged for 2 November 2010 and it demonstrated multiple strokes, mainly in the posterior circulation of the brain which were felt to be embolic.

3.3. Between 2 November and 14 November 2010 Mr Stead remained reasonably settled, although he was confused, wandering and verbally aggressive. From 14 November 2010 his behaviour became increasingly difficult to manage. He was wandering more and he had a visual distortion due to his stroke, as a result of which he could not properly understand visual inputs and as a result was quite paranoid. On 18 November 2010 Mr Stead deteriorated and became physically aggressive. As a result a discussion took place between Dr Healy and the Geriatrics Unit at the Royal Adelaide Hospital and it was decided that Mr Stead would be transferred to that hospital.

3.4. At that time a decision was made to terminate his chemotherapy treatment by Dr Healy due to inability to manage his extreme agitation. He was seen by Dr Beadnell late in the afternoon of 19 November 2010. Early that evening he exhibited aggressive and violent behaviour towards nursing staff involving some physical contact, and as a result a detention order was made at about 7pm that night. The detention order was confirmed by a psychiatrist, Dr Adams, the following day. It was made on the basis that Mr Stead required treatment to protect others from harm and himself as well[2].

3.5. Dr Beadnell had discussions with Mr Stead's family as to his resuscitation status. Following this, Dr Beadnell discussed the matter with Dr Mohamed, a consultant

geriatrician. The family were very keen for resuscitation to be provided as long as the event was reversible and the efforts would not be futile. Dr Beadnell made a note in Mr Stead's records at 2:20pm on 22 November 2010 that he was for full resuscitation. The note was as follows:

> 'FULL RESUSCITATION
> - including CPR/DEFIB/INTUBATION/VENTILATION
> - as d/w (discussed with) family
> - if no reversible causes found, to re-address resus status' [3]

3.6. On the nightshift of 23/24 November 2010 enrolled nurse Zena Connor was assigned the task of 'specialling' Mr Stead. Shortly after the commencement of her shift she noted that Mr Stead was dehydrated and made arrangements for IV fluids to be provided via a review by the on-call doctor. This occurred. EN Connor was also given the task of 'specialling' a second patient in an adjacent room to that of Mr Stead. Despite the fact that she was required to effectively provide one-on-one nursing care to two patients, EN Connor provided a very high level of care to Mr Stead during her shift. In my opinion she was diligent in her duties and was a forthright witness. She gave evidence that she last saw Mr Stead alive at approximately 3:20am to 3:25am on the morning of 24 November 2010[4]. At that time she performed oral suctioning to Mr Stead. At approximately 3:30am her attention was required by the other patient who was agitated. She was occupied with that patient for some 15 minutes. By this time Mr Stead's observations were due to be done at 4am. EN Connor said that she went into his room and found him not breathing and without a pulse[5]. She said that she immediately summoned registered nurse Sarah Mena who was only some ten steps away from the bedside at the nursing station which was nearby. EN Connor recalled that she said to Ms Mena words to the effect either that Mr Stead had passed away or had ceased breathing[6]. She said that RN Mena came with her to Mr Stead's bedside and observed him. RN Mena then went to the other end of the ward to get the other registered nurse from that area to come and see Mr Stead. EN Connor was aware that RN Mena decided that she would call the doctor on duty. EN Connor did not hear what transpired in that conversation. She said that she was not directed to call a Code Blue or to commence resuscitation[7]. She gave evidence that she was somewhat surprised that a Code Blue was not called because the usual protocol is to call one, but as two registered nurses had assessed Mr

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[2] Exhibit C7a
[3] Exhibit C17, page 89
[4] Transcript, pages 16-17
[5] Transcript, page 17
[6] Transcript, page 21
[7] Transcript, page 20

Stead she did not feel that their decision was incorrect[8]. She said that she did not make any effort to resuscitate Mr Stead because RN Mena had made the decision not to, by not calling a Code Blue.

3.7. RN Mena gave evidence that at approximately 4am she was approached by EN Connor in what she initially described in her evidence as a 'casual' manner[9]. EN Connor informed her that Mr Stead had passed away and RN Mena said that she was shocked as a result of hearing that news. She went into Mr Stead's room to assess the situation[10]. She tried to rouse Mr Stead and noted that his chest was not rising and he was pulseless. She then called out for the team leader, a registered nurse by the name of Ivy. She was informed by the registered nurse at the other end of the ward that the team leader was on her break. Accordingly she asked that registered nurse, a nurse called Cheryl, whether she should call a Code Blue or contact a doctor. According to RN Mena, Cheryl said that she was not sure but to maybe call a doctor[11]. This followed Cheryl having also examined Mr Stead.

