CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATH OF ADAM JAMES PROVIS

[2025] SACC 20

Inquest Findings of his Honour State Coroner Whittle

3 July 2025

CORONIAL INQUEST

Examination into the cause and circumstances of the death of a 50-year-old man who died in hospital whilst the subject of an inpatient treatment order. Mr Provis had recently been experiencing a decline in his mental state considered consistent with an atypical manic phase of bipolar affective disorder; the treatment order was imposed as a result of this decline. The inquest examined the circumstances of the imposition of the treatment order, and the appropriateness and adequacy of his treatment and care whilst in hospital.

Held:

1. Adam James Provis, aged 50 years of Peterhead, died at the Royal Adelaide Hospital on 17 October 2021 as a result of in-hospital cardiac arrest on a background of seizures and atheroembolic cerebrovascular disease.

2. Circumstances of death as set out in these findings.

No recommendations made.

Counsel Assisting: MR M KIRBY
Hearing Date/s: 24 October 2024
Inquest No: 38/2024 **File No/s: 2250/2021**

INQUEST INTO THE DEATH OF ADAM JAMES PROVIS [2025] SACC 20

Introduction and reason for inquest

1 Adam James Provis was born on 25 April 1971 and died on 17 October 2021 at the Royal Adelaide Hospital. He was 50 years old.

2 Mr Provis' death was a 'death in custody' as defined in the *Coroners Act 2003* as he died whilst subject to a level 2 inpatient treatment order (ITO) imposed under the *Mental Health Act 2009* and, even though the cause of death was a natural cause, Mr Provis was held in a ward wholly set aside for the treatment of persons with mental illness, so the Coroners Court must hold an inquest to determine the cause or circumstances of his death.

3 The level 2 ITO had been imposed by Dr Angela Okungu at The Queen Elizabeth Hospital on 6 October 2021. The order was due to expire on 17 November 2021.

Cause of death

4 A post-mortem examination was conducted on 26 October 2021 by Dr Neil Langlois, consultant forensic pathologist, at Forensic Science SA. Dr Langlois reported that the cause of Mr Provis' death was 'in-hospital cardiac arrest on a background of seizures and atheroembolic cerebrovascular disease'.[1] I will deal with this in greater detail later in these findings.

Background

5 Mr Provis and his sister, Kirsty, were raised in South Australia by their parents, Phillip and Margaret. Mr Provis completed schooling at Brighton High School before commencing work with Kodak. He later had his own photographic business in Port Adelaide.

6 In 2000 Mr Provis purchased his home in Peterhead where he and his father would regularly spend time together, working on their cars.

7 In 2005 he commenced working for SA Health at the Royal Adelaide Hospital, and then later at The Queen Elizabeth Hospital where he worked as a distribution officer.

8 Mr Provis was noted by his father to be in reasonable health prior to July 2021.

Medical history

9 In 2016 Mr Provis engaged with his general practitioner, Dr Sun, at the Trinity Medical Centre in relation to an upper respiratory tract infection. Prior to this time he had been diagnosed with hypertension, anxiety, depression and alcohol abuse. He was also a heavy smoker.[2]

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[1] Exhibit C2a, page 2
[2] Exhibit C8

10 In May 2021 Dr Sun recommenced a prescription of blood pressure medication after being informed by Mr Provis that he had stopped taking his medication when he began to feel well again. Mr Provis told Dr Sun he was previously prescribed antidepressant medication but had stopped this also when his mood improved.[3]

11 Dr Sun noted that during Mr Provis' engagement with the Trinity Medical Centre he reported issues including anxiety and panic disorder, low mood and agoraphobia, leg pain and general unwellness. In August 2021 Dr Sun referred Mr Provis to a psychologist for his worsening depression and anxiety symptoms, however was unsure if Mr Provis followed up with this referral.[4]

