



## FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 24<sup>th</sup> day of April 2013, the 13<sup>th</sup> day of November 2013 and the 13<sup>th</sup> day of August 2015, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Murray Lawrence Abinett.*

*The said Court finds that Murray Lawrence Abinett aged 81 years, late of Yeltana Nursing Home, 25 Newton Street, Whyalla, South Australia died at the Repatriation General Hospital, Daws Road, Daw Park, South Australia on the 11<sup>th</sup> day of May 2011 as a result of aspiration pneumonia complicating end stage fronto-temporal dementia on a background of chronic obstructive lung disease, ischaemic heart disease and chronic renal failure. The said Court finds that the circumstances of his death were as follows:*

### **1. Introduction, cause of death and reason for Inquest**

- 1.1. Mr Murray Lawrence Abinett was 81 years of age when he died at the Repatriation General Hospital on 11 May 2011. The cause of Mr Abinett's death was aspiration pneumonia complicating end stage fronto-temporal dementia on a background of chronic obstructive lung disease, ischaemic heart disease and chronic renal failure. That cause of Mr Abinett's death is stated within the pathological review of Dr Iain McIntyre of Forensic Science South Australia. Dr McIntyre's opinion is derived from his examination of Mr Abinett's clinical casenotes from the Repatriation General Hospital, the Lyell McEwin Hospital and the Yeltana Nursing Home. I accept Dr McIntyre's opinion. It is totally in keeping with Mr Abinett's clinical condition in the final period of his life.

- 1.2. As will be seen below, there is reason to believe that Mr Abinett's cause of death arose during a period of detention under the Mental Health Act 2009. Accordingly, this was a death in custody that required a mandatory Inquest.

## **2. Background and events leading to Mr Abinett's death**

- 2.1. Mr Abinett had a history of several serious medical conditions. They included severe dementia, chronic obstructive pulmonary disease, depression, mood and affective disorders, type 2 diabetes, ischaemic heart disease, hypertension, atrial fibrillation, cardiac arterial bypass graft, incontinence, gout, eczema, renal impairment, angina, a personality disorder and hyperlipidaemia. He was on numerous medications for his conditions, including risperdal, spiriva, frusemide, coloxyl, insulin, serepax and ventolin.
- 2.2. Mr Abinett had lived at home with his family until 28 October 2009 when he was moved to the Whyalla Aged Care Facilities. This entity is made up of several facilities that cater for low care residents through to high care residents. Mr Abinett was first moved to Copper Coast House which was one of the low care facilities. At that time he could still care for himself. On 19 October 2010 he was moved to Yeltana Nursing Home which is a high care facility comprising 48 high care beds, with 25 of those being secure beds with a dedicated dementia unit. Mr Abinett was moved to that facility due to his deteriorating dementia and resultant behaviour.
- 2.3. Mr Abinett was fully dependent by this stage, requiring two staff members to attend to his basic activities of daily living.
- 2.4. Whilst a resident at Yeltana Nursing Home Mr Abinett had a treating general practitioner, Dr Bamford, who visited him regularly. Mr Abinett also had a treating geriatrician, Dr Mykyta, who, although based in Adelaide, saw him quite frequently and was also kept informed about his condition through Dr Bamford.
- 2.5. In March 2011 Mr Abinett had a consultation with Dr Mykyta. There was a concern that he was developing what was described as a Parkinsonian gait, or shuffling of the feet, through his long-term medication. This was resulting in an increase in frequency of falls. After an assessment of his medication he was changed from risperdal to sodium valproate and seroquel. Mr Abinett had to be weaned off of the risperdal and this was completed by 7 April 2011. Even though the risperdal was ceased, Mr Abinett's concerning behaviours continued. He was increasingly aggressive over the ensuing days.

