



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 13th day of March 2009 and the 11th day of September 2009, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Peter Langford.

The said Court finds that Peter Langford aged 64 years, late of no fixed address died at the Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 30th day of November 2007 as a result of hospital acquired pneumonia on a background of end-stage cryptogenic liver cirrhosis. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

- 1.1. Mr Peter Langford, 64 years of age, died on 30 November 2007 while a patient at the Flinders Medical Centre (FMC). He had been admitted to the FMC on 18 October 2007 and remained there until the date of his death. The clinical picture during the course of Mr Langford's admission to the FMC and his ultimate cause of death is all clear. When Mr Langford died, a doctor's certificate of cause of death pursuant to the Births, Deaths and Marriages Registration Act 1996 was completed by Dr Danielle Blunt who had been one of the medical practitioners responsible for Mr Langford's care. As a matter of law the death certificate should not have been completed. This is due to the fact that the death was a death in custody and for that reason needed to be reported to the State Coroner pursuant to the provisions of the Coroners Act 2003.

- 1.2. However, there is no suggestion that the cause of death as set out in the doctor's certificate is in any way inaccurate. The cause of death as described in the certificate is:

- 'A Hospital Acquired Pneumonia
- B End-stage Cryptogenic Liver Cirrhosis'¹

Under the part of the document that describes other significant conditions and their duration, Dr Blunt has written 'ischaemic heart disease' of a duration of '25 years'. It appears that at some point in his life Mr Langford had been diagnosed with unstable angina. The role that ischaemic heart disease may ultimately have played in Mr Langford's death is not clear. However, that Mr Langford died of hospital acquired pneumonia and end-stage cryptogenic liver cirrhosis is quite clearly established on the evidence. The liver cirrhosis being cryptogenic in nature, as I understand it, is of an unexplained origin and is not necessarily associated with alcohol abuse. I add here that members of Mr Langford's family who have provided statements to the Inquest would suggest very strongly that Mr Langford was not an alcohol abuser. As indicated earlier, a doctor's certificate of cause of death was completed, albeit erroneously, by Dr Blunt. I nevertheless accept her assessment as to the cause of Mr Langford's death. I find that the cause of Mr Langford's death is hospital-acquired pneumonia on a background of end-stage cryptogenic liver cirrhosis. The statement as to the cause of death need make no reference to any underlying ischaemic heart disease which in any case does not appear to have had any significant bearing on the cause of death.

- 1.3. The reason this matter was ultimately reported to the State Coroner, and the reason why this Inquest has taken place, is that Mr Langford's death was a death in custody as defined in Section 3 of the Coroners Act 2003. FMC clinical staff originally overlooked the fact that Mr Langford had died while in custody. I set out relevantly the definition of death in custody:

'Death in custody' means the death of a person where there is reason to believe that the death occurred, or the cause of death, or a possible cause of death, arose, or may have arisen, while the person

- (a) was being detained in any place within the State under any Act or law, including any Act or law providing for home detention (and, for the purposes of this paragraph, a detainee who is absent from the place of his or her detention but is

¹ Exhibit C16I

in the custody of an escort will be regarded as being in detention, but not otherwise);'

During the course of Mr Langford's hospitalisation at the FMC it had been necessary for him to be detained pursuant to the Mental Health Act 1993 (MHA). I explore the reasons for that below. In the event, shortly before Mr Langford's death on 30 November 2007, the detention order was revoked because it was no longer considered to be necessary having regard to the fact that Mr Langford's health had by then reached a very low ebb. However, during the period of detention, Mr Langford had acquired the pneumonia that was eventually assigned as his principal cause of death. It will be seen from the above definition of death in custody that the definition applies in a scenario where the cause of the death arose while the person was being detained. Thus, although when Mr Langford died he was not the subject of a detention order, his cause of death had arisen while he had been detained under such an order. Therefore his death should have been viewed as a death in custody.

