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 22nd day of November 2018 and the 12th day of June 2019, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Jean Harrap.

The said Court finds that Jean Harrap aged 82 years, late of 52 Woodyates Avenue, Salsibury North, South Australia died at the Lyell McEwin Hospital, Haydown Road, Elizabeth Vale, South Australia on the 16th day of September 2015 as a result of pulmonary embolism due to left calf deep vein thrombosis. The said Court finds that the circumstances of her death were as follows:

1. Introduction, reason for inquest and cause of death

1.1. Mrs Jean Harrap died on 16 September 2015 at the Lyell McEwin Hospital (LMH), Elizabeth Vale. She was 82 years of age.

1.2. At the time of her death Mrs Harrap was detained at the LMH on a Level 1 Inpatient Treatment Order (ITO) imposed under the Mental Health Act 2009. For that reason her death was a death in custody for which an Inquest was mandatory pursuant to the provisions of the Coroners Act 2003.

1.3. The cause of Mrs Harrap's death was determined by way of a pathology review conducted by Dr Karen Heath of Forensic Science South Australia. Based on Dr Heath's pathology review[1] I find the cause of Mrs Harrap's death to have been bilateral pulmonary thromboembolism due to left calf deep vein thrombosis (DVT).

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[1] Exhibit C2a

2. Background

2.1. Mrs Harrap's daughter, Jeanette Harrap, provided a statement to the Court setting out her mother's background[2]. Mrs Harrap had seven children and was living with her husband until such time as she was taken to the Lyell McEwin Hospital. Mrs Harrap's daughter stated that in the last six months of her mother's life she observed that her mother's behaviour was changing. She had become constantly erratic, was throwing things and had threatened self-harm on numerous occasions. She had scratched and marked her arms by scraping a nail file across them. At one stage she had grabbed a blunt knife and had threatened to stab herself. All of this behaviour was no doubt out of character having regard to a previous life of relative emotional stability.

2.2. Jeanette Harrap was so concerned for her mother's welfare that she sent an email to her mother's general practitioner, Dr Zeena Farzan, at Trinity Medical Centre. Jeanette Harrap set out the occasions on which her mother was taken to hospital.

2.3. With respect to the cause of death, Jeanette Harrap stated that '*no one in our family is aware of any blood issues of DVT that mum suffered or a history of it in our family*'.

2.4. Dr Farzan provided a statement to the Court. She stated:

> 'In October 2008 Mrs Harrap had been referred for a check for deep vein thrombosis and the results had returned she was clear of DVT and there was no Baker's cyst detected.' [3]

2.5. Dr Farzan set out Mrs Harrap's attendances in relation to complaining of depression, dizziness, knee and hip joint pains, lower abdominal pain, urinary and bladder symptoms.

2.6. Mrs Harrap first showed signs of depression in January 2007 when she was prescribed Aropax. From 2010 onwards her blood pressure became an issue and she was managed with antihypertensive medication. In October 2012 she was sent to the Emergency Department at Lyell McEwin Hospital where it was reported that there was no evidence of DVT. However, the report suggested there was a small Baker's cyst on the left leg.

2.7. The last time Dr Farzan saw Mrs Harrap was on 9 September 2015, seven days prior to her death, where she made a referral to a urologist and a psychiatric registrar at the Lyell McEwin Hospital. The reason for the referral to the psychiatrist was that

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[2] Exhibit C9
[3] Exhibit C10

Mrs Harrap had told Dr Farzan that she did not want to be here and that she would walk in front of traffic. Mrs Harrap's husband confirmed her threatening to self-harm.

3. Mrs Harrap’s detention

3.1. On 13 September 2015 Mrs Harrap arrived at the Emergency Department by ambulance. At the triage stage she presented with altered mental state. She had been refusing to take her usual medication and had recently inflicted self-harm to her wrist. Mrs Harrap was seen by Dr Chloe Shelton, an intern medical officer working under the supervision of a senior medical staff at the Emergency Department. Collateral information about Mrs Harrap was obtained.

3.2. This collateral information showed Mrs Harrap had been to the Emergency Department three times in the past seven days. Mrs Harrap was uncooperative and was refusing to answer questions about her health. Dr Chu, emergency medicine consultant at the LMH, provided the following information:

> 'A full set of investigations were done in the ED to rule out an organic cause for her presentation. Her blood tests, chest X-ray and CT were normal. Her urine dipstick showed no evidence of infection. However, this could have been a false negative in the presence of antibiotics, which she was currently taking'. [4]

3.3. The result of the Emergency Department assessment was she was likely recovering from a urinary infection. However, the ongoing symptoms could possibly have been as a result of mental illness, dementia or a combination of both. Because of the severity of her presentation she was placed on a Level 1 ITO and was detained in the Emergency Department overnight.

