CORONERS ACT, 2003

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 24th day of February 2011, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Asta Silland.

The said Court finds that Asta Silland aged 83 years, late of Oaklands Residential Care Facility, 2 Jean Street, Oaklands Park, South Australia died at Oaklands Park, South Australia on the 8th day of June 2009 as a result of massive pulmonary thromboembolism due to left lower leg deep venous thrombosis. The said Court finds that the circumstances of her death were as follows:

1. Introduction and reason for Inquest

1.1. This is an Inquest into the death of Asta Silland who was 83 years of age at the time of her death on 8 June 2009 at Oaklands Residential Care Facility in South Australia.

1.2. At the time of her death she was subject to an order of the Guardianship Board requiring that she be detained at that facility and, accordingly, hers was a death in custody as defined in the Coroners Act 2003 and an Inquest was required to be held pursuant to s21(1)(a) of that Act.

2. Cause of death

2.1. An autopsy was conducted by Dr Herbst, a forensic pathology registrar, on 11 June 2009 and he prepared a report dated 19 August 2009[1]. He gave the cause of death as

[1] Exhibit C2a

massive pulmonary thromboembolism due to left lower leg deep venous thrombosis and I so find.

3. Background

3.1. I find that on the evidence and, in particular, having regard to the investigating officer's report, that of Senior Constable Przibilla[2], she was lawfully detained and accordingly there was no difficulty in relation to the status of her custody at the time of her death.

3.2. I find on the basis of Senior Constable Przibilla's investigation that the circumstances of Ms Silland's care at Oaklands Residential Care Facility were of a reasonable and appropriate standard and that the facility was clean, well-maintained and of a generally high standard.

3.3. The facility is a secure facility and it is maintained in that manner to prevent dementia patients from wandering and causing themselves harm.

3.4. Ms Silland had been diagnosed with Alzheimer's Dementia in February 2009 and the symptoms and effects of that disease resulted in the guardianship order to which I have already referred. Her mental status was such that she was unable to care for herself properly and she had short-term memory loss.

3.5. The Oaklands Residential Care Facility provided for night staff to check on residents three times during the night shift at approximately 11pm, 2am and 6:30am. Ms Silland was checked in her room at 11:15 pm and was seen to be well. She was last seen going to the toilet at approximately 2am where she was subsequently found deceased in the toilet cubicle at 5:15am.

3.6. It is clear that the deceased collapsed and died shortly after going to the toilet and it is a matter of some concern that she was not found for some three hours. In any event, the cause of death is such that I am satisfied that the failure to detect Ms Silland for that period of three hours was in no way causative of her death and I say no more than that the matter, although concerning, had no significant impact.

3.7. In summary, Ms Silland died as a result of a massive pulmonary thromboembolism causing her to collapse while in the toilet cubicle and she was detected in there some

[2] Exhibit C17a

three hours later and then appropriate steps were taken by staff at the facility to notify the ambulance service by whom death was subsequently certified.

4. Recommendations

4.1. I have no recommendations to make in this matter.

Key Words: Death in Custody

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 24th day of February, 2011.

State Coroner