3.8. RN Mena did not call a Code Blue but instead went to the nurses' station and paged the on duty doctor. When she was asked at this point in her evidence why she did not call a Code Blue, she said that she was in shock and that this was the first time she had experienced a situation such as this and was looking for guidance as to what to do[12].

3.9. She gave evidence that she spoke to a female doctor and thought that she informed the doctor, with words to the effect that she thought one of the patient's had passed away. She claimed that she told the doctor that he was for full measures and asked whether she should call a Code Blue or whether the doctor would assess him. She claimed that the doctor asked her to confirm that the patient was dead[13]. RN Mena spoke to Cheryl about that and came back to the phone to respond but there was no-one on the end of the line. She claimed that she was met with a disconnected tone and that a few minutes later three doctors arrived to examine the patient. She claimed that in the meantime she was making further efforts to page the doctor, having lost the telephone connection. She claimed that she was not told by the doctor to commence CPR or to call a Code Blue[14].

[8] Transcript, page 21
[9] Transcript, page 60
[10] Transcript, page 60
[11] Transcript, page 61
[12] Transcript, page 61
[13] Transcript, page 62
[14] Transcript, page 63

3.10. RN Mena said that at the time of giving evidence she did not know why she did not commence resuscitation on Mr Stead. She said that she thought that the reason she sought assistance from a doctor was because she thought he was already dead and so she could either start resuscitation or get the doctors to assess him. In her evidence she accepted that a Code Blue should have been called[15]. She could provide no explanation for not having done so other than that she was shocked. She said that this was the first time such a thing had happened, although it was not the first death she had observed. She said that she had been involved in MET calls after a gradual deterioration in a patient, but not a sudden event such as this one.

3.11. Later in her evidence RN Mena claimed that her shock was due to the 'casual' way in which EN Connor informed her that she thought Mr Stead was deceased[16]. On further questioning she altered her position to say that her shock was a combination of the manner in which she claimed to have been informed by EN Connor and the fact that this was the first time in which she had experienced such a situation.

3.12. When she was questioned about why she regarded EN Connor's approach as casual, she at first said that EN Connor did not appear rushed and was just leaning against a wall when she reported the news of Mr Stead's death to RN Mena. However, RN Mena departed from this claim and ultimately conceded that EN Connor had approached her in a businesslike and prompt manner[17].

3.13. I conclude that EN Connor did indeed approach the exchange in a prompt and businesslike manner, consistent with the high level of nursing care she had provided to Mr Stead throughout the evening and the forthright manner in which she gave her evidence. RN Mena on the other hand was not forthright in her manner of giving evidence. Although she readily accepted that she should have called a Code Blue, she first asserted that her shock was due to the casual nature in which she was approached by EN Connor about such a matter, but she then departed from that position entirely. Furthermore, she had initially claimed that her shock was due to inexperience but then modified that evidence to suggest that it was due to the casual nature of the approach, ultimately arriving at a position that it was attributable to both. That position was then in turn further modified by her acceptance that EN Connor actually approached her in a businesslike and prompt manner. In this respect her evidence was unsatisfactory and I have no hesitation in preferring the evidence of EN Connor.

[15] Transcript, page 66
[16] Transcript, page 71
[17] Transcript, page 77

3.14. Dr May Thwin gave evidence that on the night in question she was an intern at the Royal Adelaide Hospital assigned to the medical nightshift[18]. Her responsibility was to cover medical patients at the Royal Adelaide Hospital that night and assess their needs overnight. Dr Thwin was a very good witness. Her evidence was clear and forthright and I have no hesitation in accepting her as a witness of truth.

3.15. Dr Thwin said that at approximately 4am she received a call from a member of the nursing staff informing her that an unidentified person had informed the nurse that a patient was thought to be dead[19]. Dr Thwin described this as an atypical conversation and as vague. It is notable that her account of this part of the conversation corresponds very closely with the evidence of RN Mena, who herself acknowledged that when calling the doctor she had said words to the effect that one of the patients – she thought – had passed away. Even on her own account RN Mena acknowledged some equivocation in the matter. She did not say that the patient had definitely passed away, she said it was thought that he had done so, or that she thought he had done so. Dr Thwin said that her response was to ask the nurse what she meant by saying that she thought the patient was dead[20]. Dr Thwin said that she asked if someone was doing CPR and asked whether the patient was for full measures. When told that he was, she advised that a Code Blue be called and that CPR be commenced[21]. She then said words to the effect that 'we are on our way'[22]. She then made her way to the ward accompanied by two other doctors who had been with her at the time she received the page. The two other doctors were Drs Usher and Sporn.