3.4. Dr Jacqueline Condon, a psychiatry registrar in her first year of training at the LMH, stated that on 13 September 2015 she was advised of Mrs Harrap's attendance at the Emergency Department[5]. She obtained collateral history which described increased depression. Mrs Harrap's husband had given accounts of several occasions when Mrs Harrap had expressed suicidality. Dr Condon found that the information provided by Mrs Harrap's husband and Mrs Harrap were inconsistent. Mrs Harrap was guarded and dismissive in regards to her mental health. She was denying any suicidal ideation contrary to the collateral information which consisted of threatening to walk out in front

[4] Exhibit C8
[5] Exhibit C6

of traffic, wandering around an oval, self-harming with a nail file and threatening to stab herself with a knife. Mrs Harrap was unwilling to stay voluntarily to allow for further investigation into her behavioural changes. Dr Condon believed the risk of absconding to be very high.

3.5. Dr Condon also took into account the Emergency Department medical officer's mini mental status examination and also the Montreal Cognitive Assessment. Taking into account the collective information she had received, she maintained a decision to detain Mrs Harrap and to place her on the Level 1 ITO. Mrs Harrap was to remain in the Emergency Department until a bed was made available in the mental health ward.

3.6. Dr Jeffrey Harvey, a senior consultant psychiatrist, saw Mrs Harrap on 14 September 2015 while he was working at the LMH[6]. Dr Harvey stated that Mrs Harrap was again in denial and was reluctant to express any ideas. Dr Harvey confronted her about the marks and lacerations on her left forearm. Mrs Harrap claimed that she had knocked her arm and denied it was a result of having taken a nail file to it.

3.7. Dr Harvey stated the collateral information he obtained from other sources indicated Mrs Harrap had significant cognitive or memory deficits, scoring $^{15}/_{30}$ on the Montreal Cognitive Assessment. She had decreased self-care and possible depression that had been previously treated with anti-depressants in 2014. Since then it had been reportedly increasingly difficult to have Mrs Harrap take her medication.

3.8. As a result of Dr Harvey's assessment he confirmed the ITO and felt that a further assessment in hospital was necessary. It was unreasonable to expect Mrs Harrap to return home. Mrs Harrap was expressing unrealistic plans to leave her husband who was clearly stressed and not coping. Mrs Harrap was unwilling to stay voluntarily. Dr Harvey was of the opinion that she warranted further assessment.

4. The events leading to Mrs Harrap’s death

4.1. Mental health nurses, Shilby Joseph and Bernadette Clayton who were on duty at the time Mrs Harrap was found deceased, provided statements to the inquest[7].

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[6] Exhibit C7

[7] Exhibits C3 and C4

4.2. Ms Shilby Joseph was the mental health nurse who had responsibility for Mrs Harrap as of 6:50pm on Tuesday, 15 September 2015. She observed Mrs Harrap refusing to eat or take her medication on that day[8].

4.3. Mrs Harrap was stating that she did not belong in the ward and wanted to go home. She was refusing to eat or drink at supper. Mrs Harrap complained of a sore neck and back pain. She was provided with Panadol. Her vital observations were checked. She was placed in bed at about 10pm that night.

4.4. Ms Joseph stated that, as with all patients, 15 minute observations were conducted. Throughout the night Mrs Harrap was checked; she was sleeping.

4.5. At 6:15am Ms Joseph went into Mrs Harrap's room and could hear running water in the bathroom. She looked inside and saw Mrs Harrap lying on the floor on her back. Ms Joseph called a Code Blue and commenced CPR.

4.6. Dr Soo was the first medical officer to arrive at the scene[9]. He observed that the resuscitation team had moved Mrs Harrap from the bathroom to the corridor to allow access. CPR was continued and she was intubated. Fluids were administered. Unfortunately Mrs Harrap could not be resuscitated. After 23 minutes of ongoing CPR the emergency team pronounced life extinct.

5. Conclusion

5.1. Mrs Harrap’s death in custody was investigated by Detective Brevet Sergeant Woodroofe of SAPOL. Detective Woodroofe provide a comprehensive report to the Court[10].

5.2. Detective Woodroofe concluded that Mrs Harrap’s detention under the Mental Health Act 2009 was lawful and that the care and treatment provided to Mrs Harrap at the time was appropriate.

5.3. I agree with the conclusions of Detective Woodroofe and find that Mrs Harrap’s detention pursuant to the Mental Health Act was lawful and appropriate.

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[8] Exhibit C3
[9] Exhibit C5
[10] Exhibit C13

5.4. I do not believe that Mrs Harrap's DVT could have been anticipated or identified, or that her death from the same could have been prevented.

6. Recommendations

6.1. I have no recommendations to make 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 12th day of June, 2019.

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Deputy State Coroner

Inquest Number 13/2018 (1678/2015)