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 30th day of April 2015 and the 27th 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 Judith Beverley O'Leary.

The said Court finds that Judith Beverley O'Leary aged 75 years, late of Bupa Aged Care, 84 Reservoir Road, Modbury, South Australia died at Modbury Hospital, Smart Road, Modbury, South Australia on the 17th day of August 2012 as a result of exacerbation of end-stage chronic obstructive lung disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction, cause of death and reason for Inquest

1.1. Judith Beverley O'Leary died at Modbury Hospital on 17 August 2012. She was 75 years of age. The cause of death was established by way of a pathology review[1] of her clinical history. The review describes her cause of death as exacerbation of end stage chronic obstructive lung disease. Mrs O'Leary had suffered from a number of medical conditions including respiratory failure due to severe chronic obstructive lung disease, type 2 diabetes, oesophageal ulceration, dementia, depression and osteoarthritis. Further, during her life she had been a heavy smoker, smoking up to 50 cigarettes a day. Mrs O'Leary's death was clearly from natural causes. I accept the contents of the pathology review and find that the cause of Mrs O'Leary's death was exacerbation of end stage chronic obstructive lung disease.

[1] Exhibit C1a

1.2. At the time of her death Mrs O'Leary was subject to a guardianship order with special powers. This order was issued by the Guardianship Board pursuant to section 32 of the Guardianship and Administration Act 1993. The Court later will explain in these findings the circumstances in which this order came into being. The order commenced its operation on 26 April 2012[2]. Earlier guardianship orders had been made from January of 2012. The Public Advocate was appointed to be guardian. An interim order was made on 13 April 2012[3] that included orders that Mrs O'Leary reside in such place as the guardians from time to time think fit and that she be detained in such place as the guardians from time to time determine. This order was made in anticipation of a substantive order being made within 14 days, pending transfer to other residential care. On 13 April 2012, pursuant to that interim order, the Public Advocate issued a written determination that Mrs O'Leary reside at the Lyell McEwin Hospital and that she be detained at that hospital. On 26 April 2012 the substantive guardianship order was made. It contained the same general orders in relation to residence and detention. The designated guardian pursuant to the substantive order was again the Public Advocate. By reason of the currency of that order Mrs O'Leary's death was a reportable death pursuant to the provisions of the Coroners Act 2003.

1.3. The order for detention in the place of residence appears in both the interim section 32 order dated 13 April 2012 and the substantive section 32 order dated 26 April 2012. That part of the order relating to Mrs O'Leary's detention gave rise to the suggestion that at the time of Mrs O'Leary's death she was in a state of detention and that for that reason her death was a death in custody for which an Inquest would be mandatory pursuant to the provisions of the Coroners Act 2003. This suggestion has required some analysis on the part of the Court due to the fact that whether the order of 26 April 2012 was ever acted upon by the guardian, that is to say the Public Advocate, is not immediately apparent. However, the matter of Mrs O'Leary's death was investigated by police as if it was a death in custody and the case was presented to this Court on the same basis. In due course I return to the issue as to whether this was in truth a death in custody.

[2] Exhibit C12f
[3] Exhibit C12d

2. Background and events leading to Mrs O'Leary's death

2.1. I turn now to Mrs O'Leary's circumstances. Prior to December 2011 Mrs O'Leary had lived in a unit at Salisbury North with her husband. Mrs O'Leary was admitted to the Lyell McEwin Hospital on 22 November 2011 with a right hip fracture following a fall. A CT scan of her hip revealed a fracture to the bone. Due to Mrs O'Leary's significant co-morbidities, the fracture was not managed surgically. During this admission her right wrist was X-rayed in relation to a closed reduction procedure that she had undergone the week prior. A new cast was applied to her wrist and Mrs O'Leary was discharged back home on 26 November 2011.

