

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 5th and 21st days of July, 2000, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of George Henry Landorf.

I, the said Coroner, do find George Henry Landorf, aged 82 years, late of Clements House, Oakden Campus, Fosters Road, Oakden, died at Clements House on the 20th day of February, 2000 as a result of lateral left ventricular myocardial infarction attributed to severe left circumflex chronic calcific stenosis.

1. **Reason for inquest**

1.1 On 29 October 1999 the Guardianship Board of South Australia made an order detaining George Henry Landorf in Hillcrest Hospital for the period up to and including 29 April 2000, pursuant to Section 13 of the Mental Health Act 1993. Accordingly, at the time of his death Mr. Landorf was ‘detained in custody pursuant to an Act or law of the State’ within the meaning of Section 12(1)(da) of the Coroners Act, and an inquest was therefore mandatory pursuant to Section 14(1a) of the said Act.

2. **Background**

2.1 Mr. Landorf was a patient in Clements House, a secure ward at the Oaks, a centre providing psychiatric care to the elderly at Oakden. He was treated by Dr. F.I. Lane. Dr. Lane states that Mr. Landorf suffered from severe and unstable chronic obstructive airways disease for which he required daily treatment. He also suffered from severe dementia. His anxiety often led to physical agitation, which necessitated physical restraint. He had suffered a number of severe falls due to unsteadiness resulting in significant injury (see Exhibit C.6a, p3).

- 2.2 Mr. Landorf was given two tablets of clonazepam before he went to bed at 9.30p.m. on 19 February 2000. When placed in his bed, straps were placed around his waist and secured to the bed. He was checked half-hourly after that time.
- 2.3 At about 12.55a.m., Registered Nurse K.A. Young found him slumped down on the bed with the straps still around his waist. He appeared to have stopped breathing.
- 2.4 Cardiopulmonary resuscitation was commenced and an ambulance was called. The ambulance arrived at about 1.15a.m., and continued with resuscitation attempts for about thirty minutes, until it became apparent that he could not be revived.
- 2.5 Dr. R. Mayo, medical practitioner, attended at about 2.00a.m. and certified Mr. Landorf's life extinct (see Exhibit C.2a).

3. **Cause of death**

- 3.1 A post mortem examination was carried out on the body of the deceased by Dr. R.A. James, forensic pathologist, on 21 February 2000. Dr. James found that the cause of death was lateral left ventricular myocardial infarction attributed to severe left circumflex chronic calcific stenosis. Dr. James commented:-

- “1. No injuries or markings on the body were identified to suggest another person's involvement in the death.
2. The patient apparently had a drug allergy. There were no findings at the post mortem to suggest a drug allergy or anaphylactic reaction played a role in the death.
3. No asphyxial features were present to suggest that the restraints played a role in the death.
4. The bruising noted on the left and right arms would be consistent with bruising related to his prednisolone use.
5. The autopsy confirms that the deceased died naturally from a left lateral ventricular myocardial infarction attributed to his severe coronary atherosclerosis. Contributing factor to his death was his long standing chronic obstructive airways disease (emphysema)”. (Exhibit C.3a, p6).

I accept Dr. James' diagnosis and find accordingly.

4. **Investigation**

- 4.1 Being classified as a death in custody, a protocol developed pursuant to recommendations made by the Royal Commission into Aboriginal Deaths in Custody was put into effect. Acting Detective Sergeant V.A. Scotland attended the scene with Senior Constable Fenwick, and a crime scene officer from Holden Hill Police Station attended and took photographs. Acting Detective Sergeant Scotland's statement

(Exhibit C7a) indicates that he investigated the restraining straps and was satisfied that they played no part in Mr Landorf's death. He concluded that there was no foul play or suspicious circumstances, that Mr Landorf's death was from natural causes, and that there were no grounds for criticism of the treatment he received at Clements House.

- 4.2 Senior Constable Fenwick has also provided me with a detailed and thorough outline of the investigation (Exhibit C.8a). A thorough examination of the scene was undertaken, relevant exhibits including medication records and casenotes were seized, and records were also obtained from the Queen Elizabeth Hospital detailing treatment Mr. Landorf received there. From the investigations carried out, and Mr. Fenwick's very thorough and helpful report, I am satisfied that there is nothing arising from Mr. Landorf's death which requires further investigation.

5. **Recommendations**

- 5.1 Senior Constable Fenwick's report concludes:-

“There is no evidence to suggest that any procedure adopted by any health service had an effect on the death of George Henry Landorf. Accordingly, there are no recommendations to be made in relation to his care, or their duty of care”. (Exhibit C.8a, p7).

I agree with Mr. Fenwick's conclusions and make no recommendations pursuant to Section 25(2) of the Coroners Act.

Key Words: death in custody; dementia

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

Seal the 21st day of July, 2000.

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Coroner