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 25th day of November 2015 and the 9th day of December 2015, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of James Angus Shirra.

The said Court finds that James Angus Shirra aged 83 years, late of Grandview Court Nursing Home, 4 Kangaroo Thorn Road, Trott Park, South Australia died at Trott Park, South Australia on the 22nd day of September 2013 as a result of end stage Alzheimer's disease. The said Court finds that the circumstances of his death were as follows:

1. <u>Introduction, cause of death and reason for Inquest</u>

1.1. James Angus Shirra died on 22 September 2013. He was 83 years of age. Mr Shirra had been a resident of the Grandview Court Nursing Home (Grandview) since 7 February 2011. He would remain a resident of Grandview until the day of his death. He died at that facility.

1.2. An opinion as to the cause of Mr Shirra's death was provided by Mr Shirra's general practitioner, Dr Jonathon Hunt. In his witness statement[1] Dr Hunt's describes his patient's well understood clinical history. He states that in his opinion Mr Shirra died as a result of dementia. I have no hesitation in accepting Dr Shirra's opinion. I find that the cause of Mr Shirra's death was dementia.

1.3. For reasons that I will explain in a moment, this was a death in custody for which an Inquest was mandatory by operation of law. Dr Hunt states in effect that but for the

[1] Exhibit C4

fact that this was a death that required notification to the State Coroner, he would have issued a death certificate pursuant to the Birth, Deaths and Marriages Act 1996. Having regard to Mr Shirra's clinical history and to the circumstances surrounding his death, it is perfectly understandable that a medical practitioner in Dr Hunt's position would normally have taken that course. However, Mr Shirra's death was both a reportable death to the State Coroner as well as a death in custody and for those reasons Dr Hunt was precluded by law from issuing a death certificate.

1.4. Mr Shirra's death was reportable to the State Coroner for the following reasons. At the time of his death, Mr Shirra was subject to orders made by the Guardianship Board pursuant to the Guardianship and Administration Act 1993 (the Act). The originating order of the Guardianship Board was imposed on 7 December 2012[2]. By virtue of this order, Mr Shirra became a 'protected person' pursuant to the Act. His death was thus reportable for that reason[3]. The order also included the provision of special powers pursuant to section 32 of the Act. In this regard, the Guardianship Board specifically ordered that Mr Shirra reside in such place as his guardians from time to time think fit and that he be detained in such place as the guardian shall from time to time determine. The guardians of Mr Shirra were his four children. It is clear from the evidence presented to the Court that pursuant to this order Mr Shirra's guardians had determined that Mr Shirra should reside at Grandview where, as indicated above, he was already residing. It is also clear that by operation of the terms of the Guardianship Board's order, the guardians in effect determined that Mr Shirra should be detained at that facility. On 10 July 2013 the Guardianship Board reviewed the originating order. There was no alteration of the existing state of Mr Shirra's circumstances of detention at Grandview. Mr Shirra died at the facility on 22 September 2013. Therefore, Mr Shirra died in his place of detention and his death was for that reason a death in custody that required a mandatory Inquest pursuant to the provisions of the Coroners Act 2003[4].

1.5. It will readily be seen from the above analysis that Mr Shirra was detained within a facility at which he had been in residence even before the Guardianship Board orders were put in place. There is no evidence that as a result of the guardianship order and his consequent detention Mr Shirra's living circumstances altered in any material way.

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[2] Exhibit C8b
[3] Section 3(1) of the Coroners Act 2003, definition of 'reportable death', clause (f)(i)
[4] Section 3(1) of the Coroners Act 2003, definition of 'death in custody', clause (a))

2. Mr Shirra's medical history, decline and death

2.1. Mr Shirra's medical history included a diagnosis of emphysema in approximately 1998 which apparently had no major effect on his lifestyle, and a diagnosis of prostate and bladder cancer in approximately 2003 for which he underwent surgery and suffered no ill effects thereafter.

2.2. Approximately four to five years prior to his death Mr Shirra's health started to deteriorate. His cognitive skills declined. In about 2010 Mr Shirra was admitted to the Repatriation General Hospital for some weeks. During that admission his family noticed a significant decline in his cognitive abilities. Mr Shirra was diagnosed with dementia and his condition deteriorated over the ensuing two years.

