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 September 2016 and the 19th day of April 2017, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Jean Anne Adamson.

The said Court finds that Jean Anne Adamson aged 78 years, late of Regis Burnside Lodge, 6 Booth Avenue, Linden Park, South Australia died at the Royal Adelaide Hospitl, North Terrace, Adelaide, South Australia on the 6th day of November 2014 as a result of aspiration on a background of psychogenic dysphagia, intellectual impairment and chronic schizophrenia. The said Court finds that the circumstances of her death were as follows:

1. Introduction and cause of death

1.1. Ms Jean Anne Adamson was 78 years of age when she died on 6 November 2014 at the Royal Adelaide Hospital.

1.2. Dr Iain McIntyre of Forensic Science South Australia undertook a pathology review in relation to Ms Adamson's death on 24 December 2014[1]. I accept Dr McIntyre's opinion and find that the cause of Ms Adamson's death was aspiration on a background of psychogenic dysphagia, intellectual impairment and chronic schizophrenia.

[1] Exhibit C2a

2. Reason for Inquest

2.1. At the time of her death Ms Adamson was subject to a Level 2 Inpatient Treatment Order under the Mental Health Act 2009, and 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.

3. Background and medical history

3.1. Ms Adamson was born with an intellectual disability. She started displaying symptoms of psychosis at 6 years of age and was admitted to Parkside Hospital when she was approximately 19 years old.

3.2. After unsuccessful treatment with ECT, medication was trialled with success and Ms Adamson was formally diagnosed with chronic schizophrenia and anxiety. In her early 30s Ms Adamson was placed into accommodation at Hyde Park and then six years later was moved into a hostel at Kingswood. She remained living there for some 33 years until she was moved to Morphettville and then ultimately to Regis Burnside Lodge in Linden Park in June 2012.

3.3. She remained living at Regis Burnside Lodge until her admission to the Royal Adelaide Hospital in October 2014 where she remained until her death in November 2014.

3.4. In March 2012 Ms Adamson suffered from a clot in her lung and in the month following this event she developed a swallowing phobia. At that time the phobia led to her suffering renal failure and requiring hospitalisation. She eventually recovered from the phobia and commenced residing at Regis Burnside Lodge.

3.5. For no apparent reason the phobia returned in September 2014 leading to two hospital admissions, including the one that ended in her death.

3.6. Dr Anderson had been Ms Adamson's general practitioner since June 2012. He knew her very well and felt that when the swallowing phobia returned in September 2014 that Ms Adamson needed a higher level of medical care than could be provided by Regis Burnside Lodge, specifically in relation to the risk of dehydration.

3.7. An admission to the Royal Adelaide Hospital occurred between 24 September 2014 and 8 October 2014 and upon discharge Ms Adamson was managed by Dr Anderson who administered subcutaneous fluids as per the hospital's directions.

4. Ms Adamson’s detention at the Royal Adelaide Hospital

4.1. On 17 October 2014 Dr Anderson felt that Ms Adamson's situation could no longer be managed at the aged care facility and he placed her on a Level 1 Inpatient Treatment Order and had her admitted to the Royal Adelaide Hospital.

4.2. Upon presentation to the Royal Adelaide Hospital Ms Adamson was dehydrated and had acute kidney impairment and electrolyte imbalance. Ms Adamson was managed by the general medicine team in conjunction with the psychiatry team. The primary focus was to rehydrate her and alleviate her dry mouth and throat in the hope that this would encourage her to commence oral intake.

4.3. This process had to occur through the administering of subcutaneous fluids because no satisfactory vein could be located to administer them intravenously.

4.4. On 18 October 2014 Dr Paul Davis reviewed and confirmed the Level 1 Inpatient Treatment Order. His examination determined that she likely had the onset of dementia along with her significantly impaired cognition that was part of her intellectual disability.

4.5. On 24 October 2014 Dr Davis reassessed Ms Adamson and authorised a Level 2 Inpatient Treatment Order. Dr Davis examined Ms Adamson on a further two occasions during her inpatient stay. On the latter of those occasions, 5 November 2014, Dr Davis considered lifting the detention order, but felt that given she could still physically walk out of the hospital if she decided to, and that she still required significant medical care, he ultimately decided that the order should remain in place to enable the administration of fluids and medication.

4.6. On 1 November 2014 Royal Adelaide Hospital staff met with Ms Adamson's sister to discuss further treatment options including the possibility of a percutaneous endoscopic gastrostomy or PEG feeding tube. She was to consider the option in conjunction with Ms Adamson’s general practitioner.

4.7. On 6 November 2014 Ms Adamson was discovered to be vomiting and choking and a MET call was requested. Once the situation was resolved a further discussion was had with Ms Adamson's sister concerning her deteriorating condition and where to go from that point. It was decided that she would be given palliative care only with oxygen provided for comfort and morphine prescribed as required.

4.8. At 4:45pm on 6 November 2014 Ms Adamson suffered an aspiration event, became hypoxic and was pronounced deceased.

5. Conclusion

5.1. I find that there were no issues with regards to her care and all that could be done for Ms Adamson was done.

5.2. I find that Ms Adamson's detention was lawful and appropriate in the circumstances.

6. Recommendations

6.1. I have no recommendations to make.

Key Words: Death in Custody; Inpatient Treatment Order

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 19th day of April, 2017.

State Coroner