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 15th, 16th and 17th days of March 2016 and the 10th day of October 2016, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Kay Meredith MacMillan.

The said Court finds that Kay Meredith MacMillan aged 62 years, late of 365 Blewitt Springs Road, Blewitt Springs, South Australia died at the Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 25th day of February 2013 as a result of end-stage heart failure due to cardiac amyloidosis. The said Court finds that the circumstances of her death were as follows:

1. Introduction, cause of death and reason for Inquest

1.1. Kay Meredith MacMillan died on 25 February 2013. She was 62 years of age. An opinion as to her cause of death was given by Dr John Gilbert, forensic pathologist, as end-stage heart failure due to cardiac amyloidosis[1], and I so find.

1.2. At the time of Mrs MacMillan's death she was subject to a Level 1 inpatient treatment order which had been signed at 1715 hours on 25 February 2013 by Dr Kelly of the cardiac team at the Flinders Medical Centre. For that reason Mrs MacMillan's death, which occurred just over one hour after she was detained, is regarded as 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.

[1] Exhibit C2a

2. Issues arising at Inquest

2.1. As I have stated, the inpatient treatment order was signed at 1715 hours on 25 February 2013. A MET call was made at 1828 hours because Mrs MacMillan had gone into cardiogenic shock. Mrs MacMillan died and was declared life extinct at 1853 hours, less than two hours after the inpatient treatment order was signed.

2.2. The Inquest examined the appropriateness or otherwise of placing an inpatient treatment order on Mrs MacMillan in light of her terminal illness, which was clearly in its end stage.

3. Background

3.1. Towards the end of 2011 Mrs MacMillan was referred to a cardiologist by her general practitioner for investigation of symptoms of breathlessness. She saw a cardiologist in January and February 2012 and underwent investigations. An echocardiogram revealed moderate to severe hypertrophic cardiomyopathy of the left ventricle. Further tests were arranged to establish the underlying cause for this, including bone marrow and rectal biopsies.

3.2. In May 2012 during these further investigations Mrs MacMillan suffered two cerebral artery vascular accidents resulting in left hemiplegia. She spent 18 of the next 40 weeks as a hospital inpatient with multiple complications from the strokes and the underlying condition which was ultimately and formally diagnosed as cardiac amyloidosis on 22 June 2012.

3.3. By September 2012 Mrs MacMillan was wheelchair bound and a completely different person. Prior to the onset of her illness earlier that year Mrs MacMillan was leading a very active and busy life. She was living on a 28 acre property with her husband and working part-time. So it can be seen that the progression of her illness was extremely rapid. The severity of her disease is evident from the fact that she spent 18 of the 40 weeks prior to her death as a hospital inpatient.

3.4. During the latter half of 2012 Mrs MacMillan was treated by cardiologist, Dr Yiu. She was also seeing a Flinders Medical Centre heart failure nurse, Ms Spicer, who was assisting her living at home when she was not in hospital. Dr Yiu said that when he last saw Mrs MacMillan on 7 February 2013 she was withdrawn but still reactive with

occasional smiles and bright moments, and would communicate in short sentences. He said she was a bit tired of all the medications and fluid restrictions. He thought that it was clear that she was to some degree depressed, but she had not expressed any suicidal ideation and he did not think that she was unable to recognise that she was depressed. He said it was not a deep melancholic depression. He thought it was a reactive depression appropriate to her situation, namely that she was suffering an incurable disease and had had a stroke. He was also aware that late in 2012 her general practitioner, Dr Lim, had instituted antidepressant medication for Mrs MacMillan, namely mirtazapine at 30mg per day[2].

3.5. During the periods where Mrs MacMillan was not in hospital she required community based supports including Domiciliary Care, Disability SA, Royal District Nursing and Southern Adelaide Palliative Care Services. She required a hospital bed at home with a pressure relieving mattress, a quad walking stick and in later stages a wheelchair and modifications to her home including ramps and rails.

4. Mrs MacMillan presents to the Emergency Department on 20 February 2013

4.1. On 20 February 2013 Mrs MacMillan was sent to the Flinders Medical Centre Emergency Department by her heart failure nurse. She was brought to hospital by ambulance. The South Australian Ambulance Service patient report form recorded that she had experienced a rapid deterioration over the previous week including increased lethargy. She was sleeping 22 hours in a 24 hour period, had decreased appetite and oral intake, very low systolic blood pressure and decreased bladder and bowel awareness.

4.2. Mrs MacMillan was seen by Emergency Department registrar Dr Adams at 2000 hours that evening. Dr Adams recognised that her condition was in its end stage and the primary concern upon her presentation was her low blood pressure of $^{85}/_{60}$ and her dehydration. She was admitted to the long stay cardiac ward and was again assessed at 2200 hours by the night registrar, Dr McNeil, who noted:

> 'End stage congestive cardiac failure secondary to cardiac amyloid.' [3]

[2] It should be noted that this medication regime was actually instituted by the Repatriation General Hospital and continued under Dr Lim's care

[3] Exhibit C12

Dr McNeil also wrote:

> 'On discussion with Mrs MacMillan in the event of acute deterioration she is not for CPR/intubation/ICU. She is for MET calls and active ward measures.' [4]

4.3. Dr McNeil's plan was to order some investigations to establish what was causing Mrs MacMillan's blood pressure to be lower than normal and his differential diagnosis list included myocardial infarction and urinary tract infection. Dr McNeil also noted that a palliative care review should be considered for the following day.