2.3. Mr Shirra was ultimately admitted to the Flinders Medical Centre. During the course of this admission a consultation was undertaken between his family and medical staff concerning Mr Shirra's ability to care for himself. A decision was made to secure a place for him at a nursing home. As a result he went straight from the Flinders Medical Centre to Grandview. This occurred on 7 February 2011. As seen, Mr Shirra would remain at the facility thereafter.

2.4. Mr Shirra's wife passed away in October 2012.

2.5. The circumstances in which Mr Shirra came to reside at Grandview are described in the statement of his son, Mr Steven Shirra[5]. Mr Shirra confirms that his father's dementia had reached a stage where he required the admission to the Flinders Medical Centre. As a result of the meeting with staff that I have referred to, he and his three siblings made the decision that their father would be better cared for by his going into a residential care facility. This decision had been based on a number of factors including their mother's health as well as the fact that it was difficult to provide around the clock care for their father due to the children's own commitments. Mr Steven Shirra emphasises that the last thing they wanted to do was to put their father into a home but he and his siblings felt there was no alternative. Mr Shirra senior himself consented to the move and it was a result of all of that that he commenced his accommodation at Grandview in February 2011. Mr Shirra describes a set of circumstances regarding his father that would no doubt resonate with many members of the community.

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[5] Exhibit C1b

2.6. Mr Steven Shirra states that as far as the guardianship orders were concerned, after Mr Shirra's wife died an application was made to the Guardianship Board for an order to assist in the caring of Mr Shirra and the looking after of his affairs. In this there was consensus among all of Mr Shirra's siblings. The order of 7 December 2012 appointed all four children as limited guardians. The order enabled the family to attend to such things as the payment of Mr Shirra's bills and the ensuring of care on an ongoing basis. It gave them certainty in respect of their father's wellbeing. As to the section 32 powers, Mr Steven Shirra explains that these were put in place to cater for the undesirable event of their father attempting to leave the nursing home. The order for detention was made in order to ensure Mr Shirra's welfare. Again, all this is perfectly understandable. I might add, however, that there would hardly have been anything sinister about preventing Mr Shirra from leaving the facility in order to maintain his safety, even if no formal section 32 order was in place.

2.7. Mr Steven Shirra says this in relation to the care of their father at Grandview:

> 'From a family perspective I am able to state that we have no issues relating to the Guardianship Order nor do we have any issues relating to the care which was provided to my father at the Grandview Court Nursing Home.' [6]

2.8. It is not necessary to mention the detail in respect of Mr Shirra's decline and death. The general practitioner, Dr Hunt, describes much of this in his statement. Dr Hunt indicates that in his opinion Mr Shirra's overall health suffered a progressive decline due to dementia and advanced age. Dr Hunt saw Mr Shirra for the final time on 15 September 2013 which was a week prior to Mr Shirra's death. By then Mr Shirra's overall health had declined and he was by then not eating or drinking. After discussion with Mr Shirra's family it was decided that no further clinical investigations were to be conducted and that palliative measures only were to be put in place.

2.9. Mr Shirra passed away at Grandview on 22 September 2013.

2.10. There was nothing remarkable about the circumstances in which Mr Shirra died. Certainly, nothing was revealed in the course of a thorough police investigation to suggest that there was anything other than proper care provided to Mr Shirra at the

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[6] Exhibit C1b

nursing home. In particular there is nothing alarming about his care or the circumstances immediately prior to his death.

3. Conclusions

3.1. Mr James Angus Shirra died on 22 September 2013 at the age of 83 years. His cause of death was dementia.

3.2. There was nothing remarkable or unusual about the circumstances surrounding Mr Shirra's decline and ultimate death from dementia. His decline and death displayed a pattern typical of that seen in many elderly people, regardless of whether or not those persons had been the subject of guardianship orders and, in particular, detention pursuant to section 32 of the Guardianship and Administration Act 1993.