- 1.4. The fact that this was a death in custody was not at first appreciated by medical staff at the FMC. Dr Blunt's doctor's certificate of death was compiled as there was no doubt about the cause of Mr Langford's death and his death would not have been reportable to the State Coroner for any other reason. However, the fact that Mr Langford's death was a reportable death in custody meant that the doctor's certificate should not have been completed.
- 1.5. This is not the only occasion in which staff at the FMC have failed to report a death in custody. In this regard, I refer to my findings in relation to the death of Hans Heinrich Von Spreckelsen² delivered on the same day as these in which a FMC staff failed to appreciate that Mr von Spreckelsen's detention order was actually still extant at the time of his death.
- 1.6. The mandatory Inquest into Mr Langford's death was heard by the Coroner's Court as constituted by me.

² Inquest 24/2008

2. The relevant provisions of the Mental Health Act 1993

2.1. Before discussing the circumstances of Mr Langford's hospitalisation, detention and death, I should briefly explain the regime of detention that the MHA provides for. Section 12(1) of the MHA enables a medical practitioner to make an order for the immediate admission and detention of a person in an approved treatment centre where the medical practitioner is satisfied of a number of matters: firstly that a person has a mental illness that requires immediate treatment, secondly that such treatment is available in an approved treatment centre and thirdly that the person should be admitted as a patient and detained in an approved treatment centre in the interests of his or her own health and safety or for the protection of other persons. Section 12(2) of the Act provides that such a detention order expires 3 days after the day it is made unless it is earlier revoked. A person so detained must be examined by a psychiatrist within 24 hours of the patient's admission to the approved treatment centre or, where that is not practicable, as soon as is practicable after that admission. The examining psychiatrist must consider whether the continued detention of the patient is justified or not. If the psychiatrist is not satisfied that the continued detention of the patient is justified, the psychiatrist must revoke the order. Otherwise, the psychiatrist will confirm the order. If the psychiatrist confirms the order, this has the effect of continuing the 3-day period that had been activated by the original detention order. Before the expiry of that 3-day period, a further order for detention for a period up to 21 days may be imposed. A second 21-day order may be imposed upon the expiry of the first such order. A 21-day order may be revoked at any time during the currency of the order. Mr Langford had been subjected to the regime of detention that I have just described and had been detained under a first 21-day order. It was this order that had been revoked shortly before his death.

2.2. In circumstances where there is no question of a dying patient absconding or harming themselves or others, one can well understand clinical staff being reluctant to unnecessarily maintain the patient's MHA detention. I have recently referred to this very issue in my findings in the matter of the death of Peter David Lawrence³. I perhaps should add to what I said there that as the circumstances of this case illustrate, the revocation of detention imposed under the MHA prior to and in anticipation of a detained person's death will not necessarily avoid the rigours of the Coroners Act

³ Inquest 41/2008, Finding Delivered 7 August 2009

2003. As I indicated earlier, a question might remain as to whether the cause of death arose, or may have arisen, during the period of detention, that is to say at a time before the detention was revoked.

- 2.3. The new Mental Health Act 2009, which replaces the Mental Health Act 1993, has received the assent of the Governor in Executive Council on 11 June 2009 and will come into operation on 1 July 2010. The new legislation makes provision for the possible revocation of detention orders at all stages. The new legislation will not in any way circumscribe the obligation to report deaths in custody to the State Coroner, either in terms of the obligation generally or in respect of the various circumstances in which the obligation is enlivened.

3. **Background**

- 3.1. Mr Langford was married and had one daughter, Sandra Lee Langford, who was born in 1985.
- 3.2. Mr Langford and his family were itinerant. There were periods over the years during which the family lived out of a motor vehicle. It appears that in the period prior to Mr Langford's admission to hospital in October 2007, the family had been living out of their car.
- 3.3. In 1991 Mr Langford spent a period of admission in the Royal Adelaide Hospital where he was diagnosed with unstable angina. Following this episode he was discharged. It appears that for the most part Mr Langford had an aversion to doctors and medical treatment. For instance, it has been revealed that Mr Langford discharged himself from the Royal Adelaide Hospital in 1991 and clinical records reveal that he only had the one check up afterwards.
- 3.4. By the time Mr Langford was admitted to the FMC on 18 October 2007, his health had declined quite dramatically and his admission to hospital for treatment was long overdue. According to Sandra Langford's statement⁴, around the Queen's birthday weekend in 2007 her father started complaining about a sore and swollen left leg. They were living in their car at that stage. On 14 August 2007 Mr Langford's wife, Eugenia Langford, attended at the surgery of a Dr Phillip Thompson at Seaton. Mr Langford remained in the car while Mrs Langford went into the surgery. Dr

