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 April 2016 and the 25th day of August 2016, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Colin Peter Smith.

The said Court finds that Colin Peter Smith aged 51 years, late of 26 Montgomery Avenue, Kilburn, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 15th day of April 2014 as a result of respiratory failure and cardiac failure on a background of chronic obstructive lung disease, ischaemic heart disease and schizo-affective disorder. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

1.1. Colin Peter Smith was 51 years of age when he died at the Royal Adelaide Hospital on 15 April 2014. At the time of his death Mr Smith was the subject of a level 1 Inpatient Treatment Order under the Mental Health Act 2009, and accordingly his 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. Cause of Death

2.1. Following a review of Mr Smith's medical history, Dr McIntyre of Forensic Science South Australia provided an opinion as to Mr Smith's cause of death. Based on that opinion I find that the cause of Mr Smith's death was respiratory failure and cardiac failure on a background of chronic obstructive lung disease and schizo-affective disorder.

3. Background

3.1. Mr Smith was first diagnosed with schizo-affective disorder as a young man in his twenties. It was after this diagnosis that he entered the mental health system for the first time.

3.2. In 2009 he was admitted to the Royal Adelaide Hospital suffering from pneumonia. He was then living at a residential care facility called Peppertree Grove. However, a decision had been made by the managers of Peppertree Grove that he would be evicted from the facility due to his aggressive behaviour towards staff. As a consequence, he remained an inpatient at the Royal Adelaide Hospital for approximately two years as it was felt that he could not be released without an appropriate placement.

3.3. Accommodation was eventually secured at Alexam Place where he stayed for approximately two years. This placement finished when he threatened a staff member with a knife. In summary, his mental condition had a significant impact on his ability to find stable accommodation.

3.4. For his entire adult life Mr Smith had been a very heavy smoker. He was highly addicted to smoking and most of his daily activities revolved around obtaining and smoking cigarettes.

4. Mr Smith's decline in health

4.1. On 15 April 2014 Mr Smith was short of breath and feeling unwell. He was taken by ambulance to the Royal Adelaide Hospital and seen there by Dr Romualdez. After assessing Mr Smith both physically and mentally, Dr Romualdez issued a level 1 Inpatient Treatment Order under the Mental Health Act 2009. Her opinion was that he posed an immediate risk to himself and was unable to make sound medical decisions.

4.2. In her statement Dr Romualdez stated:

> 'From my observations I could see that the deceased was very unwell, he was short of breath, conscious, but confused and agitated. He did respond affirmatively to having suffered recently from a cough and shortness of breath. I recall that he kept asking me to go outside to have a cigarette, despite being short of breath, and made repeated motions to get off the barouche.

My initial diagnosis of the deceased was that he was hypoxic or lacking oxygen, and required support with his breathing, so I initiated the use of bilevel positive airway pressure, which uses a facemask to assist his breathing. After examining him I also thought the deceased had fluid in his lungs, so I initiated an intravenous infusion of glyceryl trinitrate to assist in the removal of the fluid. Further assessment occurred simultaneously with treatment and he underwent a chest radiograph that showed increased fluid in his lungs as well as possibly an infection. The deceased remained critically ill in the resuscitation room, with what I would describe as an acute pulmonary oedema and pneumonia.

…

Within the first two hours of treating the deceased I made the decision that he was suffering from mental illness, and because of this the deceased was unable to make informed decisions regarding his physical or mental health, as well as posing an immediate threat to himself. There were no less restrictive means available to ensure appropriate treatment of his illness, so I issued a level 1 Inpatient Treatment Order (ITO). The order was to be in place until 22nd April 2014 at 2pm.

At approximately 12pm on 15 April 2014, the deceased's condition deteriorated and he was now unable to answer any questions or converse at all, he became extremely agitated, so security was called and he was restrained, but we did not need to utilise shackles to keep him in the bed. Security seemed to calm him down and I was able to continue treating him after approximately five minutes.

It became clear after a period of time that the deceased was not responding to the treatment. As I considered the appropriateness of further treatment and the institution of invasive airway management, that is, intubation and invasive ventilation, I consulted the intensive care unit registrar, Dr Barbara Declerq, who would have to assume the care of the patient if this were to happen. It was my opinion that, given his poor response to treatment and his background of medical conditions, instituting invasive airway management was not appropriate as there would be minimal benefit gained, as well as put the patient at imminent risk of death due to the procedure. The ED consultant, Dr Megan Brooks, was also in attendance throughout this time and was aware of my opinion, and as I understand, also held this opinion. On her review of the deceased I believe that Dr Declerq agreed with the above as well.' [1]

4.3. Mr Smith's brother was consulted about his condition and a decision was made that he would be for palliative care only.

4.4. The positive airway pressure mask was removed and morphine was given to ensure comfort. Mr Smith died at 12:55pm that day.

[1] Exhibit C3

5. Conclusion

5.1. I find that Mr Smith's detention was lawful and appropriate in the circumstances and that he received the proper level of medical care upon arrival at the Royal Adelaide Hospital.

6. Recommendations

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

Key Words: Death in Custody; Inpatient Treatment Order; Natural Causes

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 25th day of August, 2016.

State Coroner