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 18th day of November 2016 and the 29th day of March 2018, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Graham Joseph Butson.

The said Court finds that Graham Joseph Butson aged 81 years, late of 137 Paruna Road, Loxton, South Australia died at the Lyell McEwin Hospital, Haydown Road, Elizabeth Vale, South Australia on the 22nd day of March 2015 as a result of aspiration of gastric contents complicating disseminated moderately differentiated adenocarcinoma of the right lung. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Mr Graham Joseph Butson was aged 81 years when he died on 22 March 2015 at the Lyell McEwin Hospital (LMH).

1.2. Mr Butson died from a natural cause. However, it was necessary for a post-mortem examination involving a full autopsy to be conducted in order to establish the cause of his death. That autopsy was carried out by Dr John Gilbert, a forensic pathologist at Forensic Science South Australia. I will come to the detail of Dr Gilbert's autopsy findings in due course, but suffice it to say at this stage I have accepted Dr Gilbert's cause of death as expressed in his post-mortem report[1], namely aspiration of gastric contents complicating disseminated moderately differentiated adenocarcinoma of the right lung. This pathology involved a primary lung tumour with numerous deposits of

[1] Exhibit C3a

metastatic tumour in the brain. It is of note that none of these lesions had been positively diagnosed prior to Mr Butson's death. However, the delirium, confusion and agitation that was probably the product of the metastatic brain lesions had led to Mr Butson being detained under the Mental Health Act 2009 (the Act) while at the LMH. He had been placed under a Level 1 Inpatient Treatment Order (ITO) that underlay his detention. That ITO had been imposed at 6:40pm on Friday 20 March 2015. Mr Butson died on the evening of Sunday 22 March 2015 and life was certified extinct at 6:10pm that evening. Thus it will be seen that Mr Butson died almost exactly 48 hours after the imposition of the Level 1 ITO.

2. Reason for Inquest

2.1. At the time of his death, Mr Butson was said to have still under detention pursuant to the Level 1 ITO. For that reason his death was believed to have been a death in custody requiring a mandatory inquest. These are the findings of that inquest. I will return to the issue as to whether this was a death in custody in the next section.

3. Detention under the Mental Health Act 2009

3.1. In the particular circumstances of this case it is necessary to describe the framework that exists for the imposition and review of a Level 1 ITO under the Act. Level 1 ITOs are governed by section 21 of the Act. Where it appears to a medical practitioner that a person has a mental illness and that because of the mental illness the person requires treatment for the person's own protection from harm, or for the protection of others from harm, and there is no less restrictive means than an ITO of ensuring appropriate treatment of the person's illness, the medical practitioner may make an order that the person receive treatment as an inpatient in a treatment centre. A treatment centre for these purposes would include the LMH. There are other governing criteria that for the moment do not need to be mentioned.

3.2. A Level 1 ITO, unless earlier revoked, expires at the time stated in the order which must be 2pm on a business day not later than seven days after the day on which it is made. Importantly there is provision for the reconsideration of the imposition of the order. This is contained within section 21(5) of the Act which I here set out.

> '(5) On the making of a level 1 inpatient treatment order, the following provisions apply:

(a) the patient must be examined by a psychiatrist or authorised medical practitioner, who must, if the order was made by a psychiatrist or authorised medical practitioner, be a different psychiatrist or authorised medical practitioner;

(b) the examination must occur within 24 hours of the making of the order;

(c) if it is not practicable for the examination to occur within that period, it must occur as soon as practicable thereafter;

(d) after completion of the examination, the psychiatrist or authorised medical practitioner may confirm the level 1 inpatient treatment order if satisfied that the grounds referred to in subsection (1) exist for the making of a level 1 inpatient treatment order, but otherwise must revoke the order.'

3.3. It will be seen that the effect of section 21(5) is that a patient who is the subject of a Level 1 ITO must be examined by a psychiatrist or authorised medical practitioner within 24 hours of the making of the order. If it is not practicable for the examination to occur within 24 hours of the making of the order, it must occur *"as soon as practicable thereafter"*. It will also be seen that after completion of the examination the psychiatrist or authorised medical practitioner may confirm the Level 1 ITO if satisfied that grounds for the making of such an order exist, but must otherwise revoke the order.

3.4. I mention this in some detail in Mr Butson's case because following the imposition of the Level 1 ITO on the evening of Friday 20 March 2015, he was not examined by a psychiatrist or authorised medical practitioner within 24 hours of the making of the order or at all prior to his death. This failure was not satisfactorily explained during the course of this inquest.