4.4. Overnight at 0403 hours the MET team was alerted to a drop in Mrs MacMillan's systolic blood pressure. They attended two minutes later and noted that she was not for invasive therapy such as inotropic support. The plan for the MET team was to continue with the current management and monitor hourly urine output.

4.5. The following morning Mrs MacMillan was seen by consultant cardiologist Dr Tideman. The casenotes reflect that a urinary tract infection was suspected as the reason for Mrs MacMillan's deterioration and she was commenced on a course of oral antibiotics. She was noted to appear flat in effect and the management plan formulated by Dr Tideman was recorded as being for palliative care input as well as a psychiatric liaison review.

4.6. The psychiatric liaison review took place the following day, 22 February 2013 at 1400 hours. The review incorporated discussions with both Mrs MacMillan and her immediate family and occupies 3½ pages of the casenotes. The entry noted that Mrs MacMillan stated that she did not have any depressive features prior to the onset of her terminal illness, that she denied any suicidal ideation or plan but that she had no energy, she could not enjoy anything and felt like she was giving up. The note concludes as follows:

> 'It is unlikely that anything we could offer will be of any additional benefit. Suggest palliative care input – already referred by team. We will review on Monday.' [5]

4.7. A palliative care referral form appears on the evidence to have been filled out that same day (22 February 2013). However it was not faxed to the Southern Adelaide Palliative Care Services until the morning of Monday, 25 February 2013 which was the day Mrs MacMillan died. This is despite the fact that there were numerous entries in the

[4] Exhibit C12
[5] Exhibit C12, page 41

notes between 20-25 February 2013 requesting and awaiting palliative care input. The referral form that was completed by a Dr Chen indicated that she spoke with someone by the name of 'Paul' from Southern Adelaide Palliative Care Services on 22 February 2013. There is nothing to indicate what the content of that conversation was. Furthermore, the Southern Adelaide Palliative Care Services notes[6] contain no record that corresponds with this conversation referred to by Dr Chen. While I have no reason to doubt Dr Chen, it would appear to be quite clear that whatever conversation took place was not sufficient to initiate any action of the part of Southern Adelaide Palliative Care Services. Any action that might have ensued as a result of the belated faxing of the form on 25 February 2013 was too late to assist Mrs MacMillan. I have no hesitation in finding that there was no response on the part of Southern Adelaide Palliative Care Services to Mrs MacMillan's situation. I make no criticism of that service. It would appear that the clinicians involved at the Flinders Medical Centre were ineffective in initiating a timely and adequate response from Southern Adelaide Palliative Care Services.

4.8. On Saturday 23 February 2014 the casenotes reflect that Mrs MacMillan was experiencing some confusion about where she was. A note by Dr Kelly of the cardiology team recorded that Mrs MacMillan was for review and discussion with the palliative care team on Monday. A nursing note of the same day revealed that Mrs MacMillan required the assistance of a full sling lifter for mobility which in turn required two to three staff members to operate.

4.9. A nursing note on 24 February 2013 reflected that Mrs MacMillan's husband had notified nursing staff of her confusion and alerted the staff as follows:

> 'Husband of patient stated that he wanted nursing staff to be aware that patient was delusional as she is relaying a story regarding family members that has little basis in reality. Husband declined to go into too much detail, however is happy to be contacted by home team if they require more details.' [7]

4.10. A nursing note at 0330 hours on the morning of 25 February 2013 referred to Mrs MacMillan not having slept much overnight and being alert, vague and confused. The note stated that she rang the call bell every half an hour and stated several times

[6] Exhibit C13
[7] Exhibit C12, page 45

that she wanted to go home. It stated that she was unaware of the time and had passed very loose brown fluid bowel movements.

4.11. There is a note of a review by the cardiology team led by Dr Balakrishnan later that morning. This record stated that Mrs MacMillan said that she was feeling better with no chest pain and no shortness of breath. It noted that she had loose bowel movements 15 times the previous day. She was orientated as to the day and year, but not the date and month and had said that she felt not able to cope at home at the moment and thought the solution was to 'downsize'. The plan was for her to come off the monitor[8], to continue current medications, for there to be social work involvement, to await palliative care and continue Warfarin. There is also a note that she may need 'capacity assessment'[9]. The entry also suggests that the palliative care referral was made on 22 February 2013 but, as I have already mentioned, the referral was not sent until the morning of 25 February 2013.

4.12. A nursing note in the late morning stated that Mrs MacMillan was given all of her medications as charted, however she needed supervision with her medications as she did not take them by herself in the morning.

