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 21st day of February 2014, the 16th day of February 2015, the 4th and 12th days of June 2015 and the 8th day of February 2016, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Patricia Ann Fidge.

The said Court finds that Patricia Ann Fidge aged 67 years, late of 9 Oliphant Avenue, Seaton, South Australia died at The Queen Elizabeth Hospital, Woodville Road, Woodville South, South Australia on the 20th day of March 2012 as a result of choking and ischaemic heart disease. The said Court finds that the circumstances of her death were as follows:

1. Introduction, cause of death and reason for Inquest

1.1. Patricia Ann Fidge died at The Queen Elizabeth Hospital on 20 March 2012. She was 67 years of age. A post-mortem examination was conducted by Dr Langlois of Forensic Science South Australia who wrote a report[1] giving the cause of death as choking and ischaemic heart disease, and I so find.

1.2. Mrs Fidge had been admitted to The Queen Elizabeth Hospital Emergency Department on 17 March 2012 suffering with delirium. She was admitted to the hospital and remained until her death on 20 March 2012, three days later. During that period she was often uncooperative with medical staff and this required that she be restrained so that she could be treated. In the interests of protecting her safety it was determined that she should be detained under the Mental Health Act 2009. As she

[1] Exhibit C2a

was detained under that Act at the time of her death, hers was a death in custody within the meaning of the Coroners Act 2003 and this Inquest was held as required pursuant to section 21(1)(a) of that Act.

2. Background and the events leading to Mrs Fidge's death

2.1. Mrs Fidge had a number of pre-existing medical conditions including chronic obstructive lung disease, type 2 respiratory failure, obstructive sleep apnoea and catatonic psychotic depression. She had been suffering from delirium for about five days prior to her admission. Blood tests taken at the hospital revealed that she was hypernatremic and so she was admitted to the acute medical unit and given oxygen and intravenous fluids. There is no controversy surrounding the circumstances in which she was detained. A senior consultant psychiatrist at the hospital, Dr Dillon, formed the opinion that she was suffering from delirium and psychosis. He prescribed a low dose of risperidone to manage her agitation and confirmed a 7-day level 1 detention and treatment order under the Mental Health Act 2009.

2.2. Within the acute medical unit Mrs Fidge was commenced on BPAP treatment. On the morning of 20 March 2012 she was assessed by medical staff as being comfortable. She did not appear to be in respiratory distress and appeared to be saturating well without the assistance of the BPAP machine. However, she was disoriented, had poor short term memory and a poor attention span. Consequently a CT head scan was planned to investigate the possibility of an intracranial cause for her disorientation.

2.3. Mrs Fidge's daughter, Ms Carol Fidge, gave oral evidence. She told me that prior to her mother's admission on 17 March 2012 she was living independently in a Housing Trust house at Seaton. Her mother received aged care assistance, including assistance with everyday living and domestic duties. She said that her mother was conveyed by ambulance to The Queen Elizabeth Hospital on 17 March 2012 after a gardener and neighbour had found her to be unresponsive in her house. She was assessed in the Emergency Department and was later admitted to the respiratory ward. On the date of her mother's admission, Carol Fidge met with a medical registrar and discussed the question of resuscitation. It was confirmed that there would be a not for resuscitation order. Carol Fidge could not recall the name the doctor she spoke with, but said that she was satisfied with the medical explanation that was given to her and with the existence of the not for resuscitation order.

2.4. Carol Fidge visited her mother regularly during her admission. She said that on the day her mother died she had contacted the hospital at about 8am and asked the nursing staff how her mother was. She was told that her mother had come out of her psychosis and that she was sitting up in bed eating her breakfast. Carol Fidge gave evidence that she attended at the hospital at just before 1pm to visit her mother. She said that when she arrived at the ward she observed a nurse sitting at a desk by her mother's bed, and that the nurse appeared to be reading a paper. She said that when she entered the room her mother looked like she was asleep as her eyes were closed. Carol Fidge approached her mother and tried to rouse her, but she was unresponsive. Carol Fidge said that the nurse who was sitting at the desk then jumped up and pushed a button on the wall and at that point a number of medical staff entered the room to attend to her mother. Carol Fidge was escorted from the room and taken to an adjoining waiting room. After approximately half an hour a person attended upon her and told her that her mother had died. She recalled that someone mentioned that the cause of death was related to her mother's respiratory problems, but she could not remember if she heard this from a doctor or a nurse.