3.5. The failure to conduct the mandatory examination is a worrying circumstance were it to be identified as an entrenched practice in treatment centres designated under the Act. The medical practitioner who imposed the Level 1 ITO was Dr Rajesh Pathy who at the time with which this Inquest was concerned was an intern at the LMH. There was no restriction on the type or rank of medical practitioner who was authorised by law to impose a Level 1 ITO. There is no criticism of Dr Pathy imposing the order. It was appropriate. As to the need for a subsequent psychiatric examination within 24 hours, Dr Pathy's witness statement asserts as follows:

> 'Any person placed on an Inpatient Treatment Order is to be assessed by a Psychiatrist within 24 hours of the commencement of the order or as soon as practicable thereafter. In this case, the order was placed on Mr BUTSON on the weekend and therefore he would

> most likely be assessed on Monday morning. The purpose of this psychiatric assessment is to determine if the order will remain in place or be revoked.' [2]

The inference that emerges from that passage of Dr Pathy's statement is that the failure to conduct an examination as required by section 21(5) of the Act was due to the intervention of the weekend immediately following the imposition of the Level 1 ITO on the Friday evening. The relevance of the weekend might conceivably be explained by the fact that a consultant psychiatrist would not be working at the hospital over the weekend and would only be available to conduct a section 21(5) examination first thing on a Monday morning. The fact that the timing of a section 21(5) examination at this particular hospital depended upon the rostering exigencies of its psychiatrists was seemingly confirmed in the statement of Dr Rahul Solanki[3] who was a Registrar involved in Mr Butson's care. In his statement[4] Dr Solanki said:

> 'My understanding regarding Inpatient Treatments Orders is that a psychiatrist reviews the patient within 24 hours in relation to their mental health and can confirm or revoke the order depending on the patient's presentation at that time. At the time of recommending the order, I believed a psychiatrist would see Mr BUTSON the next day.
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> The notes indicate that the psychiatric assessment was not completed prior to Mr BUTSON's death on 22 March 2015 which was on a weekend. I have since been made aware that a psychiatrist may not be on duty over the weekend and in that case the patient is seen as soon as practicable when a psychiatrist is next on shift.'

If psychiatric rostering was the reason that Mr Butson was not examined within 24 hours of the imposition of the ITO, then in my opinion the law was not complied with in this instance. It is true that if it is not practicable for the examination to take place within 24 hours of the making of the order it may be delayed until it is practicable. However, to my mind the fact that a consultant psychiatrist would not be working over a weekend does not mean that it was *'not practicable'* for an examination to take place within 24 hours of the making of a Level 1 ITO. *'Not practicable'* is not the same thing as *'not convenient'*. Clearly, over the weekend following the imposition of Mr Butson's ITO a psychiatrist could have been asked to attend from the private profession or from some other institution. One would pose this scenario to test the assertion that a section 21(5) examination might legitimately be delayed pending the resumption of a psychiatrist's duties after a weekend. What would happen if a Level 1 ITO was imposed on the Thursday evening before the Easter four day long weekend? If the psychiatric

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[2] Exhibit C7, page 6
[3] Exhibit C1
[4] Exhibit C1b

examination could be delayed until the following Tuesday morning on grounds of impracticability, it would mean that greater than 50% of the seven day maximum duration of a Level 1 ITO would have been exceeded before the examination took place. Clearly the Act does not envisage or countenance such a scenario.

3.6. The timing of a section 21(5) examination has been the subject of coronial comment in the past. I mention here specifically the matter of Geoffrey Scott Noakes[5]. In that case the Court passed comment on what appeared to be the fact that the timing of a section 21(5) examination was linked to the personal or professional commitments and preferences of the examining psychiatrist. That case was different from this case in that in Noakes the Court found that the examination had been timed to suit the commitments of the psychiatrist and at a time before necessary collateral information about the patient had been gathered, in other words the examination had occurred prematurely. This is the reverse of that situation. But both situations involve the timing of section 21(5) examinations primarily to suit the convenience of psychiatrists. Either situation is undesirable. If in the present case the failure to carry out the examination was due purely to rostering considerations, the failure was not in accordance with the law.

3.7. A section 21(5) examination is an important step in the process of detention under the Act. The purpose of the examination is two-fold; it can either result in the confirmation of the order on clinical grounds in which case it will remain extant for the full seven days unless later revoked, or following the examination the order may immediately be revoked which would result in the release and discharge of the patient unless, of course, the patient remains in the hospital voluntarily. Bearing in mind that a Level 1 ITO involves a deprivation of the liberty of the person concerned, it is important that the section 21(5) examination takes place in accordance with the legal requirements under the Act.