5. The evidence of Mr MacMillan

5.1. Mrs MacMillan's husband made a statement[10]. He said that on Monday 25 February 2013 various family members visited Mrs MacMillan and that he spoke with them about the 'do not resuscitate' decision. He said that all family members were comfortable with this and agreed with it. He said that at no stage did the family think there would be any issues with that decision. Mr MacMillan said that at about 5pm he was with his wife and she told him that she was getting tired of being poked by needles and she was uncomfortable because she had lost control of her bowels. She had had a rotten night the night before. Mr MacMillan said that he told her that she had said goodbye to everyone and that if she wanted to tell the hospital that she did not want any more treatment she should do so. He told her that no-one would disagree with her decision. Mr MacMillan said that sometime later a nurse came in to administer some more medication and Mrs MacMillan told them 'I do not want it, take it away', or words to that effect. A staff member went off and summoned the registrar and Mr MacMillan

[8] This is a reference to the heart monitor
[9] Exhibit C12
[10] Exhibit C1b

said 'the next thing two or three doctors were in the room and I was shuffled out as they wanted to speak alone with Kay'. Mr MacMillan said that shortly after this the registrar approached him and told him that Mrs MacMillan had repeated her request for no more medication. The registrar said he had asked her whether she thought she was suffering from depression, to which she had said yes. The registrar told him that Mrs MacMillan was sick, but not dying and was not going to die that day or the next and as a result 'he could not adhere to her wishes'.

5.2. A short time later Mr MacMillan went back into the room and said goodbye to Mrs MacMillan with the intention of seeing her again the following day. While he was with Mrs MacMillan he was handed a copy of a document by a female doctor which was a Level 1 inpatient treatment order. The doctor asked him if he knew what it was and handed him another fact sheet with rights and obligations written on it. Mr MacMillan said that he was not in the frame of mind at that time to deal with it. He did not sign anything and did not look at the paperwork and left[11]. Mr MacMillan also said that he was very surprised the next day when he was informed that because Mrs MacMillan had been detained her death would be reported to the Coroner and would be the subject of a formal Inquest. It is fair to say I think that Mr MacMillan was not at all happy, firstly that his wife had been detained and secondly that this meant that there would be the need for a formal Inquest to follow. I regret that the need for an Inquest has caused him distress and simply note that it is a requirement of the law of the State by virtue of Mrs MacMillan's detention.

6. <u>The casenote entry for 25 February 2013 at 1720 hours</u>

6.1. This casenote refers to a cardiac team review of Mrs MacMillan by Dr Balakrishnan and the team. It is as follows:

> 'Events today and family / patient wishes re resus status noted. Ongoing concerns regarding patient's capacity to make decisions given severity of depression. Have discussed with psych registrar (Laura) at length regarding these concerns. Patient now refusing medications and <u>all</u> further interventions. Refusing oral intake. Urine output dropping off. Patient has been detained in the interim. For review tomorrow. Statement of rights and copy of detention form to patient.' [12]

[11] Exhibit C1b
[12] Exhibit C12, page 48

7. Dr Balakrishnan

7.1. I was informed that I would not be able to take evidence from Dr Balakrishnan as he no longer resides in Australia. However, he made a statement which was received in evidence[13]. In that statement he said he had a Bachelor of Surgery which he obtained in 2002 in India. He came to Australia in 2005, was an intern at Flinders Medical Centre in 2006 and undertook basic physician training, completing his fellowship at the Royal Australian College of Physicians in 2010. After that he joined advanced training and geriatric medicine and then joined cardiology as an advanced trainee in 2011. As I say, at the time of the Inquest he was no longer resident in Australia and could not be called as a witness.

7.2. In the statement Dr Balakrishnan said the following about his involvement with Mrs MacMillan. On the morning of 25 February 2013 he saw her as a patient. He said:

> 'I think she was on a palliative care order[14]. The person who would normally be looking after MACMILLAN had left for an echo session so I was covering the ward. When I first saw her she seemed and looked well and in my notes I have written that she felt better but had a mild decompensation of heart failure.'

He went on to say that she was not clinically unstable in the morning. He said that the plan following the morning review was for Mrs MacMillan to continue with her current treatment 'as she was quite stable'.

7.3. Dr Balakrishnan said:

> 'In the afternoon after talking with nursing staff an issue of depression was identified and that MACMILLAN was undergoing treatment for depression. MACMILLAN was currently on mirtazapine. The thought process was that there was some difficulty with her family being able to cope with her wishes as she was bedbound and she was relying a lot upon the husband to help out. There was some difference as to her resuscitation status because she had expressed the wish to be fully resuscitated in contradiction to her families (sic) wishes. I spoke to MACMILLAN then her family who were all looking more towards a palliative and no full resuscitation (NFR) order. Because MACMILLAN had full insight into her condition I thought it was more appropriate to go with what she wanted rather than what the family wanted.' [15]

At this stage I note this paragraph of Dr Balakrishnan's statement is inconsistent with the general evidence and with Mrs MacMillan's casenotes and, indeed, with

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[13] Exhibit C11e

[14] I note that the expression 'palliative care order' has no particular meaning. It is difficult to know what Dr Balakrishnan was referring to. Certainly there is no order known to the health system, nor to the law in this State of that kind.