3.3. The orders imposed by the Guardianship Board had been applied for by Mr Shirra's family for the best of reasons, namely his continued welfare and protection. The orders were lawfully made. The regime that the orders created was appropriately imposed so that Mr Shirra could be properly cared for and protected. Mr Shirra was detained as a matter of law at Grandview from the date of the first order, 7 December 2012. The detention created was lawful. It is noteworthy that Mr Shirra was already a resident at that premises prior to the imposition of detention. There is no evidence that Mr Shirra's detention operated in any way to his detriment. They did not alter his lifestyle nor in any way shape the circumstances of his life and death. His custodial circumstances played no role in his decline or death.

3.4. This was a matter that in reality, save and except by way of the operation of law, should not have required a mandatory coronial Inquest. The Inquest was an unnecessary waste of resources. The need for a mandatory Inquest meant that following Mr Shirra's death there ensued an intricate, highly professional and time consuming police investigation conducted under the supervision of an officer of the rank of Detective Sergeant, in this case Detective Sergeant Hirlam of the SAPOL Sturt Local Service Area. Detective Sergeant Hirlam provided a lengthy and detailed report based upon the evidence that he had gathered during the course of his investigation. His investigation included the taking of statements from members of Mr Shirra's family, statements from medical professionals and other police officers,

including a ‘crime scene’ investigator. The investigation revealed nothing untoward. The intricacy of this investigation is a measure of how resource intensive police investigations are when they are conducted in preparation for a mandatory Inquest that detention pursuant to section 32 of the Guardianship and Administration Act 1993 underlies. The ultimate forensic conclusions reached two years after this death that there was nothing unusual or remarkable about Mr Shirra’s decline and death, and that his custodial circumstances played no role in that decline and death, were based on matters that required detailed investigation in order for the case to be properly presented before this Court. However, the reality is that in the days immediately following Mr Shirra’s death all of those conclusions could easily and much less formally have been reached to the satisfaction of everyone. Of course, this matter was appropriately reported to the State Coroner due to the fact that Mr Shirra had general orders in place pursuant to the Guardianship and Administration Act 1993. This obligation to report existed quite apart from the fact that Mr Shirra had been in circumstances of detention and therefore in custody. But to suggest that a matter such as this should routinely require a mandatory coronial Inquest with all of its concomitant police investigational activity and public scrutiny in an open forum such as this Court would be to overstate the position. That said, it is to be acknowledged that from time to time there may be cases in which an Inquest into the cause and circumstances of a death that has occurred when the deceased is subject to section 32 detention will be considered necessary or desirable. But the experience of this Court is that such cases will be rare, and the issue as to whether an Inquest should be held in any particular matter should be left to the discretion of the State Coroner.

3.5. In the Annual Report of the State Coroner for the financial year 2014-2015, the State Coroner reported as follows:

> 'Section 32 deaths in custody are usually characterised by the detention of an aged person with a mental incapacity who needs to be detained for their own health, safety or protection. In most cases, under this type of detention, the person dies of natural causes.
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> Over the past year the number of such cases being reported has increased markedly. They require significant resources, both of the Court and SAPOL, to investigate. In addition to this, it can be distressing to the family to find that the death of their elderly relative with dementia with psychiatric features is the subject of a long investigation followed by an Inquest. The period of waiting for resolution of the case may be up to two years. The family may assume that a Coroner is investigating the death because of

some adverse event and then expect that the Inquest will publicly reveal issues about the treatment of their loved one. In reality, Inquests in such cases are usually uneventful. They typically involve examination of a predictable trajectory of decline in the patient's medical condition. The family are left wondering why the Inquest occurred at all, and if no circumstances were revealed as adverse, then what was the purpose.

It is my view that these types of deaths should not necessarily be the subject of a mandatory Inquest. They should have an investigation that is tailored to the specific circumstances. I would maintain the discretion to hold an Inquest if I thought it necessary or desirable.'

3.6. I agree with those observations. The circumstances described in that extract are exemplified by this case. The case did not require a mandatory Inquest. It was a case that is typical of the many cases that now come before this Court arising out of detention pursuant to section 32 of the Guardianship and Administration Act 1993.

3.7. I draw this finding to the attention of the Attorney General.

4. Recommendations

4.1. There are no recommendations to be made in this case.

Key Words: Natural Causes; Death in Custody; Section 32 Powers

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

Seal the 9th day of December, 2015.

Deputy State Coroner

Inquest Number 36/2015 (1604/2013)