3.8. Another question that the Court has been asked to consider was whether, notwithstanding the absence of a section 21(5) examination, the ITO was still valid at the time of Mr Butson's death. The point was not argued fully before me and I therefore have not come to a concluded view about this issue. However, my inclination is that the order would still have been valid because, notwithstanding the fact that there had been no section 21(5) examination, at no stage had the order been revoked. There is

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[5] Inquest 25/2015

nothing within the terms of section 21(5) of the Act to suggest that a Level 1 ITO automatically ceases to have effect at the expiration of the 24 hour period since its imposition.

3.9. I would add here that these matters are somewhat academic in Mr Butson's case given that confirmation of the ITO would have been inevitable had a psychiatric examination taken place within the 24 hour period. Moreover, he would not have been discharged in any event having regard to the nature of his illness.

4. Mr Butson's post mortem examination

4.1. I have already referred to Mr Butson's cause of death and the fact that it was established at his post mortem examination that he had metastatic lung cancer. Mr Butson's previous medical history is set out in Dr Gilbert's post mortem report. It included congestive cardiac failure, atrial fibrillation for which he was prescribed the blood thinner warfarin, Type 2 diabetes mellitus, intermittent poor porphyria, gout and insomnia. He was 81 years of age at the time of his death. In his report Dr Gilbert noted that on the evening of Mr Butson's death he had been awake and was assisted with his evening meal. Approximately 20 minutes later he had been found unresponsive in a sitting position in his bed with vomit coming from his mouth. When an emergency call was made his mouth was suctioned and CPR was commenced. An ECG showed that his heart had stopped. When intubated, Mr Butson's airway was noted to be heavily soiled. Life was certified extinct approximately 35 minutes after he had been found unresponsive. It was thought that Mr Butson had aspirated. There were a number of findings at autopsy, the most significant of which were the lung tumour and metastases, most notably in the brain. There was evidence of previous myocardial infarction or heart attack. No acute ischaemic changes were seen in the heart. There was aspirated gastric contents found within some of Mr Butson's peripheral airways. All of this gave rise to the conclusion that death had resulted from the aspiration of gastric contents that had likely been contributed to by an altered conscious state associated with the extensive brain metastases to which I have referred.

4.2. From the material placed before the Court it is plain that neither the primary lung tumour nor the metastatic tumours had been diagnosed prior to Mr Butson's death. I will refer to his clinical presentation and treatment in a moment. It was clear that prior to his death Mr Butson had been a very sick man.

5. The circumstances of Mr Butson's hospitalisation and death

5.1. On 6 March 2015 Mr Butson presented at the Loxton Health Centre. He was unable to walk and he presented with some right knee pain, slurred speech and confusion. Mr Butson was sent to the Loxton Hospital where a CT scan of his head was arranged. The radiologist noted several areas of the brain which at that time were thought to be gyral calcifications but there were no signs of a bleed or other matters of particular concern. The post mortem, as seen, would reveal several areas of metastatic tumour within the brain. After a number of days in hospital Mr Butson's knee pain improved and he was able to mobilise independently. He was discharged home in consultation with family members.

5.2. On Thursday 12 March 2015 Mr Butson again presented with worsening right knee pain. An X-ray undertaken on that day was believed to have shown evidence of a fracture. Mr Butson was then transferred to the LMH where he would die on 22 March.

5.3. The transfer to the LMH occurred on 14 March 2015. Mr Butson was noted by his family to be experiencing increased confusion and disorientation. He was admitted to the orthopaedics unit of the LMH.

5.4. On 15 March 2015 a CT of Mr Butson's right knee was conducted. There was a significant knee effusion consistent with acute gout, but no fracture was actually identified.

5.5. At 7:20pm on 15 March a medical emergency was called. Mr Butson was highly agitated. He was experiencing shortness of breath and exhibited a very irregular heart rate with tachycardia and atrial fibrillation. Dehydration was also identified.

5.6. At 7:42am on 16 March 2015 a further medical emergency involving atrial fibrillation occurred. Mr Butson's heart rate was 140 beats per minute with no rate control. As a result of the two medical emergencies to date, Mr Butson was transferred to the Intensive Care Unit. He was commenced on IV amiodarone. Chest X-rays showed a consolidation in the right mid zone but with an absence of signs and symptoms of infection. Consideration was therefore given to the possibility that Mr Butson's presentation could involve a malignancy. There were periods of confusion and difficulty communicating with staff over the ensuing few days. However, Mr Butson's atrial fibrillation stabilised with medication.