[15] Exhibit C11e, page 3

Dr Balakrishnan's own actions. The statement that she was 'undergoing treatment for depression' is wrong, although it was correct that she was on mirtazapine. The diagnosis of the psychiatric team the previous Friday was that she was not suffering from major depression, but rather the natural consequences of a person nearing the end of her life with a particularly unpleasant cardiac condition. Secondly, Dr Balakrishnan's suggestion that there was some difference as to Mrs MacMillan's resuscitation status between her own wishes and those of her family is completely false. There was no evidence of any such dispute and indeed no such dispute existed. Mrs MacMillan and the members of her family were all of the same mind in relation to that question. It is unfortunate that Dr Balakrishnan was not able to be called as a witness as it would have been appropriate to question him closely on this assertion. Thirdly, Dr Balakrishnan's statement that Mrs MacMillan 'had full insight into her condition I thought it was more appropriate to go with what she wanted rather than what the family wanted' is completely inconsistent with Dr Balakrishnan's decision as the leading clinician to have Mrs MacMillan detained. If she did indeed have full insight into her condition and did indeed want to be treated, there would be no need to have detained her even if, contrary to the facts, the rest of the family members had not wanted her to be treated. In short, Dr Balakrishnan's version of events is alarmingly different from that to be derived from the evidence of all of the other witnesses and the relevant documentation. I will return further to the subject of Dr Balakrishnan's behaviour and credibility later in this finding.

7.4. Dr Balakrishnan then asserted that later in the day one of his resident medical officers told him that Mrs MacMillan had declined to take her tablets and was declining anything orally and this was the opposite of what she had been like in the morning. He said that he then spoke with Mrs MacMillan and she confirmed that she was declining 'everything again'. According to Dr Balakrishnan she was not very willing to talk to him. He said:

> 'I felt that this was really unusual for someone who in the morning looked well and wanted everything to be done to have changed their mind by the afternoon. After speaking with MACMILLAN I met her husband who told me about the NFR order again. I recall telling him that MACMILLAN was sick, not dying, and that we can't adhere to her wishes.' [16]

[16] Exhibit C11e, page 4

Dr Balakrishnan continued:

> 'I suspected that there may have been an episode of aggravating or negative depression or depressive psychosis but MACMILLAN was not psychotic so I made a call to Dr. Randall LONG[17] for a professional opinion. I did not speak with LONG though, I spoke with a psychiatric registrar for their opinion as to whether they could come and review MACMILLAN prior to us detaining her. The registrar informed me she wasn't able to. I then got a call from LONG asking me to detain her if I thought she was appropriate to be detained. I thought that it was very unusual for a patient's decision making, especially not to engage in conversation and have a very flat mood suddenly. She had all the symptoms of depression so I decided to detain her.
>
> A diagnosis of depression depends on the psychiatrist. In MACMILLAN'S notes the psychiatry team wrote that they were unable to determine it exactly as she was not able to give proper history, she was not engaging. To have named it as depression earlier in my statement MACMILLAN could have been suffering depressive symptoms but not actually diagnosed with depression. You can still treat symptoms of depression with tablets without actually having a diagnosis of depression and in some cases the patients respond. If she was not depressed or suffering any depressive symptoms she should not have been on the treatment of mirtazapine[18].' [19]

7.5. Dr Balakrishnan then stated that he was later advised that Mrs MacMillan had died. From this it is clear that he was not present when she died, only a little more than an hour after Dr Balakrishnan's decision to detain her. I note that Dr Balakrishnan did not himself sign the documentation for the Level 1 inpatient treatment order. Instead that was carried out by one of his resident medical officers. However, it was plainly a decision made by that resident medical officer as a result of Dr Balakrishnan's guidance and influence and Dr Balakrishnan's conversation with Dr Long. The resident medical officer was not a participant in the discussion with Dr Long and could only have acted on the history of that discussion as relayed by Dr Balakrishnan. In short, there is no doubt that the moving force behind the decision to detain Mrs MacMillan was Dr Balakrishnan even if he did not himself deign to sign the Level 1 inpatient treatment order.

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[17] Consultant Psychiatrist

[18] Exhibit C11, page 5

[19] Dr Balakrishnan's assertion that the psychiatry team had written in the notes that they were unable to determine whether Mrs MacMillan had depression because she was not able to give a proper history and was not engaging is completely at odds with the notes of the psychiatric review of the previous Friday. To the contrary, Mrs MacMillan was engaging with the psychiatric team and was giving a proper history, and they were able to form the view that she was not suffering from a reversible depressive disorder, but was in fact behaving in the manner of any person who was facing the prospect of imminent death.

8. The evidence of Drs Chen and Kelly

8.1. I heard evidence from the two junior doctors on the cardiology team. It was Dr Chen who filled in the form for the referral to the Southern Adelaide Palliative Care Services. It is her writing that records the conversation between the cardiology team and a person named 'Paul'. Dr Chen could not remember this conversation or whether she was the person who spoke to 'Paul'. It follows that she was not able to remember the content of the conversation either. There was an inference that it was Dr Chen who spoke with the person called 'Paul' because she completed the form and the form was finally faxed on the morning of 25 February 2013. Furthermore, there is nothing in the notes of the Southern Adelaide Palliative Care Services that any such call was made, nor any evidence as to who 'Paul' was. In the end it is not possible for me to make a finding as to this aspect of the matter. What is quite clear is that there were multiple references in Mrs MacMillan's notes that a number of different clinicians had seen the need for her to be reviewed by the palliative care team. Despite them all recognising this, it appears that either no action was taken to ensure that it had happened, or whatever action was taken was wholly inadequate to ensure a timely response. We now know that the palliative care experts were not involved in any of the unfortunate events of 25 February 2013.

