



## FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 25<sup>th</sup> day of August 2016 and the 26<sup>th</sup> day of April 2018, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Leonie Faye Jeisman.*

*The said Court finds that Leonie Faye Jeisman aged 45 years, late of 44/1 Noblett Street, Findon, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 30<sup>th</sup> day of January 2015 as a result of Type 2 respiratory failure and aspiration pneumonia on a background of end-stage chronic obstructive lung disease and schizoaffective disorder. The said Court finds that the circumstances of her death were as follows:*

### **1. Introduction and cause of death**

1.1. Leonie Jeisman was 45 years of age when she died on 30 January 2015 at the Royal Adelaide Hospital (the RAH). The cause of Ms Jeisman's death was established by way of a pathology review undertaken by Dr Iain McIntyre of Forensic Science South Australia. The cause of death identified by Dr McIntyre was Type 2 respiratory failure and aspiration pneumonia on a background of end-stage chronic obstructive lung disease and schizo-affective disorder<sup>1</sup>. I find that to have been the cause of Ms Jeisman's death.

### **2. Reason for Inquest**

2.1. At the time of her death Ms Jeisman was the subject of orders granted by the Guardianship Board pursuant to the Guardianship and Administration Act 1993

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<sup>1</sup> Exhibit C2a

including powers of detention under section 32 of that Act. On 4 July 2014 an order was granted for the Public Advocate to become the guardian of Ms Jeisman. On 12 September 2014 additional orders were granted with the special powers of detention to which I have referred. These latter orders empowered the guardian to make decisions about where Ms Jeisman was to reside including the power to detain in that place. Both orders would remain in place until the time of Ms Jeisman's death. On 12 September 2014 the Public Advocate determined that Ms Jeisman should reside at Ward R8 at the RAH and was not to move to different accommodation without the permission of the Public Advocate. In addition, a determination was made that Ms Jeisman be detained at Ward R8 of the RAH. In the event Ms Jeisman died at the RAH. All this meant that Ms Jeisman's death was a death in custody in respect of which a mandatory Inquest was necessary. These are the findings of that Inquest.

### **3. Background and medical history**

- 3.1. Ms Jeisman's relevant medical history included a 20 year history of chronic drug resistant schizophrenia resulting in multiple admissions to Glenside Hospital and other facilities. She had suffered from morbid obesity, chronic obstructive airways disease, hypertension, Type 2 diabetes and obstructive sleep apnoea.
- 3.2. Ms Jeisman's history is described in the statement of Ms Heather Blight who was Ms Jeisman's aunt on her father's side<sup>2</sup>. Ms Blight became involved in Ms Jeisman's affairs in late 2012. Ms Blight explains that in 2011 Ms Jeisman's partner had died. Prior to that Ms Jeisman had suffered from a mental health condition as well as physical health issues such as the matters I have described above. Prior to her partner's death Ms Jeisman had coped much more effectively. Following the death of her partner Ms Jeisman's mental and physical health suffered. She had admissions to the QEH in relation to her mental health issues and remained in the hospital's Cramond Clinic for several months. In the event Ms Blight became Ms Jeisman's guardian. Ms Blight explains that Ms Jeisman also had an admission or admissions at Glenside Hospital. She also had a unit rented from the South Australian Housing Authority. Unfortunately due to excessive smoking Ms Jeisman's health never improved sufficiently to enable her to reside independently at the unit. In May 2014 meetings were held at Glenside in order to review Ms Jeisman's care plan. In June 2014 Ms Blight decided that due to the complexity of Ms Jeisman's care needs she could not continue in the role of

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<sup>2</sup> Exhibit C6

guardian. This culminated in the involvement of the Public Advocate as Ms Jeisman's guardian.

- 3.3. In the event the orders from the Guardianship Board to which I have referred were sought and granted. There is no question but that they were appropriate and necessary in the interests of Ms Jeisman's health and safety.
- 3.4. On 9 August 2014 Ms Jeisman was admitted to the RAH with haemophilus pneumonia. She had been unable to give up smoking and was intolerant of an oxygenating CPAP mask. This admission ultimately continued for the ensuing five months until her death on 30 January 2015. It was considered that Ms Jeisman lacked judgment. She was not cooperative with many of the aspects of the management plan that the hospital wanted to institute for her. During her admission within the RAH she was investigated for recurrent deep vein thrombosis.
- 3.5. After a period of treatment at the RAH Ms Jeisman's options regarding discharge were considered. It was decided that Glenside Hospital was not a viable option. A nursing home placement also was not considered feasible due to her relatively young age. Ms Jeisman was not able to return home to live independently.

#### **4. Ms Jeisman's decline in health**

- 4.1. Ultimately it became apparent that Ms Jeisman had a terminal respiratory illness with a poor prognosis. RAH palliative care consultants and the Public Advocate together discussed her situation at length. In the event a decision was made to institute palliative care. The final RAH separation summary compiled in respect of Ms Jeisman upon her death stated:

'Leonie Jeisman is a 45 year old woman well known to the General Medical Unit after 4 prior admissions throughout this year, with poorly controlled COPD, chronic hypoxia, and ongoing smoking preventing her from qualifying for domiciliary oxygen therapy.

She had a prolonged admission of nearly 5 months on this occasion, during which time there was progression of multifactorial Type 2 respiratory failure, likely secondary to poor CPAP compliance, obstructive sleep apnoea and obesity hypoventilation syndrome. In the context of disease progression, declining function, and worsening reusability, the decision of the medical and palliative care teams in conversation with social work and mental health was to initiate palliative measures. Measures were put in place to maintain her dignity and comfort in the terminal phase of her life, and she passed away at 1935 hours.'

4.2. As indicated in the separation summary, Ms Jeisman died in Ward R8 of the RAH at about 1935 hours on 30 January 2015. She was in the company of nursing staff when she died.

**5. Conclusions**

5.1. The Court agrees with the conclusions of the investigating officer, Detective Brevet Sergeant Paul O'Donnell<sup>3</sup> of SAPOL Western Adelaide CIB that the circumstances surrounding the death of Ms Jeisman were not suspicious and did not indicate the involvement of any third party. In his report Detective O'Donnell indicates that he had not identified any deficiency in the care afforded to Ms Jeisman while detained at the RAH. This Court also has not identified any such deficiency.

5.2. Ms Jeisman's circumstances of detention did not in any way contribute to her death.

**6. Recommendations**

6.1. There are no recommendations to be made in this matter.

*Key Words: Death in Custody; Natural Causes; Section 32 Powers*

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

*Seal the 26<sup>th</sup> day of April, 2018.*

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*Deputy State Coroner*

Inquest Number 46/2016 (0209/2015)

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<sup>3</sup> Exhibit C8