⁴ Exhibit C1b

Thompson provided a statement to the Inquest⁵ and describes the incident. Dr Thompson had to examine Mr Langford in the car as the latter was too weak to alight and walk to the surgery. Mr Langford had severe swelling of both legs and serum was oozing from them. Dr Thompson thought that Mr Langford may have been suffering from congestive cardiac failure but was unable to examine Mr Langford properly due to his position in the car and his inability to come into the surgery. Mr Langford refused investigations that would have involved hospital admission such as chest X-rays and cardiographs. Dr Thompson also thought that Mr Langford may have required a transfusion but Mr Langford made it clear that he did not want to go to hospital. Dr Thompson prescribed some medicine for Mr Langford in an effort to manage the suspected cardiac failure.

- 3.5. According to his daughter Sandra, Mr Langford displayed what can only be described as alarming symptoms that involved one of his legs copiously leaking fluid. As well as that, her father suffered a dramatic loss of weight. She describes his overall health as deteriorating quite significantly.
- 3.6. Mr Langford returned to see Dr Thompson on 11 September 2007. Dr Thompson again saw Mr Langford in his vehicle as the latter was again unable to make his way into the surgery. On this occasion Mr Langford's legs were settling and the swelling had reduced. His breathing was better but he complained of loose stools and abdominal pain. Dr Thompson prescribed some further medication.
- 3.7. On 17 October 2007, the day before Mr Langford's admission to FMC, Mr Langford again presented to Dr Thompson's surgery and again Dr Thompson was forced to see Mr Langford in the vehicle. Mr Langford's legs were still oozing, he had persistent diarrhoea and he was not eating properly. Dr Thompson records that at that stage it was obvious that Mr Langford needed hospital treatment. There was obvious infection in his legs so Dr Thompson prescribed an antibiotic. Dr Thompson states that there was so much serum oozing from Mr Langford's legs that his pants were stuck to his legs. Naturally Mr Langford's wife, Eugenia, was anxious for her husband to attend hospital. Dr Thompson clearly shared that view and to that end he wrote out a referral to the FMC. Evidently Mr Langford indicated that he was willing to go to the FMC but would not entertain the idea of going to the Queen Elizabeth

⁵ Exhibit C12a

Hospital. In the event, he was taken to the FMC the following day after a serious collapse.

- 3.8. 17 October 2007 was the last occasion on which Dr Thompson saw Mr Langford. Dr Thompson sums up Mr Langford's attitude to medical treatment as follows:

'He was determined to not have any serious medical interventions to assist his health.'⁶

- 3.9. The other complicating feature of Mr Langford's declining condition was that he had also developed an aversion to taking proper sustenance because of his chronic diarrhoea.

- 3.10. According to Sandra Langford, on 18 October 2007 Mr Langford collapsed in a toilet at Semaphore Beach. He could not walk. His left leg was very badly affected. He was taken by car to the FMC.

- 3.11. By the time Mr Langford presented to the FMC on 18 October 2007 he was by all measures extremely ill. His presentation on admission prompted one of the nursing staff who worked in the FMC Intensive and Critical Care Unit (ICCU) and who examined Mr Langford at the time to observe:

'I was astonished that he was able to function in his lifestyle without medical intervention.'⁷

4. Mr Langford's hospitalisation and detention

- 4.1. A number of statements of the medical and nursing practitioners responsible for Mr Langford's care were tendered to the Inquest. I have already mentioned Dr Danielle Blunt as being one of those practitioners⁸.

- 4.2. Mr Langford was admitted to the FMC on 18 October 2007 with a diagnosis of left leg cellulitis. Attempts were made to treat this florid condition but they were unsuccessful. As a result Mr Langford's left leg required amputation above the knee. The amputation took place on 21 October 2007, which was at a time prior to Mr Langford's detention under the MHA.