8.2. Dr Chen's evidence was that after ward rounds the various tasks that had been decided upon during the course of the rounds would be divided amongst the interns and resident medical officers. However, it is impossible to know to whom each task was allocated because there is no record about that. All that one can rely on are the notes evidencing what was in fact done and the author of the note. There is no note of any phone call on the Friday night to anyone from the Southern Adelaide Palliative Care Services.

8.3. There is no need for me to refer to the evidence of Dr Kelly. It was she who signed the Level 1 inpatient treatment order. It was clear that she was heavily influenced by Dr Balakrishnan in signing that order, although she claimed in her evidence that the decision was one she independently supported. Of course, she would have to make that acknowledgement because it would be unlawful to act under the direction of some other doctor in signing such an order.

9. The evidence of Dr Long

9.1. Dr Long is a consultant psychiatrist and runs the consultation liaison psychiatry service at the Flinders Medical Centre. His evidence was that on 25 February 2013 he was informed by his psychiatry registrar, Dr Allen, that she had seen Mrs MacMillan on the previous Friday afternoon for the psychiatry review that I have already referred to. Dr Allen reported the results of the review to Dr Long on the following Monday morning, 25 February 2013. Dr Long said that Dr Allen's assessment was that Mrs MacMillan's mood was indeed low and that this was consistent with the progressive and severe cardiac failure she was experiencing. She told him that the recommendations were for good palliative care and that there were no acute psychiatric interventions that were recommended[20]. This is consistent with the notes I have already referred to. Dr Long said that Dr Allen had also informed him that Mrs MacMillan was on antidepressant medication and he said that this did not necessarily mean she had depression and it was his assumption that she had been prescribed it in the community, perhaps by her general practitioner[21].

9.2. Dr Long said that cardiac disease has a high prevalence of depression for various reasons. He said that typically cardiac conditions mean that the brain is not being perfused as healthily as it normally would[22]. He said in short that Mrs MacMillan was thinking about the increasing effort of battling a terrible form of cardiac failure and this was a very different situation from someone who has major depressive disorder whose thinking can be distorted and irrational, and not based in reality[23]. Dr Long gave evidence of his conversation with Dr Balakrishnan late on 25 February 2013. Dr Long said that he had a long discussion with Dr Balakrishnan. He said that Dr Balakrishnan gave 'strong arguments' and 'believed quite strongly' that Mrs MacMillan's low mood and her changed decisions as to treatment were not just due to cardiac failure. Dr Balakrishnan 'argued quite strongly' that there was depression that was incapacitating Mrs MacMillan. Dr Long said that he pressed Dr Balakrishnan as to why the symptoms could not be attributed to Mrs MacMillan's physical condition, but that

[20] Transcript, page 127
[21] Transcript, page 128
[22] Transcript, page 129
[23] Transcript, page 130

Dr Balakrishnan maintained that her treatment had been going well and this was a sudden change[24].

9.3. Interestingly, Dr Long recorded in the notes[25] a note of his conversation with Dr Balakrishnan. The note contains the following:

> 'Told the last couple of days Mrs MacMillan wanted full resuscitative treatment and all the family did not want her to be resuscitated.'

This substantiates the account given in Dr Balakrishnan's record of interview referred to above. This reflects that Dr Balakrishnan was providing what was in fact a false account to Dr Long. Dr Long said that he again quizzed Dr Balakrishnan about the nature of this change and noted that Dr Balakrishnan wanted to treat Mrs MacMillan as he suspected depression and not a cardiac reason for the change of instructions[26]. Dr Long said that Dr Balakrishnan said to him words to the effect 'I know cardiac failure and this is something different'[27]. Dr Long said that Dr Balakrishnan's was a 'strong opinion, it was an unusually strong opinion, and the doctor argued it quite persuasively'[28]. Dr Long explained to Dr Balakrishnan the circumstances in which inpatient treatment orders could be made[29]. Dr Long said that Dr Balakrishnan was explaining that Mrs MacMillan was at physical risk because of the asserted mental condition because she was refusing to take her tablets and this would be bad for her. He said that she needed her cardiac treatment, her medication and her treatment for fluid overload. Dr Balakrishnan conveyed that he felt the situation was grave. As a result Dr Long felt that it was his duty to inform Dr Balakrishnan about the option of an inpatient treatment order[30].

9.4. Dr Long referred to an entry he made in the notes following Mrs MacMillan's death[31]. The note was as follows:

> 'Post mortem entry. Informed patient has passed away overnight. Was detained by cardiology. Psychiatry registrar assessment reviewed. Agree with assessment and advice. Post mortem assessment indicates that depression could have been one factor in her presentation, however in retrospect physical deterioration and dysphoria associated with decompensating cardiac status and its cerebral sequelae may account for her mood

[24] Transcript, page 132
[25] Exhibit C12, page 54
[26] Transcript, page 133
[27] Transcript, page 134
[28] Transcript, page 134
[29] Transcript, page 134
[30] Transcript, page 135
[31] Exhibit C12, pages 56-57

disturbance. This may also have been an autonomous authorisation of end of life treatment withdrawal as explained by Dr Allen.'