2.2. On 5 December 2011 Mrs O'Leary presented to the Lyell McEwin Hospital with a radial fracture to her left wrist. She was admitted to the surgical ward where a closed reduction procedure was performed. Mrs O'Leary would remain at the hospital until February. During her admission at the hospital Mrs O'Leary was provided with medication to assist with her chronic obstructive pulmonary disease. She was observed to remain medically stable during her admission. The separation summary for this admission states that the main issue for staff concerning Mrs O'Leary's admission was her discharge back to the family home. The social work unit was tasked with the responsibility of implementing a discharge plan for her, and consequently Ms McKessor a social worker at the Lyell McEwin Hospital met with Mrs O'Leary. During the meeting with Ms McKessor, Mrs O'Leary became verbally aggressive. Further, she was adamant that she wanted to be discharged back to the family home. Hospital staff then spoke to Mr O'Leary about this arrangement, he told them that he could no longer provide the high level of care that Mrs O'Leary required and that in those circumstances it would be inappropriate for her to return home.

2.3. On 22 December 2011 Mrs O'Leary was assessed by a psychiatrist at the hospital, Dr Zirabi. He determined that she did not have the mental capacity to make her own decisions. Consequently the treating medical team determined that the Guardianship Board should become involved. The social work team consulted with Mr O'Leary and he agreed with this course of action. Ms McKessor filed an application with the Guardianship Board requesting that the Public Advocate allocate Mrs O'Leary a guardian. Further, she requested that the Public Trustee manage Mrs O'Leary's finances.

2.4. On 24 January 2012 a hearing was held at the Guardianship Board in relation to the application. On this date the Guardianship Board appointed the Office of the Public

Advocate as guardian for the health, accommodation and lifestyle of Mrs O'Leary. This was the first time that Mrs O'Leary had come to the attention of the Office of the Public Advocate. At this time Mrs O'Leary remained in the care of the Lyell McEwin Hospital.

2.5. On 3 February 2012 the Public Advocate consented to the Aged Care Assessment Team reviewing Mrs O'Leary. This assessment occurred on 10 February 2012. On 14 February 2012 the Lyell McEwin Hospital was notified that Mrs O'Leary had been allocated a guardian by the Office of the Public Advocate. On 23 February 2012 the guardian notified Ms McKessor that Mrs O'Leary would be discharged into the care of her daughter Ms Nevionne Pandya. Consequently, on 24 February 2012, Mrs O'Leary was discharged from the Lyell McEwin Hospital into her daughter's care to her premises at Salisbury North. Ms McKessor was not comfortable with this arrangement as she was concerned that Mrs O'Leary's daughter would not be able to provide the high level of care that Mrs O'Leary required. She made an endorsement to this effect in the case notes.

2.6. On 4 March 2012 Mrs O'Leary was again admitted to the Lyell McEwin Hospital as a result of a Quetiapine overdose which resulted in her suffering respiratory depression. On this occasion she was admitted to the Intensive Care Unit and was intubated. Assessment by the psychiatry team determined that Mrs O'Leary was not acutely depressed or suicidal, and that the living arrangement with her daughter and son-in-law was working well. On 9 March 2012 she was discharged home to her daughter's address.

2.7. On 13 April 2012 a duty worker at the Office of the Public Advocate applied to the Guardianship Board for an urgent hearing to request interim section 32 powers. This was due to the fact that Mrs O'Leary's daughter had advised the Office of the Public Advocate that she was unable to continue to care for her mother and that force may be required to remove her mother from the premises. The interim powers were granted for a period of 14 days until a full hearing could be conducted by the Guardianship Board.

2.8. The section 32 powers were exercised and as seen Mrs O'Leary was directed by the guardian, the Public Advocate, to reside and be detained at the Lyell McEwin Hospital. Mrs O'Leary was conveyed by ambulance from her daughter's house to the hospital. On 17 April 2012 the Office of the Public Advocate consulted with the

Lyell McEwin Hospital and with Mrs O'Leary and her daughter about the transfer of Mrs O'Leary from hospital into a residential care facility. Mrs O'Leary agreed to be admitted to the Bupa Aged Care facility at Modbury. On 17 April 2012 Mrs O'Leary was discharged from the Lyell McEwin Hospital into the care of the Bupa Aged Care facility at Modbury. Clearly in those circumstances the previous direction that Mrs O'Leary reside and be detained at the Lyell McEwin Hospital lapsed.

