



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 21st day of May, the 18th day of June and the 3rd day of November 2020, by the Coroner's Court of the said State, constituted of Ian Lansell White, Deputy State Coroner, into the death of Louise Kitty Whiskey.

The said Court finds that Louise Kitty Whiskey aged 51 years, late of Unit 167, 176 Angas Street, Adelaide, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 7th day of September 2017 as a result of community acquired pneumonia. The said Court finds that the circumstances of her death were as follows:

1. Introduction and cause of death

- 1.1. Louise Kitty Whiskey was born on 4 November 1965 and died on 7 September 2017 at the Royal Adelaide Hospital (RAH). She was 51 years of age.
- 1.2. A pathology review of Ms Whiskey's clinical history and medical records was undertaken by Dr Jane Alderman in discussion with Dr Neil Langlois, forensic pathologist, at Forensic Science South Australia. In her report of that review Dr Alderman has provided the cause of Ms Whiskey's death as community acquired pneumonia. Based on this review and the evidence presented at this inquest, I find the cause of death as community acquired pneumonia.

2. Reason for inquest

- 2.1. Ms Whiskey's death was the subject of a mandatory inquest pursuant to Section 21(1)(a) of the Coroners Act 2003 as Ms Whiskey had been on an Inpatient

Treatment Order (ITO) at the time she died. A Level One ITO had been imposed pursuant to Section 21 of the Mental Health Act 2009. It was put in place by Dr Natalie Montarello at about 3pm on 2 September 2017. It was due to expire at 2pm the following day.¹

- 2.2. At 10:23 am on 3 September 2017 Ms Whiskey was seen by the RAH psychiatrist, Dr Roman Onilov, and at 10:40 am he confirmed the order.² That order remained in place at the time of Ms Whiskey's death. It was the second ITO that had been put in place during Ms Whiskey's admission to the RAH. The first was made by Dr Victoria Lu on 26 August 2017 and then later revoked by Dr Davis on 28 August 2017.³
- 2.3. In addition to the ITO, Ms Whiskey was under a Guardianship Order pursuant to Section 29 of the Guardianship and Administration Act 1993.⁴ Ms Belinda Lake was the Office of the Public Advocate guardian appointed for Ms Whiskey. Ms Whiskey had a history of orders being made pursuant to Section 32 of the Guardianship and Administration Act 1993 authorising her guardian to determine her place of residence and authorising detention at that location. In addition, special powers under Section 32 that authorised the use of physical and chemical restraint to treat Ms Whiskey's condition were granted by the South Australian Civil and Administrative Tribunal on 6 September 2017. Ms Lake then authorised the RAH to use those measures.⁵
- 2.4. It does not appear those additional powers were utilised as Ms Whiskey was subject to an ITO at the time of her death.
- 2.5. There are no concerns in relation to the lawfulness of custody.

3. Background

- 3.1. Ms Whiskey was an aboriginal woman who grew up in the Northern Territory and was the mother of three children.⁶ According to her cousin, Ms Whiskey had been a 'drinker' for a considerable part of her life. In 2016 her elder sister died due to alcohol

¹ Exhibit C7

² Exhibit C7

³ Exhibit C15

⁴ Exhibit C10

⁵ Exhibit C10

⁶ Exhibit C9

abuse.⁷ Ms Whiskey used to say that ‘she wanted to die like her sister and not to stop her drinking’.

4. Medical History

4.1. Ms Whiskey’s medical history included chronic alcohol misuse, intravenous drug abuse, liver cirrhosis, recurrent respiratory infection, multi-lobar pneumonia, lung abscesses, a fractured right radius and ulna (non-union) and a fractured left clavicle.⁸

4.2. On 31 March 2017 Ms Whiskey was admitted to the RAH by ambulance for respiratory distress and hypoxia. On arrival she was noted to have severe multi-lobar pneumonia.⁹ On 4 April 2017 she absconded but returned voluntarily later that evening. On 13 April 2017 she was discharged.¹⁰

4.3. In June 2017 Ms Whiskey left South Australia and travelled to Alice Springs. Contact was made between the Office of the Public Advocate and the hospital in Alice Springs numerous times between 14 and 29 June 2017.¹¹

4.4. On 29 June 2017, upon Ms Whiskey’s return to South Australia, she spoke with Ms Lake. Ms Whiskey indicated to Ms Lake that she was going to travel to Queensland however Ms Lake advised against it due to concerns with her health.¹²

4.5. On 5 July 2017 the Office of the Public Advocate were unable to locate Ms Whiskey and a missing person report was filed with South Australia Police. On 11 July 2017 staff received notification that Ms Whiskey was in the Intensive Care Unit of a Cairns hospital after being found in the city with ongoing seizures.¹³