9.5. Dr Long said that in retrospect and hindsight he would not have wanted Mrs MacMillan to be cared for under an inpatient treatment order[32].

9.6. Dr Long was asked why he did not make a recommendation to Dr Balakrishnan as to whether or not Mrs MacMillan should be detained. He said that one of those reasons was that he would be called upon to review the decision the following day as required under the Mental Health Act 2009[33]. It was pointed out to Dr Long that surely other psychiatrists could have conducted the 24 hour mandatory review and he conceded that this was true[34]. He said that he considered at the time he was speaking to Dr Balakrishnan whether he should himself attend to review Mrs MacMillan there and then. He said he made a conscious decision not to do so because Dr Balakrishnan was saying that her cardiac failure was worsening and Dr Long was concerned that if he did attend he would see Mrs MacMillan 'just in cardiac failure' which would 'trump and mask' the features of a major depression that was being pressed by Dr Balakrishnan[35]. Dr Long did agree that he could have told Dr Balakrishnan not to have detained Mrs MacMillan if he had formed that opinion himself[36]. It was suggested to Dr Long that some of the treatments being pressed by Dr Balakrishnan such as diuretic therapy to clear fluids from her lungs could have waited until the following day and that the missing of one dose would not have made much difference, but he demurred saying that it was a cardiological question[37]. However, he did acknowledge that he did not ask Dr Balakrishnan that question[38].

9.7. Dr Long said that his understanding of Dr Balakrishnan's intentions was to use the inpatient treatment order to re-establish Mrs MacMillan's regular medications and that there was a degree of urgency about it with a need for urgent action that evening[39].

9.8. It was pointed out to Dr Long that Dr Balakrishnan did not speak with family members, including Mr MacMillan, before making the decision to detain Mrs MacMillan. He acknowledged that this should have happened and that Dr Balakrishnan was in error by

[32] Transcript, page 140
[33] Transcript, page 162
[34] Transcript, page 163
[35] Transcript, page 163
[36] Transcript, page 164
[37] Transcript, page 167
[38] Transcript, page 167
[39] Transcript, page 167

not doing so[40]. He acknowledged that it would have been appropriate to say to the family members that because she was refusing treatment that the staff were considering detaining her to obtain information from them to assist in making the decision. He acknowledged the correctness of that proposition[41]. Dr Long acknowledged that in order to validly detain a person under the Mental Health Act 2009 there had to be treatment available at the facility for the mental illness[42]. Dr Long was then asked what that treatment was going to be for and he said 'for depression'. As a matter of record, the only treatment for Mrs MacMillan's supposed depression that was directed by Dr Balakrishnan was to increase her mirtazapine dosage from 30mg to 45mg[43]. Dr Long was asked about that and responded by saying that the focus was on a treatment for the life threatening physical condition[44]. He was then asked what was going to be done to treat her mental state and he responded that he hoped that they would talk to her, understand her, comfort her and give her good palliative care rather than medications and other things[45]. In essence Dr Long was reluctant to admit that he did not address the question of what mental health treatment might have been available in order to justify the detention of Mrs MacMillan[46]. Dr Long was asked about Dr Balakrishnan's statement asserting that he detained Mrs MacMillan at Dr Long's request. Dr Long denied telling Dr Balakrishnan to detain Mrs MacMillan[47]. I have no hesitation in accepting that Dr Long made no such direction and that Dr Balakrishnan is being untruthful in making that assertion.

10. <u>What treatment was afforded to Mrs MacMillan following the detention</u>?

10.1. The evidence is quite clearly to the effect that after Mrs MacMillan was detained that nothing happened by way of medical treatment before her death, just over one hour later. In short, she was given no tablets, she was given no intravenous therapy that she was not already in receipt of[48] and no other measures were taken until she collapsed and the MET arrived and commenced resuscitative efforts before realising that she was not for resuscitation at which point resuscitative efforts were, mercifully, ceased.

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[40] Transcript, page 171
[41] Transcript, page 172
[42] Transcript, page 173
[43] That change would not have affected Mrs MacMillan's mental state quickly. It would have taken weeks to be effective.
[44] Transcript, page 173
[45] Transcript, page 173
[46] Transcript, pages 173-174
[47] Transcript, pages 136, 178
[48] Mrs MacMillan was already receiving IV fluids and these were still infusing despite her wishes for no further medications. She was not insisting that the IV lines be removed.

10.2. This places in perspective Dr Balakrishnan's insistence that Mrs MacMillan required urgent treatment that night. Having detained her he proceeded to do nothing to ensure that she received any urgent treatment whatsoever. In fact, the evidence shows that Dr Balakrishnan was not present when Mrs MacMillan collapsed and died just over one hour after Dr Balakrishnan had detained her for the urgent medical treatment he insisted was necessary and so pressing that she needed to be detained under a Level 1 inpatient treatment order. Whether Dr Balakrishnan was still in the hospital or not is not clear. It was late in the day, it may be that he had decided to go home.