2.9. On 26 April 2012 the Guardianship Board held a full hearing and granted section 32 powers for a period of six months with the order due to expire on 25 October 2012.

2.10. Ms Susan Goldeband is a delegated guardian employed in the Office of the Public Advocate. Her statement[4] indicates that she was appointed the guardian of Mrs O'Leary on 15 June 2012. Her statement also describes the history of Mrs O'Leary's interaction with the Guardianship Board and the office of the Public Advocate. In that statement Ms Goldeband asserts that the section 32 powers were not utilised to facilitate Mrs O'Leary's move to Bupa nor were used to direct her to reside there. She states that the only occasion the section 32 powers were utilised was between 13 and 17 April during which time Mrs O'Leary was detained at the Lyell McEwin Hospital. I have not seen any written direction or other type of determination of the guardian, the Public Advocate, in relation to residence or detention that is based on the order of 26 April. I know of no written direction or determination, for instance, that she reside and be detained at Bupa.

2.11. Whilst at Bupa Mrs O'Leary was medically managed by Dr Robertson, a general practitioner who attended at the facility to treat inpatients. Dr Robertson noted that Mrs O'Leary presented as anxious, irritable and at times agitated which he postulates may have been as a result of a number of factors, including her adjustment to her new surroundings, her chronic shortness of breath and mental illness. He observed that she demonstrated a mild cognitive impairment, being oriented to place but not time. Whilst at the aged care facility Mrs O'Leary experienced difficulty breathing and so Dr Robertson increased her dose of Prednisolone. Mrs O'Leary's last consultation with Dr Robertson was on 7 August 2012. On this occasion he noted that her breathing was starting to improve. During treatments of Mrs O'Leary, Dr Robertson also managed her haemoglobin levels and completed blood examinations in May and July 2012.

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[4] Exhibit C7a

2.12. On 14 August 2012 Mrs O'Leary was transferred from Bupa Aged Care to the Modbury Hospital due to increasing breathlessness and a productive cough. Mrs O'Leary would die there three days later. I have not seen any written direction that she reside at or be detained at the Modbury Hospital. She presented to the Emergency Department with shortness of breath, reduced saturation, an increased respiratory rate and reduced responsiveness. A blood examination was conducted which revealed an infection that had likely originated in Mrs O'Leary's chest. After further medical assessment she was diagnosed with infective exacerbation of chronic obstructive pulmonary disease with type 2 respiratory failure. She was medically managed with BiPAP therapy, steroids, a nebuliser and antibiotics. Mrs O'Leary's condition continued to deteriorate and she was palliated and provided with comfort care. Her guardian Ms Goldeband was contacted, and after consultation with Mrs O'Leary's family, a decision was made that Mrs O'Leary was not for resuscitation.

2.13. On 16 August 2012 Mrs O'Leary's guardian, Ms Goldeband, spoke with the medical team and requested that Mrs O'Leary be transferred to a hospice. Unfortunately there were no hospice beds available and so Mrs O'Leary remained in the Critical Care Unit at the Modbury Hospital. On 17 August 2012 Mrs O'Leary passed away in the presence of her family at the hospital.

2.14. Ms Goldeband's statement asserts that at the time of her death, Mrs O'Leary was not detained at the Modbury Hospital.