⁶ Exhibit C12a, page 4

⁷ Exhibit C8a, Amy Louise Waters, Registered Nurse

⁸ Exhibits C5a and C5b

- 4.3. Mr Langford was also diagnosed with cirrhosis of the liver of a cryptogenic origin, meaning that the cause was unclear.
- 4.4. Although Mr Langford's aversion to medical treatment was established even before he entered the FMC, his deteriorating condition in hospital if anything only exacerbated his reluctance to accept necessary medical treatment. Although the above knee amputation wound responded reasonably well following surgery, Mr Langford refused medical intervention from both medical and nursing staff and from allied health practitioners such as physiotherapists. Investigations into both the underlying cause of his cirrhosis as well as the complications that had arisen throughout his admission were refused. He also refused essential medication for his treatment and, by his refusal, he was becoming more ill. Of importance was the fact that his refusal of treatment for liver cirrhosis meant that he became encephalopathic. This condition is an acute confusional state caused by the accumulation of toxins that would normally be eliminated by the liver. It is usually characterised by delirium.
- 4.5. Up to and including 14 November 2007, the date when Mr Langford was first detained, he was refusing to allow investigations and tests such as nasogastric feeding, scans and X-rays. He also refused to eat meals that were supplied by the hospital, preferring to eat food that was brought in by his wife. This only served to complicate Mr Langford's already malnourished condition and was of further detriment to his liver function. Mr Langford suffered from ascites, which is a build-up of fluid within the abdomen, and the poor diet that was being supplied to him was adding to the complications of that.
- 4.6. Mr Langford also initially showed reluctance to participate in physiotherapy that was designed to aid in his rehabilitation post amputation. Between 31 October and 7 November 2007 Mr Langford refused to participate altogether. The refusal of physiotherapy slowed down his recovery. The lack of physical activity also had the potential to lead to the development of lung complications. Sedentary patients, be they healthy or unhealthy, are at an increased risk of developing serious lung conditions such as pneumonia. One factor that can result in this is compromised inflation in certain areas of the lungs. For physiotherapy to be effective, the patient must be able and willing to cooperate with the interventions. Although he became more compliant as time went by, Mr Langford still demonstrated reluctance to

undergo physiotherapy and, as a result, his overall progress with rehabilitation was slow.

- 4.7. According to Ms Amy Waters, a registered nurse within the ICCU at FMC⁹, Mr Langford had little insight into the seriousness of his predicament.
- 4.8. A Ms Julieanne O'Connor, a senior social worker employed by FMC, provided a statement to the Inquest¹⁰. Ms O'Connor had contact with both Mr Langford and his wife and daughter. Ms O'Connor's perception of the family was that they all had difficulty understanding the medical procedures that were being undertaken. Mrs Langford and her daughter were very concerned about Mr Langford but Ms O'Connor's impression was that they did not really grasp the gravity of the situation. The statements of both Mrs Langford and Sandra Langford express concern about some aspects of Mr Langford's treatment, and in particular as to the necessity for his detention. However, according to Ms O'Connor, aside from them not really grasping the seriousness of the situation, she believed that Mrs Langford and her daughter also had difficulty coming to terms with Mr Langford's loss of cognitive abilities.
- 4.9. Ms O'Connor and other social workers attempted to encourage Mr Langford to participate in physiotherapy. However, it was evident that he lacked insight into the need to comply with medical treatment and physiotherapy, saying that he wanted to go home. His cognitive state and willingness to participate in therapy fluctuated according to Ms O'Connor. On some days he participated and on other days he did not. Overall he lacked the understanding and insight into the need to participate in treatment.
- 4.10. Eventually Mr Langford was detained under the MHA by virtue of a Form 1 under the regulations. This detention was administered by a Dr Lin who was an intern within the gastroenterology team at FMC. Although an intern, he was authorised to detain patients under the MHA. Psychiatric evaluation is only required for the first time at the time of confirmation of the original order. Dr Lin furnished the Inquest with a statement¹¹. Dr Lin refers to Mr Langford's chronic liver disease and the resulting hepatic encephalopathy. He also refers to his non-compliance with medication despite ongoing advice and repeated encouragement. As well, Dr Lin was aware of

⁹ Exhibit C8a

¹⁰ Exhibit C9a

¹¹ Exhibit C13a

Mr Langford's refusal to undergo the necessary medical investigations relative to the causes of his liver disease. Dr Lin says as follows:

'Throughout his stay under our care there was an ongoing concern as to whether he was in a position to make informed decisions about his medical care, owing to the continual impaired judgement with regards to his own health. His impaired judgement could have been a result of hepatic encephalopathy and/or delirium.'¹²

It can be seen from other practitioner's assessments of Mr Langford that Dr Lin's assessment, as encapsulated in that paragraph above, was correct.