4.6. Ms Whiskey returned to Adelaide and Ms Lake visited her at home on 17 July 2017.

5. Clinical circumstances including diagnosis and treatment

5.1. On 23 August 2017 Ms Whiskey attended at the RAH with aspiration pneumonia and right non-union of mid shaft radial fracture. She presented with a history of Class C cirrhosis secondary to chronic alcohol abuse, active smoking including cannabis and

⁷ Exhibit C9

⁸ Exhibit C0

⁹ Exhibit C15

¹⁰ Exhibit C15

¹¹ Exhibit C10

¹² Exhibit C10

¹³ Exhibit C10

amphetamines, previous intravenous drug abuse and multiple prior admissions with multi-lobar pneumonia.¹⁴

- 5.2. There were initial concerns about Ms Whiskey absconding. She was under a Section 29 Guardianship Order to remain at the RAH at that time.¹⁵
- 5.3. On 25 August 2017 Ms Whiskey suffered a seizure that was attributed to alcohol withdrawal. Over the course of the next 28 hours there were three code blacks called as a result of Ms Whiskey attempting to abscond from the hospital. She was acting aggressively and violently towards hospital staff. It was the second of those incidents, at approximately 1:20pm on 26 August 2017 that resulted in the initial ITO being put in place.¹⁶
- 5.4. Two further code blacks were called on 29 and 31 August 2017 as the result of Ms Whiskey's further violent behaviour. The same behaviour was repeated on 2 September 2017 when another ITO was put in place.¹⁷ This ITO was in operation at the time of Ms Whiskey's death.
- 5.5. Throughout the course of her treatment at the RAH Ms Whiskey was uncooperative and obstructive in the receipt of care. She had a guard stationed outside her room 24 hours a day during the majority of her admission.¹⁸
- 5.6. On 4 September 2017 Ms Whiskey was transferred from the old RAH to the new RAH without incident.¹⁹ Notwithstanding Ms Whiskey's behaviour hospital staff were able to treat Ms Whiskey for her condition.

6. Circumstances surrounding Ms Whiskey's death

- 6.1. On the morning of 5 September 2017 Ms Whiskey was seen by Dr Yu who noted that Ms Whiskey was medically well.²⁰ At about 12pm on 6 September 2017 nursing staff noted that Ms Whiskey's condition deteriorated, resulting in her transfer to the ICU.²¹

¹⁴ Exhibit C6

¹⁵ Exhibit C6

¹⁶ Exhibit C6

¹⁷ Exhibit C6

¹⁸ Exhibit C8

¹⁹ Exhibits C11 and C12

²⁰ Exhibit C8

²¹ Exhibit C8

This occurred at about 12:30am on 7 September 2017.²² Due to her condition, both senior registrars and multiple junior doctors were immediately involved in her care.²³

- 6.2. Both before and after her transfer to the ICU, Ms Whiskey received ongoing treatment which was not effective. Her condition deteriorated rapidly with increasing oxygen requirement, falling blood pressure, falling urine output and worsening acidosis. Concerns were raised as to whether there was another source of sepsis, possibly ischaemic gut. Ms Whiskey was reviewed by general surgeons resulting in dialysis.²⁴ Ms Whiskey was too unstable for a CT scan or laparotomy and so intensive care treatment continued in the hope she would stabilise.²⁵
- 6.3. Dr Hauser was one of the treating ICU doctors. Arrangements were made for Ms Whiskey to be monitored electronically by an arterial line. At about 2am on 7 September 2017 she was recording a blood pressure of 60mmHg systolic, which was dangerously low.²⁶
- 6.4. To treat her low blood pressure Ms Whiskey was given noradrenaline through an Acomed pump. The noradrenaline should have increased Ms Whiskey's blood pressure but it did not. It was discovered by Dr Hauser that the pump administering the medication had failed without alarming. Dr Hauser took the noradrenaline line out of the pump and administered the medication manually. A Gemini pump was utilised and Ms Whiskey's blood pressure improved briefly, but then deteriorated.²⁷
- 6.5. Ms Whiskey was intubated at approximately 3:30am following an increased respiratory rate, hypoxia and hypotension. At 4am a dialysis catheter was inserted and dialysis commenced without complication. At 6am a bedside echocardiogram was performed demonstrating moderately severe left ventricular systolic dysfunction and almost global hypokinesia. Ms Whiskey was given adrenaline.²⁸
- 6.6. At 7:06am Ms Whiskey went into arrest with a loss of cardiac output. The emergency alarm was activated across the ICU and numerous medical staff attended.²⁹ Intensive Care Nurse Donna Ross commenced CPR, however she was advised by one of the

