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 13th day of August 2013 and the 13th day of August 2015, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Ivy Mavis Trengove.

The said Court finds that Ivy Mavis Trengove aged 87 years, late of 47 Alawoona Avenue, Mitchell Park, South Australia died at the Repatriation General Hospital, Daws Road, Daw Park, South Australia on the 24th day of July 2011 as a result of acute intracranial haemorrhage. The said Court finds that the circumstances of her death were as follows:

1. Introduction and reason for Inquest

1.1. On 24 July 2011 Ivy Mavis Trengove, aged 87 years, died from an acute intracranial haemorrhage. At the time of her death she was an inpatient at the Repatriation General Hospital to which she had been admitted on 7 April 2011 for a deep vein thrombosis (DVT) in her left leg.

1.2. At the time of her death, Mrs Trengove was the subject of a Level 3 – Detention and Treatment Order imposed on 28 June 2011 by the Guardianship Board pursuant to section 29 of the Mental Health Act 2009. Mrs Trengove's death was therefore a death in custody that required a mandatory Inquest.

2. Background and events leading to Mrs Trengove's death

2.1. Mrs Trengove had a previous medical history of hypertension, hypothyroidism, profound deafness, glaucoma, asthma and dementia. She was prescribed medications

including Norvasc, which is an anti-hypertensive, Pravachol, a hyperlipidaemic, Thyroxine, an anti-thyroid medication, and Ventolin for the conditions. On 7 April 2011 Mrs Trengove saw her general practitioner, Dr Colin Jacobson, with sudden swelling and pain in her left leg. Dr Jacobson was concerned that she might have a DVT and immediately referred her to the Repatriation General Hospital for urgent assessment. Radiological investigations undertaken at the Repatriation General Hospital where she was admitted confirmed that Mrs Trengove had an extensive above and below knee DVT.

2.2. Mrs Trengove was referred to the cardiology team for treatment and management of her condition. Warfarin and clexane were introduced with the instruction to monitor her neurovascular integrity and to watch for compartment syndrome and possible infection. The following day Mrs Trengove's son was consulted regarding her condition and treatment and he instructed that a conservative approach be taken to manage the condition. On 8 April 2011 Mr Trengove signed a resuscitation order for his mother in her presence which instructed 'Call MET code blue but no CPR'.

2.3. Over the ensuing time Mrs Trengove's behaviour declined in line with her advancing dementia. This gave rise to the need for periods of inpatient treatment pursuant to the Mental Health Act.

2.4. Mrs Trengove's son was consulted throughout her admission, including with respect to the medication regime that was in place, and also with regard to the possibility of the use of restraint. Ultimately a decision was made that it was no longer appropriate for her to remain on the medical ward and it was determined that she should be transferred to Ward 18, which is the acute mental health ward at the Repatriation General Hospital.

2.5. On 27 May 2011 Mrs Trengove was temporarily transferred to Glenside Campus as there were no beds available in Ward 18. On 1 June 2011 she was transferred back to the Repatriation Hospital and to a bed on Ward 18.

2.6. On 12 July 2011 orders pursuant to section 32 of the Guardianship and Administration Act 1993 were imposed. The orders appointed Mr Wayne Trengove to be the full guardian of Mrs Trengove. This order was made in anticipation of Mrs Trengove ultimately being discharged from the Repatriation General Hospital and returning to live in the community.

2.7. On Friday 22 July 2011 a bed became available for Mrs Trengove at the Eldercare Nursing Home in Seaford. The protocol with regard to securing the particular bed involved a need on the part of the proposed resident to attend at the facility in person. Rather than discharge Mrs Trengove prematurely in response to the bed being available, Repatriation General Hospital staff decided to maintain her admission in case she needed to return, and so she was granted leave to attend at the nursing home for the purposes of taking up the bed. A transfer was arranged for Monday 25 July 2011. It was envisaged that the existing Level 3 Detention and Treatment Order would be lifted at that time.

2.8. At about 6am on Sunday 24 July 2011 nursing staff at the Repatriation General Hospital discovered Mrs Trengove in her bed unresponsive, incontinent and with a slight mouth droop. A MET call was placed in line with her resuscitation orders and she was immediately transferred to the Intensive Care Unit. Discussions were then held with her family about her ongoing care. At this time a new resuscitation order was instituted, indicating the following:

> 'MET call, no CPR if arrests. Not for intubation, for adequate medical care and treatment.'

2.9. It was agreed that no aggressive or invasive treatment would be undertaken from this point. Mrs Trengove underwent a CT scan about 9am that morning, however the images were unable to be viewed at the time due to an outage with the GE systems that operate the machines. Although the Radiology Department attempted to resolve the problem as quickly as possible, Mrs Trengove's death occurred at 1:15pm prior to any images or report being received.

2.10. At 5:15pm on that day Mrs Trengove underwent a post-mortem CT head scan. This revealed that Mrs Trengove had suffered a large acute intracranial haemorrhage. Consultant psychiatrist, Dr Michael Page, who was involved in Mrs Trengove's care while she was in hospital, states that the warfarin therapy instituted for her DVT may have contributed to her risk of stroke. However, on 24 July 2011 her INR was 1.9 which is just below the therapeutic range for a person on warfarin therapy and therefore of no materiality.

3. Cause of death

3.1. No autopsy was carried out in respect of Mrs Trengove. Dr Iain McIntyre of Forensic Science South Australia indicated in a pathology review that in the circumstances it

was not necessary for an autopsy to be carried out. Dr McIntyre stated the cause of death in his pathology review as 'acute intracranial haemorrhage'[1]. The clinical circumstances support that as the cause of Mrs Trengove's death. I find that the cause of Mrs Trengove's death was acute intracranial haemorrhage.

4. Conclusions

4.1. The investigating police officer has concluded that the detention under the Mental Health Act was at all times lawful and appropriate. I observe that the order that was in existence at the time of Mrs Trengove's death had been imposed by an independent authority, namely the Guardianship Board. I agree with the conclusion of the investigating officer and have nothing further to add.

4.2. The investigating officer has also expressed the view that Mrs Trengove's medical care appears to have been adequate and that there does not appear to have been anything more that could have been done for her. I agree with that observation. Having regard to the nature of the resuscitation order that was put in place upon Mrs Trengove's collapse on the morning of her death, the delay in the viewing of the CT head images and any consequent delay in establishing a diagnosis of an intracranial haemorrhage at a time before she died, are of no materiality.

5. Recommendation

5.1. The Court does not see any need to make any recommendation 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 13th day of August, 2015.

Deputy State Coroner

[1] Exhibit C3a