2.5. Carol Fidge told the Court that the police then arrived and that she spoke with them. She also said that a statement was taken from her by police. However, although she did not recall reading the statement, she did recall signing a statement in a notebook at the hospital. She said that she told the police that she was distressed by the fact that the nurse at the desk had apparently not realised that her mother was unresponsive before Carol Fidge herself made that discovery. It was her view that her mother did not receive a good standard of care at The Queen Elizabeth Hospital on 20 March 2012.

2.6. I received affidavits from eight police officers who had attended at The Queen Elizabeth Hospital on the day of Mrs Fidge's death. Each of those attending officers gave evidence that they did not obtain a statement from Carol Fidge. In particular, Constable Paton[2] stated that she attended the hospital on that day and spoke to Carol Fidge. She obtained an identification statement from Carol Fidge, but said that apart from that no other statement was obtained. Constable Paton did recall speaking at some length with Carol Fidge. It was Constable Paton's recollection that she was told by Carol Fidge that her mother had choked on some food while eating and was having

[2] Exhibit C16c

problems with swallowing and fluid build-up in her throat or chest, which made it difficult for her when eating. Constable Paton recalled that Carol Fidge had made a remark about her mother being left to eat unattended and that she should have been watched more closely. She said that Carol Fidge was upset and appeared to be confused at the time of their conversation. However, Constable Paton did not make any notes of this conversation and was unable to recall it in detail.

2.7. I also heard evidence from three of the nursing staff involved in Mrs Fidge's care. Minimol Scaria is a registered nurse[3]. She gave evidence that she was Mrs Fidge's 'nurse special' on 20 March 2012 and it was her task to maintain constant observations on Mrs Fidge during her shift. She said that Mrs Fidge was not subject to any special dietary requirements. This was Ms Scaria's first interaction with Mrs Fidge as a patient. She was required to monitor Mrs Fidge's vital signs, provide medication and to remain with her at all times. If she went on a break another staff member had to take over the monitoring. Ms Scaria said that she took a lunch break at 12pm for half an hour and that during that time Ms Brodie, an enrolled nurse who was working in the room and observing other patients, took over the role of maintaining observations of Mrs Fidge.

2.8. Ms Scaria said that she returned from lunch at 12:30pm. At that time she observed Mrs Fidge slowly eating a sandwich. She said that after Mrs Fidge had finished the sandwich she was sitting upright and did not display any abnormal signs or symptoms. However, after about ten minutes Ms Scaria heard sounds coming from Mrs Fidge's throat which resembled a gurgling noise. She said that at this point her team leader, Ms Paul, entered the room and told her to encourage Mrs Fidge to cough up any obstruction. Ms Paul also told her to increase Mrs Fidge's oxygen concentration. Ms Scaria told me that at that time Mrs Fidge's heart rate and oxygen saturation were normal and she was not showing any difficulty with her breathing. Ms Scaria said that she checked Mrs Fidge's mouth and did not locate any obstructions. She said that within a couple of minutes she noticed a pale discolouration around Mrs Fidge's mouth which she recognised as evidence of desaturation and a medical decline. She said that she then called on Ms Brodie to assist her. She increased Mrs Fidge's oxygen and tried to initiate the BPAP machine, but Mrs Fidge continued to decline. Ms Scaria said that she first noticed Carol Fidge

[3] Exhibits C5a and C5b

at the hospital while she was out of the room obtaining the emergency medical trolley. She said that she had not met Carol Fidge previously and only knew who she was because one of the other nurses pointed her out. Ms Scaria said that Carol Fidge had not attended the hospital until after Mrs Fidge had started making the gurgling noises and the medical staff had attended to assist with her decline. She disputed Carol Fidge's account and did not accept that Carol Fidge had attended the hospital before the medical team had arrived to assist with Mrs Fidge's collapse.

2.9. Ms Sheryl Brodie was an enrolled nurse who also gave evidence[4]. She confirmed that she was working on 20 March 2012 and that she had been supervising the other three patients who shared the room with Mrs Fidge. She said that she took her lunch break at about 12:30pm and that when she returned and entered the room Ms Scaria called her over to assist with Mrs Fidge, who appeared at the time to have stopped breathing. Ms Brodie then advised the team leader, Ms Paul. She said that she first observed Carol Fidge in the hospital room after the medical team had attended and while the curtain was being pulled around Mrs Fidge's bed. Ms Brodie requested that a student nurse take Carol Fidge to the patient lounge. She said that she later met with Carol Fidge in the company of Dr Ramsay after Mrs Fidge had died. Ms Brodie said that she did not herself speak to Carol Fidge, but remained as a support. She also said that she did not discuss Mrs Fidge's cause of death with Carol Fidge.