11. Expert opinion - palliative medicine physician, Dr Crawford

11.1. Dr Crawford gave evidence and provided a report for the Court[49]. Dr Crawford summarised the situation as follows. He said that Mrs MacMillan came to the hospital at the beginning of her admission with very low blood pressure, increasing shortness of breath, incontinence and increased difficulty managing at home. He noted the history of deterioration in the previous week with sleeping up to 20 hours per day[50]. He noted that Mrs MacMillan had been introduced to palliative care some six months before when she was in rehabilitation at the Repatriation General Hospital[51]. He said that it is reasonable that on presentation to an Emergency Department there is a period of uncertainty about what conditions might be reversible, but he said that in Mrs MacMillan's case the ultimate outcome was going to be her death and palliative care assessment was necessary[52]. Dr Crawford said that he thought that Drs Adams, McNeil and Tideman had highlighted palliative care and end of life discussions prominently in their assessments and considered that to be very appropriate[53]. However, Dr Crawford said that there was a lack of continuity of care at the level of senior doctors and what continuity of care did exist was only at the level of junior doctors[54]. Dr Crawford noted that a lowered mood in cardiac failure is a common problem and not necessarily indicative of major depression[55]. He said that his view was that the assessment and advice of the psychiatric liaison team was entirely appropriate[56].

[49] Exhibit C15a
[50] Transcript, page 194
[51] Transcript, page 196
[52] Transcript, page 196
[53] Transcript, page 200
[54] Transcript, page 201
[55] Transcript, pages 203-204
[56] Transcript, page 205

Dr Crawford was critical of the fact that between 20 and 25 February 2013 palliative care input was not obtained for Mrs MacMillan.

11.2. Dr Crawford noted that over the weekend there was a reference in the notes[57] to Mrs MacMillan's husband taking her out to 'feed the ducks'. He commented that this was an appropriate and valuable contribution to her situation by family members involving some fresh air and sunshine to assist in comforting her and making her feel a bit better. He regarded it as unfortunate that before the family were permitted to take her outside they were required to sign a risk form saying that she was being taken outside at their own risk and against medical advice[58].

11.3. Dr Crawford was critical of the fact that the nursing note reflecting that Mr MacMillan had expressed concern about Mrs MacMillan being delusional and telling a story regarding family members with little basis in reality with the offer of discussing the matter with the home team was never followed up by the home team, or anyone else[59]. He said that he would interpret that as a 'very strong request that the home team should be actively seeking to explore this further with the family'[60]. As a matter of fact that never occurred.

11.4. Dr Crawford said that the medical notes record very strong signs that Mrs MacMillan's condition was deteriorating quite significantly[61]. He noted that Mrs MacMillan's claim to be feeling better when being spoken to on the Monday morning could not be accepted at face value in view of what the notes recorded as having taken place over the previous 12 hours or so[62].

11.5. Dr Crawford was critical of Dr Balakrishnan for not having spoken with his senior cardiologist, Dr Tideman, before making the decision to detain Mrs MacMillan.

11.6. Dr Crawford noted that Dr Balakrishnan's assertion in his statement that Mrs MacMillan was requesting full resuscitation and full measures was completely inconsistent with 'everything else in the casenotes' which 'suggest quite the opposite'[63].

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[57] Exhibit C12
[58] Transcript, page 213
[59] Transcript, page 215
[60] Transcript, page 215
[61] Transcript, page 215
[62] Transcript, page 216
[63] Transcript, page 227

11.7. Dr Crawford was critical of the imposition of the inpatient treatment order and described it as heavy handed[64]. He said that the imposition of the inpatient treatment order was inconsistent with the response of MET when they arrived, namely to not resuscitate her[65]. He said that he did not think there was anything MET could have done in any event because Mrs MacMillan was severely hypotensive with a slow heart rate that stopped[66].

11.8. Dr Crawford was very critical of Dr Balakrishnan's failure to consult with Mr MacMillan about the decision to impose the inpatient treatment order[67].

12. Conclusions

12.1. In my opinion Dr Balakrishnan clearly formed the view, quite erroneously, that Mr MacMillan was acting against Mrs MacMillan's interests. He conscientiously therefore did not consult Mr MacMillan about what ought to happen next because he erroneously thought that he was acting against Mrs MacMillan's interests. Dr Balakrishnan misread the situation hopelessly. Without having heard from him I cannot reach any conclusion as to how he managed to do so. Every other person involved in Mrs MacMillan's treatment readily understood the circumstances. No other actor in this case reached such an erroneous conclusion about the matter.

12.2. I have already noted that Dr Balakrishnan said in his statement[68] that her family were having difficulty coping with her wishes as she was bedbound and was relying a lot on her husband to help out. None of that is correct. Dr Balakrishnan could not have gained that impression from the hospital notes, or from any of the other players with the possible exception of Mrs MacMillan who had already, as reported by Mr MacMillan, been exhibiting delusional thought processes and saying things about the family that were incorrect. I suppose it is conceivable that Dr Balakrishnan derived this information from Mrs MacMillan. However, he made no record in her medical notes of having derived any such information from her. If he had derived such information from her it was incumbent upon him to make a record of that information in her notes.

[64] Transcript, page 239
[65] Transcript, page 240
[66] Transcript, page 240
[67] Transcript, pages 251-252
[68] Exhibit C11e

He did not do so, and I consider it highly unlikely that she did say any such thing to him. I merely note that it is a possibility.