²² Exhibit C3

²³ Exhibit C3

²⁴ Exhibit C5

²⁵ Exhibit C5

²⁶ Exhibit C4

²⁷ Exhibit C4

²⁸ Exhibit C5

²⁹ Exhibits C3 and C4

doctors to stop after about 20 seconds.³⁰ That advice was given on the direction of consultant Associate Professor Mary White who had been speaking with one of the treating doctors, Dr James Briggs, at the time Ms Whiskey went into arrest. Associate Professor White was of the opinion that given Ms Whiskey's very poor cardiac output and lack of response to maximal support, CPR would not have been effective.³¹ Ms Whiskey was certified life extinct at 7:30am.³²

7. Issue with pump

- 7.1. As a result of the failure of the Acomed pump Dr Hauser submitted a Safety Learning Systems report of the incident.³³ Dr Hauser raised concerns as to what extent the period of hypotension suffered by Ms Whiskey contributed to poor end organ perfusion and Ms Whiskey's death.³⁴
- 7.2. It is noted that following detection of the pump failure and the administering of the noradrenaline, the improvements in Ms Whiskey's blood pressure were brief before her condition continued to deteriorate.³⁵ She did not suffer the fatal cardiac arrest until a number of hours after the issue was rectified.
- 7.3. Associate Professor Mary White noted that at the time of Ms Whiskey's cardiac arrest she was already on maximal doses of noradrenaline, vasopressin and increasing dosages of adrenaline. In spite of that support Ms Whiskey's blood pressure was low at 50 with a pulse pressure of 10. Ms Whiskey had very poor output and lack of response to maximal medical support.³⁶
- 7.4. A panel of reviewers considered the concerns raised about the pump by Dr Hauser and formed the opinion that death was not as a result of pump failure.³⁷ Nothing is contained in the pathology review to suggest the pump failure contributed to the death of Ms Whiskey.³⁸
- 7.5. Although Ms Whiskey's death is not due to the failure of the Acomed pump it was of great concern that it did fail. The inquest was adjourned for further submission to be

³⁰ Exhibit C2

³¹ Exhibit C5

³² Exhibit C3

³³ Exhibit C4

³⁴ Exhibit C4

³⁵ Exhibit C4

³⁶ Exhibit C5

³⁷ Exhibit C4

³⁸ Exhibit C0

made on the reliability of this type of pump in general. I received two further statements on this issue from Mr Foundas, counsel assisting the inquest.

- 7.6. Dr Sundararajan, Director of the Intensive Care Unit reviewed Dr Hauser's report as a medical expert on a panel investigating this failure. He found the issue to be 'transient'³⁹ and did not contribute to Ms Whiskey's death. He further analysed multiple reports in 2017 of Acomed pump failure based on mechanical and software issues. This prompted a review of these issues that after some testing and reconfiguring were resolved.
- 7.7. Further training of ICU staff of use and maintenance of the improved pumps then followed.
- 7.8. The rate of failure or malfunction has decreased significantly as a result. 'Wear and tear' issues still remain as well as variability in maintenance and upkeep. These are procedural issues and therefore should be monitored carefully.
- 7.9. In May 2018, there was a 'fleet update' that has resulted in the pumps 'performing as expected'.⁴⁰
- 7.10. As such, I am satisfied this issue has been properly reviewed and improvements implemented after thorough testing.
- 7.11. I am satisfied proper guidelines for use and maintenance have been set and therefore will not make recommendation on this issue.

8. Coronial investigation

- 8.1. Detective Brevet Sergeant Kelly Lavington from the Eastern Adelaide Criminal Investigation Branch was tasked with investigating the death in custody of Ms Whiskey. After a thorough investigation, Detective Lavington formed the opinion that the care and treatment provided to Ms Whiskey at the RAH was appropriate and that her detention under the Mental Health Act 2009 was lawful.⁴¹

³⁹ Exhibit C18, Statement of Dr Sundararajan dated 11 June 2020 paragraph 6

⁴⁰ Exhibit C17, Statement of David Spigiel, employee of RAH who was on a panel responsible for procurement and supply chain management for State and RAH tenders dated 11 June 2020

⁴¹ Exhibit C15

8.2. In addition, Detective Lavington investigated issues in relation to the pump failure and is of the opinion that it did not contribute to the death of Ms Whiskey. No concerns have been raised by the next of kin of the deceased.

9. Conclusion and recommendations

9.1. Consistent with the views of Detective Lavington, I find that Ms Whiskey's detention was lawful and did not contribute to her death. I find that Ms Whiskey received an appropriate level of care and treatment during her detention at the Royal Adelaide Hospital. I further find that the failure of the pump did not contribute to Ms Whiskey's death.

9.2. 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 3rd day of November, 2020.

Deputy State Coroner