2.10. Ms Sony Paul is a registered nurse. She was the team leader on 20 March 2012 and gave evidence[5]. She said that she knew Mrs Fidge from a previous admission but had never met Carol Fidge and did not see her on the day of Mrs Fidge's death. Her evidence corroborated that of Ms Scaria and Ms Brodie, and confirmed their versions of the events leading up to Mrs Fidge's medical decline and death.

2.11. I am left in the situation where the treating medical staff have given evidence which is quite at odds with the version provided by Carol Fidge.

2.12. The Queen Elizabeth Hospital or, more accurately, the Central Adelaide Local Health Network Incorporated, and the staff members, Ms Scaria, Ms Brodie and Ms Paul were represented by counsel who I refer to as counsel for the hospital. Counsel for the hospital submitted that I should find that the care, management and treatment provided to Mrs Fidge by the hospital and staff throughout her admission, and

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[4] Exhibits C6a, C6b and C6c
[5] Exhibit C13a

particularly on 20 March 2012, was entirely appropriate. It was submitted that I should find that Carol Fidge was not present prior to her mother going into arrest on that day and that she only arrived a short time after that occurred when the staff were trying to save Mrs Fidge. She did not submit that Carol Fidge was deliberately attempting to mislead the Court, but submitted that it is reasonable and understandable to conclude that Carol Fidge was extremely distressed after witnessing her mother in cardiac and respiratory arrest on that day and that she may have become confused about what actually transpired.

2.13. Dr Peter Joyner provided an overview with respect to the medical care and treatment of Mrs Fidge. He was of the opinion that her not for resuscitation order was appropriate and that a review of the medical notes caused him to believe that at the time of Mrs Fidge's choking episode she had been appropriately medically managed. Dr Joyner was not asked to comment on the dispute between Carol Fidge and the medical staff as to whether or not proper observations were being conducted immediately prior to Mrs Fidge's collapse. That of course is a factual issue that is for the Court to determine. Dr Joyner said that it would not have been appropriate to intubate Mrs Fidge because of the not for resuscitation order. He said that would not have been a guaranteed method of recovery in a choking situation as it may not have reversed the respiratory arrest. Furthermore Dr Joyner was of the opinion that, given Mrs Fidge's significant comorbidities, she would be unlikely to make a proper recovery from the severe foreign body inhalation injury. Medical staff acted appropriately by not undertaking extended care and intubating her. Dr Joyner acknowledged that Mrs Fidge was given bag and mask ventilation and that specific examination of her mouth was made. He was of the opinion that it was not surprising that medical staff did not see the deeper food contents at the time as at autopsy the foreign food particles were found down at the level of the right main bronchus. He concluded that Mrs Fidge received appropriate care and management from the medical team and that in the circumstances her death could not have been prevented.

2.14. That leads me to the matter of the evidentiary dispute between the evidence of Carol Fidge and that of The Queen Elizabeth Hospital staff. Accepting Carol Fidge's version of events would mean finding that each of the hospital staff had deliberately misled the Court. There is no question that their evidence could be explained by confusion or mistake. Before reaching a conclusion such as that I must have regard to

the seriousness of the allegation and the need for something significantly more than proof merely on the balance of probabilities. Furthermore, the fact is that there were three staff witnesses whose accounts were consistent with one another.

3. Conclusion

3.1. In all the circumstances, I have come to the conclusion that I cannot reach the necessary level of satisfaction in order to accept the account of Carol Fidge. She arrived at the hospital expecting to find her mother free of her psychosis and relatively well, as that is what she had been told in her earlier telephone call to staff that morning. Instead, she found her mother in a state of collapse. This must have been extremely distressing and it is entirely to be expected that she would be shocked. The reliability of her memory of the event would naturally be affected. I think it probable that she misconstrued something that she saw and drew a wrong conclusion. I therefore find that Carol Fidge arrived at a time and in the circumstances described by the nursing witnesses from the Queen Elizabeth Hospital. It follows that I do not accept Carol Fidge's account that she arrived to observe the nurse sitting at a desk reading the newspaper and not noticing that Mrs Fidge had become unresponsive.

4. Recommendations

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

Key Words: Death in Custody

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

Seal the 8th day of February, 2016.

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State Coroner