4.11. On 13 November 2007 a mini-mental examination (MMSE) was performed and the result suggested that there was severe cognitive impairment in Mr Langford.

4.12. On 14 November 2007, Dr Lin discussed Mr Langford's case with a member of the psychiatry team and a plan was formulated that in light of Mr Langford's current presentation, urgent attention was indicated. After further discussion with Dr Blunt, Dr Lin formally detained Mr Langford at 2:45pm on 14 November 2007. The Form 1 sets out his grounds as follows:

'Refusal of medical treatment investigations, MMSE of 13/30, and likely incapable of making decisions with regard to his own medical treatment.'

4.13. As seen earlier, the original detention order made by Dr Lin needed to be reviewed within 24 hours. The review was conducted by Dr Martha Kent who is a psychiatrist¹³. On 15 November 2007 she was working as a consultation liaison psychiatrist with the responsibility to review patients in the hospital who required psychiatric evaluation. That day she examined Mr Langford. He was reasonably cooperative but seemed wary and demoralised. Initially he agreed to stay in the hospital and consented to further investigations and treatment but later in the interview he changed his mind. To Dr Kent he demonstrated some features of cognitive impairment that was entirely consistent with the presence of multiple medical illnesses. He was significantly disoriented and his short-term memory was patchy. On physical examination he showed a positive grasp reflex on the right hand which indicated frontal lobe impairment, a physical sign consistent with cognitive impairment. Dr Kent formed the view that Mr Langford required further investigation into his liver complications and brain function but thought that he was unlikely to

¹² Exhibit C13a, page 3

¹³ Exhibit C11a

provide consent to any further intervention in that regard. As a result, Dr Kent confirmed his detention under the MHA by way of the completion of a Form 2 at 11:52am on 15 November 2007. The form refers to Mr Langford's inability consistently to consent to necessary medical treatment.

4.14. Dr Kent's confirmation of the order meant that Dr Lin's original order stood for a period of 3 days. On 17 November 2007 Mr Langford required further review under the MHA. This review was conducted by a psychiatrist, Dr Andrew Champion, who provided a statement to the Inquest¹⁴. Dr Champion reviewed Mr Langford's psychiatric notes and noted that Mr Langford had been admitted to the hospital with multiple medical conditions including liver failure that may have been contributing to his confused state. Dr Champion reviewed Mr Langford at his bedside at 1:50pm and observed that Mr Langford showed evidence of cognitive impairment. He was unable to state his correct age, was disoriented in time and he displayed behaviour whereby he would answer some questions with an answer that related to previous questions, sometimes repetitively. Dr Champion was satisfied that Mr Langford was suffering from a mental illness that required further treatment in relation to the health and safety of Mr Langford himself. Dr Champion's main concern was that Mr Langford was unable to make competent decisions to refuse treatment or to discharge himself from hospital. He therefore completed a Form 3 under the regulations and further detained Mr Langford for a period of 21 days from that day. The purpose underlying the order was to allow for Mr Langford to be treated by medical staff to a point where he was capable of making informed decisions as to further treatment. It was evident that Mr Langford required such intervention.

4.15. Although the primary focus was on treatment for Mr Langford's physical illness, in my view the detention was authorised under Section 12(1) of the MHA. His delirium and general confused state could be characterised as an 'illness or disorder of the mind' in accordance with the definition of mental illness in Section 3 of the MHA. That mental illness itself required immediate treatment because it was the very reason Mr Langford was refusing treatment for his life-threatening physical illness. His detention was therefore necessary in the interests of his health and safety. It is to be observed that the MHA is not solely confined to the compulsory treatment of mental illness. Section 18 authorises the treatment of a detained patient in an approved

¹⁴ Exhibit C10

treatment centre not only for the mental illness that is the catalyst for the detention, but for any other illness. Such treatment may be given notwithstanding the absence or refusal of consent of the detained person or any other person. In my view therefore, Mr Langford was detainable, notwithstanding that the primary motivation of the person detaining him was the treatment of a physical illness.