Mr Provis' hospital admissions

12 As noted in the affidavit of his father,[5] Mr Provis began to feel unwell in July 2021 and began exhibiting signs of confusion. He was having circulation issues with his leg and was referred to The Queen Elizabeth Hospital for medical treatment. On 27 June 2021 Mr Provis stayed at his parents' home for about five nights before returning to his home for about three nights. He returned to stay with his parents again for the next 16 nights. His parents were aware something was wrong, but did not know what.[6]

13 Whilst staying with his parents in early August 2021, Mr Provis demonstrated signs of confusion. One evening he telephoned his parents from their hallway saying he was confused and did not know where he was.[7]

14 On 5 August 2021 Mr Provis attended the Trinity Medical Centre where a mental health care plan was put into place. He reported increasing anxiety, on a history of anxiety and depression.

15 On 20 August 2021 Mr Provis collapsed during breakfast at his parents' home, with his head falling to the table. His father put him on the floor where he commenced thrashing around making noises. His father called an ambulance which conveyed Mr Provis to the Flinders Medical Centre. He was diagnosed with grand mal seizures, without mention of intractable epilepsy.

16 Mr Provis returned to normal quickly whilst in hospital and was discharged from the Flinders Medical Centre three days later, staying with his parents again. He was referred to the Flinders Medical Centre neurology seizure clinic for follow up in six months. He was also booked for an MRI and EEG to occur in September 2021. Mr Provis was commenced on thiamine and atorvastatin. He remained with his parents for five days but began to show signs of confusion again and wanted to go home.

17 On 28 August 2021 Mr Provis returned to his home, with his parents advising they would visit him the following day.

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[3] Exhibit C8
[4] Exhibit C8, page 3
[5] Exhibit C1a
[6] Exhibit C1a, page 2
[7] Exhibit C1a, page 3

18 On 29 August 2021 Mr Provis' parents attended his home for a visit and took him for a drive around Port Adelaide, something he usually enjoyed. Mr Provis' father stated that upon returning home:

> 'Adam went inside and we thought he was going inside to get his clothes to come back to our place. Instead, Adam took his clothes off and lay on the floor, he said, "I'm dead".'

19 Mr Provis' father called an ambulance, and Mr Provis was admitted to The Queen Elizabeth Hospital presenting with 'confusion, paranoia and a seizure from an unknown cause'.[8]

20 On 2 September 2021 Dr Alan Xu assessed Mr Provis noting his presentation to hospital with acute onset behavioural disturbance of one to two days characterised by disinhibited behaviour disrobing at home and the suspected seizures. Whilst in hospital Mr Provis was observed as more confused and disorganised, verbally and physically aggressive, and it was thought that he might be experiencing auditory hallucinations along with paranoid ideation. Dr Xu placed Mr Provis under a level 1 ITO.

21 On 9 September 2021 Dr Bhargavraman Parthasarthy assessed Mr Provis noting that his behavioural disruption and confusion had settled significantly, however he continued to be paranoid with recent memory impairment leading to confusion and disorganisation. He noted the risk of aggression remained high and imposed a level 2 ITO. According to his father, Mr Provis fluctuated in his levels of confusion during this time.

22 MRI scans conducted on Mr Provis on 31 August 2021 showed abnormalities compatible with subacute lacunar infarcts.[9]

23 On 15 September 2021 Mr Provis attended a case conference with the neuropsychiatry team at the Royal Adelaide Hospital with a view to diagnosing and determining how best to treat him. As a result of this conference, it was determined that Mr Provis' presentation was consistent with 'atypical manic phase of bipolar affective disorder'.[10]

24 Mr Provis' level 2 ITO was revoked on 16 September 2021 to facilitate his discharge to the Western Intermediate Care Centre where he could recover with the aim of returning to work.

