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 26th day of August 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 Angela Beryl Firth.

The said Court finds that Angela Beryl Firth aged 63 years, late of Unit 2, 1 Peninsula Drive, Mawson Lakes, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 22nd day of November 2014 as a result of metastatic adenocarcinoma of the lung. The said Court finds that the circumstances of her death were as follows:

1. Introduction and cause of death

1.1. Angela Beryl Firth was 63 years of age when she died on 22 November 2014 at the Royal Adelaide Hospital. A pathology review was undertaken by Dr Iain McIntyre of Forensic Science South Australia on 25 November 2014 in relation to Mrs Firth's death. In his report Dr McIntyre gave the cause of death as metastatic adenocarcinoma of the lung[1], and I so find.

2. Reason for Inquest

2.1. At the time of her death Mrs Firth was subject to a Level 1 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.

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[1] Exhibit C2a

3. Background

3.1. Mrs Firth was married with one child, a daughter. Until her condition declined she had lived at home with her husband and he had cared for her while she was having chemotherapy and treatment for her lung cancer.

3.2. Mrs Firth's medical history included asthma, hypertension, elevated blood glucose levels, malignant lung neoplasm, hyperparathyroidism, calicectomy, renal cancer and a hysterectomy.

3.3. At the time of her death Mrs Firth's lung cancer had metastasised and spread to her brain. As a result she had displayed some bizarre and unusual behaviour. She had undergone intensive radiotherapy on her brain. Her behaviour was abrupt and aggressive. She was difficult to deal with.

3.4. On 20 November 2014 SAPOL and SAAS were tasked to her home address for a welfare check. A report had been made by a gentleman who was a courier. He had attended the home and Mrs Firth had invited him inside. Following his entry to the premises Mrs Firth had denied him exit. She had detained him for a period of 15 minutes and during that time was demanding that he point his mobile phone at the television to expel demons or something of that nature. It appeared that she was quite paranoid.

3.5. The courier took an opportunity when Mrs Firth was distracted to sneak out of the home and call emergency services to report that she needed someone to check on her. As a result of the welfare check Mrs Firth was taken to the Royal Adelaide Hospital to be assessed. At 12:30pm on this day Mrs Firth left the hospital of her own accord. She was not detained at that point and the hospital staff could not stop her. A friend called police and advised that she had returned home in a taxi. She was located by police and found to be generally well.

3.6. Mrs Firth's family were concerned about her over the course of that day and at approximately 9:30pm they obtained assistance from the Northern Mental Health Service team who attended to assess her. They considered that she should be detained and that she needed to go to hospital. Mrs Firth did not want to go on a voluntary basis and so the Northern Mental Health Service team invoked section 56 of the Mental Health Act 2009. Mrs Firth was uncooperative and aggressive.

3.7. An ambulance was called and arrived at approximately 11:40pm to convey Mrs Firth to the Royal Adelaide Hospital. A Level 1 Inpatient Treatment Order was imposed at approximately 3am on 21 November 2014.

3.8. At 12:40pm on 21 November 2014 a Code Black was called as Mrs Firth was attempting to leave the hospital. Hospital security staff escorted her back to her bed and at that point constant observations were instituted to ensure that she could not leave the premises again. Her behaviour remained confused and anxious.

3.9. Nursing continued in the usual fashion, with food and medication monitored and continued under standard protocols.

4. Mrs Firth's decline in health and subsequent death

4.1. At 7:10pm on 22 November 2014 a Code Blue was called as a result of Mrs Firth's declining health. She was experiencing breathing difficulties and it was clear that she was in the terminal phase of her illness. She was diagnosed with severe type 1 respiratory failure.

4.2. The medical staff liaised with family and an end of life care plan was devised. Comfort care only was to be instituted from that point on. Mrs Firth died at 8:02pm that evening surrounded by her family.

5. Conclusion

5.1. I find that the order for detention under the Mental Health Act 2009 was lawful and appropriate and that the medical treatment provided to Mrs Firth was also appropriate.

6. Recommendations

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

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.

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State Coroner

Inquest Number 43/2016 (2041/2014)