12.3. Dr Balakrishnan went on in his statement to say there were differences about her resuscitation status between Mrs MacMillan on the one hand ('because she had expressed the wish to be fully resuscitated in contradiction to her family's wishes') and her family on the other hand[69]. For this statement there can be no similar explanation, not even theoretical. It was fully documented in the records that Mrs MacMillan was not for resuscitation. The Medical Emergency Team when they arrived some 90 minutes later had no difficulty in recognising that she was not for resuscitation. They saw no ambiguity in the situation. It is simply not the case that there was any contradiction between Mrs MacMillan's wishes in this regard and those of her family.

12.4. Finally, Dr Balakrishnan asserted in his statement that 'because (Mrs MacMillan) had full insight into her condition I thought it was more appropriate to go with what she wanted rather than what the family wanted'[70]. This is a serious matter. It is impossible to reconcile Dr Balakrishnan's assertion in that passage that Mrs MacMillan had 'full insight into her condition' with his decision at the same time to impose a Level 1 inpatient treatment order upon her. It is important to note that Dr Balakrishnan's statement was made on 28 May 2013 and signed on 21 June 2013, in other words some four months after Mrs MacMillan's death while the events were still fresh in his mind. Why would Dr Balakrishnan say that Mrs MacMillan had full insight into her condition knowing that he himself had recommended that she be detained because she was not in a position to make appropriate decisions about her own treatment? The two positions are at odds with one another. The only explanation that presents itself to my mind is that Dr Balakrishnan was attempting to fabricate an explanation for his erroneous decision to detain Mrs MacMillan by constructing a story that her family were somehow acting against her interests with respect to resuscitation, contrary to her own wishes. It is bad enough for a doctor to construct any false explanation with a view to justifying what was obviously a bad decision, but it is utterly reprehensible to construct a justification based on a false assertion that a family has wished to insist that their loved one not be fully resuscitated when the patient herself had a desire to continue to live. If Dr Balakrishnan had been in Australia at the time of the Inquest he would have

[69] Exhibit C11e page 3
[70] Exhibit C11e, page 3

been closely questioned about these matters. Were he in Australia at the time of the publication of this finding I would have no hesitation in referring this case to the Australian Health Practitioner Regulation Agency to investigate his conduct, which I regard as reprehensible and unprofessional.

12.5. The responsibility for the decision to detain Mrs MacMillan rests solely with Dr Balakrishnan. It was a wrong decision on any view. It was probably in contravention of the Mental Health Act 2009. Mrs MacMillan died within some 90 minutes of the detention order being made and in that 90 minutes was afforded no treatment whatsoever. In the meantime Dr Balakrishnan had decamped without ensuring that the supposed urgent medications required for Mrs MacMillan's cardiac condition were duly administered. By his actions he put the lie to his assertions that there was a need to detain Mrs MacMillan and treat her.

12.6. I find that Mrs MacMillan's detention was unnecessary and almost certainly unlawful. It was caused by the inexplicable, erroneous and reprehensible behaviour of one person, namely Dr Balakrishnan.

13. Recommendations

13.1. There is no need for me to make any recommendations in this case because no systemic change or procedural change could prevent a repetition of this errant and unpredictable behaviour by a doctor in future.

13.2. I note that there is presently a debate in the South Australian Parliament about euthanasia. I make no comment on that subject one way or the other. I merely note that those commentators who offer our palliative care system as a reassurance to those fearing an unpleasant death would do well to read this finding to acquaint themselves with its shortcomings.

14. Response from the Chief Executive of the Department of Health

14.1. During closing submissions I asked counsel for Southern Adelaide Local Health Network Incorporated to obtain a statement from the Chief Executive of the Department of Health, Mr David Swan, about his view of Dr Balakrishnan's behaviour. An affidavit of Mr Swan was received in early May 2016. It is dated 2 May 2016 and I

have designated it as Exhibit C16 in this matter. Mr Swan addressed the issue as follows:

> 'Dr Balakrishnan asserts that Mrs MacMillan expressed the wish to be fully resuscitated in contradiction to her family's wishes. I am advised that this is inconsistent with the information in the medical record and evidence of Mr Donald MacMillan, Dr Erin Kelly, Dr Angela Chen and Dr Randall Long to the effect that Mrs MacMillan was for active ward measures and MET calls only and not full resuscitation throughout her admission to FMC. If it is the case that Dr Balakrishnan did not thoroughly review Mrs MacMillan's medical records and was not aware of her resuscitation status, then such conduct is inappropriate and unprofessional.'

14.2. I am disappointed in that response from Mr Swan. He has missed the point of my request which was to seek his response to what is apparent on the face of the material, namely that Dr Balakrishnan falsely asserted that the family were insisting that Mrs MacMillan not be resuscitated in the face of her own wishes to the opposite effect. Mr Swan has failed to address that issue which is an issue of the utmost seriousness. It is extremely concerning that Mr Swan apparently did not appreciate the significance of my request, or if he did, was not prepared to address the matter frankly in his affidavit. In my opinion it is a very serious matter for a doctor falsely to assert that a family would act against the interests of their loved one and I would have hoped that the Chief Executive of the Department of Health would have readily shared that opinion.

14.3. I have nothing further to add.

Key Words: Death in Custody; Natural Causes; Management and Accountability

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 10th day of October, 2016.

State Coroner