25 Mr Provis was admitted to the Western Intermediate Care Centre on 21 September 2021. His initial assessments suggested an emerging schizoaffective disorder. He was prescribed medication including sertraline and valproate.[11] Over the course of the next several days his condition deteriorated. On assessment on 29 September 2021, he had recently developed right-side weakness in his hand and foot. He had marked fluctuations in his confusion, especially with disorganised thoughts and behaviours and mild dysarthria. He was diagnosed with sub-acute delirium, or as experiencing catatonic features of his new psychotic illness.

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[8] Exhibit C14
[9] Exhibit C2a
[10] Exhibit C7, page 2
[11] Exhibit C13

26 A level 1 ITO was put in place on 29 September 2021 by Dr Gupta and Mr Provis was transferred to The Queen Elizabeth Hospital. He had been noted as very confused and having problems with his communication.

27 On 6 October 2021 Dr Okungu assessed Mr Provis and identified that his mental state was at risk of further decline. She imposed a level 2 ITO on this date. This is the order Mr Provis was subject to at the time of his death.

28 Mr Provis was transferred to the RAH later that day in accordance with his care plan.

29 Mr Provis was to remain on a level 2 ITO until 17 November 2021 within the acute mental health ward of the RAH. His regular medications were to continue, and future cognitive screening was to occur. There was an aim for further neuropsychology team input and further functional assessments to determine deficits in caring for himself.

30 In the days leading to Mr Provis' death, he continued to display confused, disorientated and paranoid behaviours during interactions with hospital staff.

31 At about 6:34am on Sunday 17 October 2021 Mr Provis had visual observations conducted. At approximately 8am registered nurse Christina Crossman attended to administer medication to Mr Provis. She located him unresponsive and called a code blue. CPR was commenced, however was unsuccessful and Mr Provis was pronounced life extinct at 8:31am.

Discussion re cause of death

32 In his report Dr Langlois provided a comprehensive categorisation and review of the clinical care and investigations undertaken by the medical professionals responsible for Mr Provis' care.[12]

33 Dr Langlois found evidence of the mini strokes detected at The Queen Elizabeth Hospital. Unusually though, he could not identify the source of the infarctions. He noted that the MRI findings[13] were supported in the post-mortem discoveries.

34 Dr Langlois noted the history and clinical notes and stated that behavioural changes could be the result of a mini stroke or an epileptic event, or both.[14] It was not possible to determine post-mortem. Of note, seizure activity may not be physically observed, and even though he had commenced anti-seizure treatment, it may not be effective.

35 I am satisfied that Dr Langlois' opinion as to cause of death is correct and appropriate and I find the cause of Mr Provis' death to be in-hospital cardiac arrest on a background of seizures and atheroembolic cerebrovascular disease.

36 According to Dr Langlois this would not have been a straightforward case for Mr Provis' treating team. For example, there was clear evidence of the lacunar infarcts during investigations, yet Dr Langlois was unable to locate a source for those.

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[12] Exhibit C2a, pages 2-3
[13] MRI undertaken on 31 August 2021 at TQEH
[14] Exhibit C2a, page 5

Coronial investigation and conclusions

37 Detective Brevet Sergeant Hannah Stirling of Western District Criminal Investigation Branch was the investigating officer in this matter and provided a comprehensive report assessing the lawfulness of custody and the adequacy of the treatment provided to Mr Provis.[15]

38 Detective Stirling stated that she did not identify any deficiency in the treatment or care provided whilst Mr Provis was a patient at The Queen Elizbeth Hospital, the Flinders Medical Centre, Western Intermediate Care Centre or the Royal Adelaide Hospital.

39 I note that Mr Provis' father stated he was 'happy' that his son was 'cared for properly' in the lead up to his death.[16]

40 I find that the ITOs imposed on Mr Provis were both valid and appropriate and that the care and treatment he received during his admissions was appropriate.

Recommendations

41 I make no recommendations in this matter.

Keywords: *Death in Custody; Inpatient Treatment Order*

[15] Exhibit C11
[16] Exhibit C1a, page 6