- 4.16. In my opinion Mr Langford's detention was at all times lawful and indeed highly appropriate.
- 4.17. Dr Steven Due, who was another practitioner responsible for Mr Langford's care at the FMC, describes some of Mr Langford's progress subsequent to his original detention. He says in his statement that from that point the detention meant that medical staff were allowed to conduct necessary investigations and management of Mr Langford's medical condition, such as insertion of the nasogastric tube to allow proper feeding. Abdominal paracentesis which is designed to drain ascites as a result of liver disease was also instigated. Mr Langford was also given lactulose for hepatic encephalopathy. This measure is designed to reduce the accumulation of the toxins that create the confusional state. After the administration of lactulose, Mr Langford's hepatic encephalopathy improved as did his cognitive function in part.
- 4.18. On 23 November 2007 an endoscopy was performed in respect of Mr Langford. Oesophageal varices were discovered, a life-threatening condition giving rise to haemorrhage. Variceal bands were applied. Oesophageal varices are another complication of cirrhosis of the liver.
- 4.19. When Mr Langford was originally admitted he had been subjected to a chest X-ray. There were certain possible pathologies noted on this occasion including bilateral infiltrates. He had been placed on antibiotics that were specific chest targeting antibiotics.
- 4.20. Dr Blunt's statement of 3 April 2008¹⁵ and Dr Due's statement dated 30 January 2008¹⁶ reveal that on 26 November 2007 Dr Blunt diagnosed Mr Langford with hospital-acquired pneumonia. This diagnosis was made in conjunction with radiological evidence in the form of a chest X-ray showing a consolidation in his left lung. Dr Blunt took active measures to treat this condition including antibiotic

¹⁵ Exhibit C5b

¹⁶ Exhibit C6a

therapy. The development of hospital acquired pneumonia is not an uncommon occurrence. Dr Blunt suggests in her statement that an endoscopy that was performed on 23 November 2007, in which a life-threatening bleed was detected, may have caused some aspiration due to the nature of the procedure. Aspiration can cause pneumonia. However, Dr Blunt cannot definitely say if this occurred in Mr Langford's case. The time of onset, being 3 days after the procedure had been conducted, is not necessarily in keeping with pneumonia from that cause.

- 4.21. From 26 November 2007 Mr Langford's condition worsened dramatically, notwithstanding vigorous treatment. On 27 November 2007 Mr Langford was subject to a medical emergency team call. This was the result of reduced oxygen saturation. At that time a decision was contemplated that Mr Langford would not be for resuscitation in the event of a cardio-respiratory arrest. This decision was confirmed in consultation with Mr Langford's wife and daughter on 28 November 2007. Mr Langford nevertheless continued to receive active ward measures.
- 4.22. On 28 November 2007 Dr Due was contacted by the psychiatry team. It was decided that the detention order was superfluous as Mr Langford was no longer resisting treatment and was not able to abscond. Dr Due points out that it was the policy of the hospital that persons who are no longer resisting, or likely to abscond, should not be further detained. After consultation with other medical practitioners, Dr Due completed a Form 5 under the regulations and revoked the detention. This took place at 2:30pm on 28 November 2007.
- 4.23. Over the next 36 hours Mr Langford continued to deteriorate with severe sepsis and shock and at 2:10am on 30 November 2007 he passed away.
- 4.24. In conclusion there is no suggestion that Mr Langford's detention under the MHA in any way exacerbated or aggravated his condition. Quite the contrary. The detention was necessary to effect the various remedial measures that could be put in place for Mr Langford's own welfare. Mr Langford was a very sick man even before he entered the FMC. There is no suggestion that Mr Langford's medical treatment was in any way unnecessary, excessive or incompetent. There is also no suggestion that his medical treatment was in any way different from what it would have been but for the detention.

4.25. The only other comment I would make is that if the FMC has not revised its procedures with a view to ensuring that deaths in custody are immediately identified as such, and reported accordingly, then it should do so as a matter of priority.

Key Words: Death in Custody; Natural Causes

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

Seal the 11th day of September, 2009.

Deputy State Coroner

Inquest Number 7/2009 (1751/2007)