3.16. Dr Thwin said that when they arrived several members of the nursing staff were present. No-one was performing CPR on Mr Stead. Dr Thwin examined Mr Stead and noted that he remained shackled. He was cold, waxy and stiff. Dr Thwin said he had all the signs of a deceased person – there was no respiratory effort, no pulse and the eyes were fixed and dilated. She concluded that he was deceased and to use her words, 'for more than a few minutes'[23]. She was told by a female member of the nursing staff that this was how he had been found, namely cold and unresponsive. Dr Usher also examined Mr Stead and agreed with Dr Thwin. The senior registrar, Dr Mignone, was called. She examined Mr Stead and advised Dr Thwin to complete a certificate of death which she did.

[18] Transcript, page 80
[19] Transcript, page 84
[20] Transcript, page 86
[21] Transcript, page 86
[22] Transcript, page 88
[23] Transcript, page 89

3.17. Dr Thwin said that it was her habit to keep a notebook of all calls that she received while on night duty. She would write down the dot point notes of what she was told by the callers paging her[24]. She said that it was not uncommon to get 40 to 50 calls in a night and, by making notes, she was able to complete the tasks she had to do. She said that when she made an entry in Mr Stead's casenotes that night she made reference to her own dot point notes that she had made earlier. She said that all of her notebooks were shredded in accordance with hospital policy and she did not have them either when giving evidence or when being interviewed some months after the event. Dr Thwin said that she was not paged a second time in relation to Mr Stead. She was aware that a Code Blue had not been called because no Code Blue team was present upon her arrival and none arrived subsequently[25].

3.18. At 0415 hours Dr Thwin made an entry in the casenotes in which she recorded that the nurse had been advised to call a Code Blue but that no code had been called and there were no apparent attempts at resuscitation[26].

3.19. At 0550 hours RN Mena made a subsequent note to that of Dr Thwin. Her note recorded that she had called 'med nights'[27]:

> '… to inform them and ask if a Code Blue should be called, given that pt (patient) was for full measures → informed by MO to check that pt definately (sic) deceased and it was agreed by x3 nurse that he was, told MO and did not get a response, a few seconds later the phone had been hung up on other end of phone line. Shortly after, med nights, med admissions and registrar arrived on ward.' [28]

3.20. There was thus a dispute between Dr Thwin and RN Mena on the face of the notes and in their evidence at the Inquest as to the contents of the telephone call that was made between them. I have already set out their respective accounts, but should add that Dr Thwin was asked whether she had hung up as asserted by RN Mena. She denied that she had done so and said that she had completed her telephone conversation by directing that a Code Blue be called, that CPR be commenced and advising that she was on her way[29].

3.21. I unhesitatingly accept the evidence of Dr Thwin as to what transpired between she and RN Mena.

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[24] Transcript, pages 93-94
[25] Transcript, page 92
[26] Exhibit C17, page 95
[27] For all intents and purposes this was a reference to Dr Thwin
[28] Exhibit C17, page 97
[29] Transcript, page 96

3.22. In the result, it is quite clear that Mr Stead had been deceased for more than a few minutes when Dr Thwin and her colleagues arrived. They arrived as rapidly as a Code Blue team would have arrived in any event. It is plain that even if RN Mena had called a Code Blue - as she herself acknowledged she should have done – nothing further could have been done on the arrival of the Code Blue team. In all likelihood Mr Stead was deceased, and irreversibly so, when found by EN Connor. The effect of this is that the failure to conduct any resuscitative efforts did not have any impact on the outcome. The same applies to the failure to call a Code Blue.

3.23. Clearly Dr Thwin was concerned about the failure to call a Code Blue as required by hospital protocol. She made an entry in the notes, to which I have already referred, no doubt as a result of her concern about the failure to comply with hospital protocol. It was appropriate that she do so. While the breach of protocol may have made no difference in this case, it is important that the breach be noted and acted on to ensure that it was not repeated in a subsequent situation where a failure to call a Code Blue may have resulted in an unnecessary death. Clearly Dr Thwin, in making the note she did, acted in the interests of good hospital procedure and not out of any malice towards RN Mena or anyone else.

3.24. Dr Thwin was an impressive witness who, in my opinion, acted appropriately on the night and gave her evidence in a forthright and truthful manner.

4. Recommendations

4.1. I have no recommendations to make in this matter.

Key Words: Death in Custody; Natural Causes

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 19th day of September, 2012.

State Coroner