CORONERS ACT, 1975 AS AMENDED

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 15th of May 2001, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Brian Murray Roberts.

I, the said Coroner, find that Brian Murray Roberts, aged 76 years, late of Downey House, Glenside Hospital, 226 Fullarton Road, Eastwood, South Australia, died at The Royal Adelaide Hospital, North Terrace, Adelaide, South Australia, on the 27th of May 2000 as a result of respiratory failure secondary to right pneumonectomy and chronic obstructive airways disease. I find that the circumstances of death were as follows.

1. Reason for inquest

1.1. On 19 May 2000, Dr T Page and Dr S Heint, both Psychiatrists, made an order pursuant to Section 12(6) of the Mental Health Act 1993 that Mr Roberts should be detained in Glenside Hospital for a period of 21 days. Accordingly, at the time of his death, Mr Roberts was 'detained in custody pursuant to an Act or law of the State' within the meaning of Section 12(1)(da) of the Coroner's Act, and an inquest was therefore mandatory pursuant to Section 14(1a) of the said Act.

2. Background

2.1. Mr John Roberts states that his father had surgery for lung cancer approximately 25 years ago in which his right lung was removed. He said that his father continued to suffer severe pain from the scarring left by the operation, but, notwithstanding this, he continued to smoke until his death. (Exhibit C3a, p1).

2.2. In the last few years, Mr Roberts suffered repeated severe respiratory infection, requiring long admissions to Flinders Medical Centre.

2.3. In August 1999 Mr Roberts became a resident at Warekila Lodge at Aberfoyle Park. After that time he began showing signs of dementia, which gradually became worse to the extent that, in January 2000 he was admitted to the Daw Park Repatriation General Hospital's psychiatric unit.

2.4. Unfortunately, Mr Roberts' condition continued to deteriorate to the extent that, on 27 April 2000, Dr Soetretma made an order pursuant to Section 12(1) of the Mental Health Act 1993 for Mr Roberts' admission and detention to Glenside Hospital. This order was confirmed pursuant to Section 12(4) of the Mental Health Act 1993 by Dr T Page on 28 April 2000 and on 30 April 2000 an order was made by Dr Joanne Pieters, Psychiatrist, pursuant to Section 12(5) of the Mental Health Act 1993 detaining Mr Roberts for 21 days. On 19 May 2000, Doctors Page and Heint made an order pursuant to Section 12(6) of the Mental Health Act 1993, further extending the period of detention, as I have already mentioned.

2.5. On 19 May 2000, Mr Roberts appeared drowsy and flat and, although he had no overt signs of infection, further tests were ordered.

2.6. On 21 May 2000, Mr Roberts collapsed and was noted to be suffering Adult Respiratory Distress Syndrome. He was transferred to the Royal Adelaide Hospital.

2.7. Dr Ho Ly noted that he had acute respiratory distress. Unfortunately his condition continued to deteriorate, despite intravenous antibiotics, steroids, nebulised bronchodilators and prophylactic clexane. (Exhibit C4a, p2).

2.8. On 24 May 2000 decisions were taken by the treating specialists in consultation with the family that Mr Roberts would receive comfort care only and this was maintained until 0130 hours on 27 May 2000 when he died.

2.9. Mr Roberts' life was formally pronounced extinct by Dr Greg Rice. (Exhibit C2a).

3. Cause of Death

3.1. Dr Ly suggested that the cause of death was respiratory failure secondary to right pneumonectomy and Chronic Obstructive Airways Disease. (Exhibit C4a, p3). I accept Dr Ly's opinion, and find accordingly.

3.2. On the basis of Dr Ly's opinion I find that the cause of Mr Roberts' death was unrelated to his detention at Glenside Hospital and the Royal Adelaide Hospital.

3.3. The investigation into this death has revealed no grounds for concern about the quality of the treatment given to Mr Roberts during his period in custody.

4. Recommendations

4.1. There are no recommendations pursuant to Section 25(2) of the Coroner's Act.

Key Words: Death in Custody

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 16th day of May, 2001.

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Coroner

Inq.No. 8/01