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 27th day of November 2018, the 29th day of April 2019 and the 29th day of May 2019, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Glenda Rae Field.

The said Court finds that Glenda Rae Field aged 59 years, late of Clearview Manor Retirement Village, 1 Leicester Street, Clearview, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 5th day of November 2015 as a result of hypoxic-ischaemic encephalopathy due to acute upper airway obstruction. The said Court finds that the circumstances of her death were as follows:

1. Introduction and reason for Inquest

1.1. Ms Glenda Rae Field was born on 27 May 1956 and died on 5 November 2015 aged 59 years. Ms Field was a resident at Clearview Manor House in Clearview at the time of her death. Clearview Manor Home is a locked care facility and Ms Field had resided at that location since 30 November 2009.

1.2. At the time of her death Ms Field was subject to a guardianship order pursuant to section 32 of the Guardianship and Administration Act 1993, the terms of which meant that she could not leave the facility. Ms Field's death was therefore 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. The cause of Ms Field's death, as determined by a pathology review conducted by Dr Iain McIntyre of the Forensic Science South Australia on 10 November 2015, was hypoxic ischaemic encephalopathy due to acute upper airway obstruction[1], and I so find.

3. Background and medical history

3.1. Ms Field's sister provided a statement which was tendered to the Court[2]. In her statement she noted that, although happily employed for several years, Ms Field experienced a breakdown following the termination of a pregnancy resulting from a relationship with a co-worker. The relationship ended at about the same time. Ms Field was said to be electively mute and catatonic.

3.2. Episodes of muteness and catatonia continued for the remainder of Ms Field's life. She was diagnosed with chronic paranoid schizophrenia and factitious disorder. She was referred to Southern Mental Health for community support. She struggled with the diagnosis and treatment was very difficult.

3.3. There are extensive hospital admission records for Ms Field. Having factitious disorder meant that she would often present at hospitals claiming falsely to have suffered from a stroke or a heart attack or other serious illness which would then require investigation. There were also many admissions over the years to mental health facilities such as Glenside Hospital and the Margaret Tobin Centre.

3.4. Ms Field received fortnightly depot injections of the long acting anti-psychotic medication Fluoxenol.

3.5. The effects of her mental illness left her very socially isolated, including estrangement from her family from whom she cut herself off. Ms Field's mental health disease was of course devastating for her family.

3.6. Ms Field's mental illness became progressively worse despite treatment until it was determined that she could no longer care for herself. She could not clean her home or pay her utilities and she would be found without electricity or water. Her self-care was

[1] Exhibit C2a
[2] Exhibit C0

poor and she was malnourished and anaemic as she would not eat for days if her supplies had run out. Ms Field would often fail to dress herself before going out in public. She engaged in reckless behaviour such as walking out into traffic without looking or stopping for the traffic. It was the opinion of her treatment team that she could not survive in the community independently and was a risk to herself.

3.7. In September 2009 the orders referred to above were made, and so Ms Field entered Clearview Manor.

4. The incident

4.1. Clearview Manor had a dining room for the residents, but Ms Field would often request to eat her meals outside under the pergola near the dining room. Ms Field had no identified eating or swallowing difficulties and was on a normal diet. The staff had noticed Ms Field ate her food very quickly, but there were no concerns from a medical perspective that she might choke.

4.2. On Wednesday 4 November 2015 Ms Field was sitting outside on the outdoor benches eating dinner at about 5:30pm. She was eating toast, having declined the usual dinner that was served to the residents. One of the aged care workers, Ms Weber, noticed that Ms Field was slumped over and so went to check on her. She observed that Ms Field was unresponsive and purple in the face and had toast in her mouth. Ms Weber went inside to get the assistance of a fellow worker and resuscitation attempts were initiated by the staff and food was removed from Ms Field's mouth.

4.3. The South Australian Ambulance Service and MedSTAR were called at 5:41pm. The first ambulance attended at 5:56pm. Upon their arrival Ms Field was in cardiac arrest. Resuscitation attempts were in progress and the worker was being talked through those resuscitation attempts by the triple zero operator. The MedSTAR team, including a doctor, attended at 6:09pm. Intubation at the scene was accomplished, but only after further food was removed from Ms Field's oesophagus with the use of forceps by the doctor.

4.4. Circulation was restored after 36 minutes of chest compressions. Ms Field was conveyed to the Royal Adelaide Hospital where she continued to require ventilation

and cardiovascular support in the ICU. A CT scan of her brain showed generalised hypoxic brain injury. Dr Wong conducted an examination of Ms Field and determined brain death.

4.5. There has been some confusion in the evidence about the position that Ms Field might have been in during the resuscitation by the staff. Ambulance paramedic Sparrow did not see anything of particular concern when he attended. He stated that:

> 'She was trying to do what she could to help her and I imagine if she tried to put the patient on the ground she may well have hurt herself or given the patient a head injury.' [3]

4.6. In an addendum statement Mr Sparrow stated:

> 'I can state that the patient was seated in a normal seated position with her back against the backrest of the bench seat and her feet on the ground in a normal sitting position. Her head was slumped to the side and resting on her shoulder.' [4]

4.7. From this it would appear that the CPR was being conducted whilst Ms Field was in a seated position, rather than supine as is normally the case. Mr Sparrow said that he saw the carer sitting next to the patient attempting compressions to the patient side on.

4.8. The carer, Ms Kaur, stated that she commenced CPR straight away and was very worried about Ms Field. She stated:

> 'I was kneeling on the floor in front of Glenda doing the compressions to her chest and breaths in her mouth whilst Glenda was still sitting on the bench. I was not able to move her on my own as Glenda was a very heavy lady, but I knew I had to help her straight away.' [5]

4.9. Later in her statement Ms Kaur said that following a discussion with the triple zero call taker she received instructions to move Ms Field to the ground and that was done, albeit with some difficulty.

4.10. In any case, it appears that there were quite a few difficulties in removing all of the bolus to begin with, and there was some 15 minutes to 20 minutes before the ambulance arrived.

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[3] Exhibit C5
[4] Exhibit C5a, page 2
[5] Exhibit C28, page 3

5. Conclusion

5.1. While there does seem to be an inconsistency between the accounts of Mr Sparrow and Ms Kaur it is not uncommon to see that in a situation that was very stressful and fast moving. I do not think that the Court can reach any conclusion as to precisely what position Ms Field was in during the various stages of CPR. What is clear is that CPR was commenced by Ms Kaur expeditiously, and it would have been difficult for her to move Ms Field to the ground and to place her in a supine position.

5.2. In my opinion there was nothing inappropriate in Ms Field's general care at Clearview Manor and the circumstances surrounding her detention were lawful.

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

Key Words: Death in Custody; Section 32 Powers; Choking

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 29th day of May, 2019.

State Coroner