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 14th day of October 2013 and the 28th day of November 2014, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Kathleen Olive Florence Blain.

The said Court finds that Kathleen Olive Florence Blain aged 79 years, late of 24 Oakley Crescent, Aldinga Beach, South Australia died at the Repatriation General Hospital, 216 Daws Road, Daw Park, South Australia on the 14th day of October 2011 as a result of acute myocardial infarction and acute pulmonary oedema. The said Court finds that the circumstances of her death were as follows:

1. Introduction and reason for Inquest

1.1. Kathleen Olive Florence Blain died on 14 October 2011. She was 79 years of age. She was a patient at the Repatriation General Hospital at the time of her death and was subject to a Level 2 detention and treatment order made under the Mental Health Act 2009. Accordingly, hers was a death in custody within the meaning of that expression in the Coroners Act 2003 and this Inquest was held as required by section 21(1)(a) of that Act.

2. Background

2.1. Mrs Blain had had a relatively uncomplicated medical history prior to 31 May 2011 when she was found at her home address by members of the police force, apparently having collapsed. She was transferred to the Flinders Medical Centre where she was diagnosed as having suffered a stroke with disabling deficits involving her right hand side. While at the Flinders Medical Centre she suffered a non ST segment elevation

myocardial infarction and was referred to the cardiology team for further management. On 3 June 2011 a case conference decided that Mrs Blain would be a good candidate for rehabilitation following her stroke. As a result of this she was transferred to the Stroke Rehabilitation Unit at the Repatriation General Hospital. That transfer occurred on 9 June 2011.

2.2. On her admission to the Repatriation General Hospital Mrs Blain's medical conditions, namely the stroke and the cardiac condition, remained stable. The primary focus became the task of rehabilitation following the stroke with a view to getting Mrs Blain home or to other suitable accommodation.

2.3. Unfortunately Mrs Blain began to withdraw and would not to engage with those around her, particularly health professionals. On occasion she would deliberately close her eyes and not answer their questions, or would provide monosyllabic answers. She also began to refuse most food and drink and occasionally her medication. She expressed sadness and, on occasions, she expressed a desire to die. A diagnosis of depression was formalised and treatment for that condition was commenced. Regrettably, Mrs Blain's medical notes show that despite the periods where she appeared to be brighter and more responsive, her depression was not susceptible to treatment for the most part of her stay. Mrs Blain refused to participate in almost all physiotherapy sessions that were offered to her and her physical strength diminished. As a result her physical strength deteriorated to the point where she was unable to walk unaided and her prospects of returning to the community continued to diminish. Her physical state suffered from her refusal to take food and liquids on most occasions when they were offered. When she did consume food or water it was only in the smallest possible quantities.

2.4. Throughout her stay Mrs Blain's family were regularly involved with her and were regularly consulted about her by medical staff. The medical staff adopted a multi-disciplinary approach with input from psychiatry, general medicine, dieticians, physiotherapy, social workers, nursing staff, cardiology, neurology and the family members. Between 9 June 2011 and 11 June 2011 Mrs Blain was tried on mirtazapine. Between 17 June 2011 and 22 June 2011 she was placed on citalopram and from 23 June 2011 to 5 July 2011 her dosages were increased. Between 6 July 2011 and 15 July 2011 they were further increased and in late July 2011 they were increased again. Despite the dosages then being at an optimal level, the depression was continuing and the citalopram was not considered to be working. It was decided

to make a switch from the Selective Seratonin Reuptake Inhibitors[1] to the Serotonin–Norepinephrine Reuptake Inhibitors[2]. Accordingly, a step down program was introduced to wean her from the citalopram and she was introduced to desvenlafaxine on 28 July 2011. However, by 31 July 2011 Mrs Blain was refusing to take the medication orally. Being a slow release medication, desvenlafaxine could not be crushed or provided in any other fashion so a decision was made to switch to venlafaxine on 1 August 2011. The medication could be administered to Mrs Blain via her peg feeding tube which had been inserted by that stage. The dosage of venlafaxine was gradually increased over time throughout August 2011 until early October 2011 when it was at its maximum dose. Unfortunately it appeared to be ineffective.

2.5. From the point of view of her physical health, there was a family meeting on 28 June 2011 at which it was agreed that a nasogastric tube be introduced to assist with Mrs Blain's nutrition. At that time it was clear that the clinicians had some optimism that once Mrs Blain's depression was treated and overcome, her mood would improve and her physical health would then enable her to recommence participation in the stroke rehabilitation program. By late July 2011 it was still thought that she might be responsive to treatment for her depression, and that was when the peg was inserted. It remained insitu until her death. There were no complications with the peg feeding tube and it was regularly monitored and maintained with no difficulties, infections or other problems.

2.6. In late August consultant psychiatrist Dr Weeks began to consider the introduction of electroconvulsive therapy (ECT) given that Mrs Blain's depression seemed to be resistant to pharmacological treatment. Prior to commencing ECT it was considered that both neurological and cardiological opinions should be sought and this was carried out. On 23 August 2011 Mrs Blain had a neurology review which reported no contraindication to ECT. On 31 August 2011 an application was made to the Guardianship Board for permission to undertake the ECT. On 1 September 2011 the Guardianship Board granted an order for 12 treatments. An order was also made placing Mrs Blain under the guardianship of her daughter. On 7, 8 and 9 September 2011 cardiology reviews were undertaken and concerns were expressed with regards to Mrs Blain's cardiac health and suitability for ECT. A dobutamine stress echocardiogram was to be undertaken. This was done on 21 September 2011 and no

[1] SSRI - of which citalopram is an example
[2] SNRI

inducible ischaemia was detected. This finally cleared the way for the ECT to occur and treatments were administered on 30 September, 5 October, 7 October, 10 October and 12 October 2011. For each of these treatments the indications were that the treatment had been effectively administered and that Mrs Blain suffered no ill effects. She was returned to the ward with a successful recovery on each occasion. There were some slight indications of an improvement in her mood spasmodically, but generally it remained low.

3. Cause of death and conclusion

3.1. As I have noted, Mrs Blain was subject to a detention and treatment order under the Mental Health Act 2009. This was imposed in order to allow assertive medical management of her in the treatment of her depression. In my view, it was entirely appropriate that this course be adopted, and I have no concerns regarding it.

3.2. Unfortunately, despite all psychiatric and medical interventions, Mrs Blain's condition continued to deteriorate. After much careful treatment, care and consideration, the treating clinicians and members of Mrs Blain's family decided that she would not be for assertive medical intervention in the event of a decline and Mrs Blain died as I have noted on 14 October 2011. A medical deposition was completed by Dr D Rao of the Repatriation General Hospital who gave the cause of death as acute myocardial infarction and acute pulmonary oedema, and I so find.

4. Recommendation

4.1. I consider that Mrs Blain's medical treatment at the Repatriation General Hospital was appropriate at all times and I have no recommendations to make in this case.

Key Words: Death in Custody; Natural Causes

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 28th day of November, 2014.

State Coroner