3. <u>Conclusions</u>

3.1. I have accepted Ms Goldeband's evidence that the only period during which the section 32 powers relating to residence and detention were utilised was between 13 and 17 April 2012. Ms Goldeband does say that Mrs O'Leary was 'detained' at her principal place of residence at Bupa, but only by virtue of the fact that she had been accommodated in a secure dementia ward at that location. This arrangement appears to have been a defacto arrangement only and one that was not a directed arrangement, nor one that involved a formal direction that Mrs O'Leary be detained at that accommodation. It appears that Mrs O'Leary's accommodation at Bupa was secured with the knowledge and tacit approval of the guardian, but I doubt that this is to be characterised as residence in respect of which the guardian had 'thought fit' in terms of the order of the Guardianship Board. It seems reasonably clear the guardian's input into the decision to accommodate Mrs O'Leary at Bupa was minimal and Ms

Goldeband's statement so asserts. One thing is certain and that is that when Mrs O'Leary died on 17 August 2012 at the Modbury Hospital she was not in any place of detention.

3.2. The Court has also given consideration as to whether Mrs O'Leary's death was a death in custody based upon the possibility that the cause of her death had arisen while she had been detained at the Lyell McEwin for the period between 13 and 17 April 2012. The cause of Mrs O'Leary's death was the exacerbation of end stage chronic obstructive lung disease. The exacerbation in question had occurred quite recently and it was that which prompted Mrs O'Leary's transfer from Bupa to the Modbury Hospital, her presentation consisting of an increasing level of breathlessness and a productive cough. She had an acute lower respiratory tract infection for which she was prescribed antibiotics and to which she had shown no response. Her level of consciousness had also acutely declined. To my mind there is no evidence that Mrs O'Leary died while she was under detention pursuant to law. Nor did her cause of death arise during any such period.

3.3. Although the matter is not free from difficulty, to my mind Mrs O'Leary's death was not a death in custody. On a fair and early assessment of the circumstances of Mrs O'Leary's death this Inquest was unnecessary, particularly having regard to the fact that Mrs O'Leary died of a clear natural cause and in circumstances that were unremarkable. Mrs O'Leary appears to have received the best of care. Even if she had been 'detained' at Bupa or at the Modbury Hospital pursuant to the section 32 order, the outcome would have been the same. I would add here that the consistent experience of this Court is that the vast majority of mandatory Inquests into the cause and circumstances of deaths that occur while deceased persons were detained pursuant to section 32 of the Guardianship and Administration Act 1993 are unnecessary. This is not to say that such deaths should not be reported to the State Coroner. They should be, but the proposition that they should invite a mandatory Inquest is unconvincing.

4. <u>Recommendations</u>

4.1. An assessment as to whether the death of a person undergoing a guardianship regime imposed under section 32 of the Guardianship and Administration Act 1993 was a death in custody depends upon whether or not the protected person had resided in such place as the guardian had thought fit and had been detained in that place. As

seen here, it is not always the case that a guardian appointed pursuant to a section 32 order will have had any input into the decision as to where the protected person should reside.

4.2. When these matters are reported to the State Coroner, as they must be by virtue of the underlying order that the person in question was a protected person, with or without orders as to residence and detention, it is not always easy to determine whether or not the matter may also be a death in custody requiring a mandatory Inquest and also, in practical terms, whether a detailed police investigation into the matter is needed to support that Inquest. This difficulty exists because any direction, determination or other decision that has been made or given by the guardian as to residence and detention may have been communicated informally and may not be in writing.

4.3. It is therefore suggested that when an order is made pursuant to section 32 that includes orders that the protected person reside in such place as the guardian from time to time thinks fit, and an order that the protected person be detained in such place as the guardian shall from time to time determine, an order should also be made that such direction or determination of the guardian in that regard be reduced to writing.

4.4. I direct this recommendation to the President of the South Australian Civil and Administrative Tribunal which entity now has responsibility in relation to the imposition of orders pursuant to the Guardianship and Administration Act 1993.

Key Words: Section 32 Powers; Natural Causes

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

Seal the 27th day of August, 2015.

Deputy State Coroner

Inquest Number 6/2015 (1365/2012)