- 2.6. On 9 April 2011 Mr Abinett was reviewed by Dr Bamford with a view to recommencing risperdal. That was not done on that day. The decision was made to monitor his behaviour. Unfortunately the behaviour deteriorated to a level where, on 12 April 2011, Dr Bamford was contacted by staff at the nursing home and was asked to intervene. As a result Mr Abinett was transferred to the Whyalla Hospital where changes were made to his medication. He was maintained on sodium valproate and seroquel. His behavioural pattern continued while he was in hospital.
- 2.7. Mr Abinett returned to the Yeltana Nursing Home on 18 April 2011 with increased doses of seroquel at 100mg three times a day, plus 200mg at night, and 50mg as required if it was thought necessary. Again, despite this change in his medication, Mr Abinett continued to be verbally aggressive. In consultation with Dr Bamford, it was decided that Mr Abinett should be sent back to Whyalla Hospital where Dr Bamford would detain him under the Mental Health Act 2009 with a view to sending him to Adelaide for stabilisation of his mood through medical intervention. The hope was that Mr Abinett would be able to be accommodated at the Repatriation General Hospital in their specialised geriatric ward.
- 2.8. On 20 April 2011 Mr Abinett was detained on a Level 1 detention and treatment order under the Mental Health Act 2009. He was readmitted to Whyalla Hospital and then transferred in the first instance to the Royal Adelaide Hospital. On 21 April 2011 he was reviewed by a psychiatrist, Dr Rafakewitz. This doctor confirmed the detention order at 1:30pm on that day. Later that day Mr Abinett was transferred to the psychogeriatric ward of the Lyell McEwin Hospital, waiting on a bed to become available at the Repatriation General Hospital High Dependency Unit.
- 2.9. On 27 April Mr Abinett was reviewed by psychiatrist Dr Luiza Gheorghiu and a Level 2 detention order was authorised by her. At about 8:30pm on 29 April 2011 Mr Abinett was witnessed by nursing staff to vomit a copious amount of undigested food and fluid. At about 10pm that same night the surgical night intern attended and assessed Mr Abinett and concluded that there had been no ill effects from the vomiting episode. He consulted with the overnight medical registrar and together they directed four hourly observations be conducted. No other aspiration event occurred, or is recorded as having occurred, between 29 April 2011 and 2 May 2011 when Mr Abinett was ultimately transferred to the Repatriation General Hospital.

- 2.10. At the outset of Mr Abinett's admission to the Repatriation General Hospital medical staff formed a view that he might have been suffering from aspiration pneumonia due to his uncoordinated swallowing and delayed swallow trigger. With this suspicion in mind, on 3 May 2011 a chest X-ray was undertaken but it was completely clear. Mr Abinett's physical condition deteriorated. On 9 May 2011 he was found to have pneumonia and a urinary tract infection. It was clear throughout that Mr Abinett was for palliative care only and that no active resuscitation or life saving measures were to be instituted should his physical health decline further.
- 2.11. On 9 May 2011 Dr Jacqueline Symonds, psychiatrist, revoked Mr Abinett's detention order under the Mental Health Act as his health had deteriorated to such a point that he was no longer aggressive. In addition, the prognosis was that he only had a short time to live. Dr Symonds therefore felt that detention was no longer warranted. At this juncture Mr Abinett was transferred to a medical ward within the Repatriation General Hospital and he passed away early in the morning on 11 May 2011. At the time of his death Mr Abinett was not the subject of a mental health detention order. However, as seen earlier, it appears that the ultimate cause of Mr Abinett's death had arisen during his period of detention under the Mental Health Act, and so this was a death in custody that required a mandatory Inquest.

### **3. Conclusion**

- 3.1. The Court agrees with the opinion of the investigating police officer that the level of care provided to Mr Abinett was satisfactory taking into account his various medical issues, decreasing mental state and age.

### **4. Recommendation**

- 4.1. The Court does not see the need to make any recommendations in this matter.

*Key Words: Death in Custody; Natural Causes*

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

*Seal the 13<sup>th</sup> day of August, 2015.*

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*Deputy State Coroner*