5.7. On 18 March 2015 Mr Butson was transferred to a medical ward and was noted to be very drowsy at times.

5.8. On 19 March 2015 Mr Butson was noted to be confused. He was commenced on antibiotics for possible pneumonia.

5.9. On 20 March 2015 Mr Butson was taken for a further CT scan of the chest and abdomen. However, he became acutely confused, delirious and agitated. As a result, the CT could not be completed. It was on this day that the Level 1 ITO was implemented. The statement of Dr Solanki, to whom I have referred, indicates that as of 19 March 2015 a plan had been on foot to investigate Mr Butson's lung opacity or mass and that a request was made for a CT of the chest, upper abdomen and brain in an effort to determine the nature of the lung lesion and to identify possible metastases, particularly in the brain. It was thought that the lesion in Mr Butson's lung was most likely cancer due to its size, but that it required further radiological investigation. Unfortunately, as indicated, on the evening of 20 March 2015 when Mr Butson was sent for the CT scan he was agitated and it therefore could not be performed. After he returned from the attempted scan nursing staff advised Dr Solanki and Dr Pathy that Mr Butson had been trying to get out of bed. An understandable concern existed that Mr Butson was at risk of falling. He continued to be agitated and did not respond to medical practitioners. He was administered a sedative but he continued to be agitated. It was considered that he was in danger of hurting himself. With the help of security Mr Butson had to be assisted back to bed. He was restrained with soft shackles for his arms and legs as the medication did not immediately take effect. Dr Solanki asserts:

> 'If we had not restrained him there was a serious risk that he would attempt to get out of bed and fall causing serious injury to him.'

The plan was for a nurse to maintain constant overnight observations to prevent him from attempting to get out of bed and from falling. As to the ITO Dr Solanki states as follows:

> 'Inpatient Treatment Orders come under the Mental Health Act and are used when a person may have an underlying mental illness and they are at risk of harming themselves or others. Because Mr BUTSON was delirious and had been since prior to our team treating him, we were unsure if he had an underlying mental illness.
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> Due to our observations, I deemed Mr BUTSON to be delirious and was a serious risk of harming himself. The recommendation was to detain him under an Inpatient Treatment Order. Dr PATHY was the doctor who made the order and contacted the family.'

5.10. Mr Butson was prescribed risperidone for the agitation. Over 21 and 22 March 2015 there were periods of intermittent unresponsiveness.

5.11. On 22 March 2015 at around noon there were discussions with Mr Butson's family about his condition and the course to be taken from that point forward. At about 5:15pm Mr Butson was awake and was being assisted to consume a meal. A registered nurse, Ms Morris, fed him soup, some quiche and a small amount of jelly. Nurse Morris' statement[6] indicates that at the conclusion of the meal she ensured that Mr Butson had completely swallowed the food and that there was none remaining within his mouth.

5.12. At approximately 5:35pm Mr Butson was checked and was located sitting up in bed. He was then unresponsive. Vomit was coming from his mouth. The doctor present immediately commenced suctioning. A MET call was made. CPR was commenced. An ECG showed asystole. Mr Butson was intubated. Resuscitation efforts, which unfortunately were unsuccessful, continued for approximately 30 minutes. Mr Butson's life was declared extinct at 6:10pm.

6. <u>Conclusions</u>

6.1. I do not believe that Mr Butson's death was preventable. He had several areas of metastatic tumour within the brain. I agree with the conclusions of the investigating officer, Detective Senior Constable First Class Aaron O'Malley, that it was clear that medical staff were dealing with many complicated issues and that a number of lines of inquiry were being investigated to resolve Mr Butson's symptomatology. I also agree with the conclusion that it is unlikely that other methods of medical intervention would have significantly improved the outcome for Mr Butson.

6.2. The issuing of the Level 1 ITO was highly appropriate having regard to Mr Butson's level of agitation. It was imposed for his own safety. The fact that it was not reviewed within 24 hours is of no clinical significance. If a review had taken place it is clear that there would have only been the one outcome, namely the confirmation of the order. In any event, it is also clear that his discharge from hospital would have been highly unlikely having regard to his condition. Mr Butson's circumstances of detention pursuant to the ITO did not contribute to his death.

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[6] Exhibit C6

7. Recommendations

7.1. The Court makes no recommendations in this matter.

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

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

Seal the 29th day of March, 2018.

Deputy State Coroner

Inquest Number 65/2016 (0482/2015)