



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 June 2016 and the 5th day of September 2016, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Alfred Geoffrey Bannister.

The said Court finds that Alfred Geoffrey Bannister aged 84 years, late of Monreith Aged Care Facility, 401 Portrush Road, Toorak Gardens, South Australia died at Monreith Aged Care Facility, 401 Portrush Road, Toorak Gardens, South Australia on the 2nd day of November 2014 as a result of general inanition on a background of dementia with contributing ischaemic and hypertensive heart disease. The said Court finds that the circumstances of his death were as follows:

1. Cause of Death

1.1. Mr Alfred Geoffrey Bannister was 84 years of age when he died on 2 November 2014 at the Monreith Aged Care Facility in Toorak Gardens. An opinion as to his cause of death was given by Dr Stephen Wills of Forensic Science South Australia as general inanition on a background of dementia with contributing ischaemic and hypertensive heart disease¹, and I so find.

2. Reason for Inquest

2.1. At the time of his death Mr Bannister was subject to orders under the Guardianship and Administration Act 1993, including special powers under section 32 of that Act. By reason of those orders Mr Bannister was regarded in the eyes of the law as being

¹ Exhibit C2a

detained. Accordingly, his was a death in custody within the meaning of that expression in the Coroners Act 2003 and this Inquest was held as required by section 21(1)(a) of that Act and for no other reason.

3. Background

- 3.1. In March 2008 Mr Bannister was diagnosed with prostate cancer and began a course of treatment including hormone suppression therapy and radiotherapy. This therapy commenced in April 2008. Around September 2008 he started to become increasingly vague and forgetful. This became worse following his radiotherapy treatment.
- 3.2. Mr Bannister's general practitioner diagnosed him with what he called disturbed memory and made a referral for him to see a consultant physician, Dr Hecker, from the Calvary Rehabilitation Hospital who specialised in memory disorders.
- 3.3. Dr Hecker assessed Mr Bannister in January 2009 and ultimately diagnosed him as having a mild cognitive impairment and suspected that his condition would deteriorate over the next couple of years. Dr Hecker reviewed Mr Bannister in August 2010 and noted there was a decline in his condition, but it was not overly significant. He diagnosed Mr Bannister as still having a mild cognitive impairment and suggested general lifestyle factors to help in slowing disease progression.
- 3.4. In May 2013 Mr Bannister started having confused episodes overnight and his wife was having trouble caring for him. Mr Bannister would leave the house in the middle of the night. His wife started locking the house to prevent him from getting out.
- 3.5. On 21 July 2013 he was reported missing by his wife when he failed to return from a walk. He had become disoriented and confused and was ultimately found by police nearby.
- 3.6. On 27 July 2013 he was again reported missing by his wife. On this occasion Mr Bannister had moved a piece of temporary fencing in the backyard and left the premises through that. He returned to the house some two hours later. Despite repairs to the fence thereafter, Mr Bannister would still manage to leave the property overnight.

- 3.7. On 31 January 2014 Mr Bannister had an episode of confusion. An ambulance was called and he was taken to the Wakefield Hospital and then to the Royal Adelaide Hospital early on 1 February 2014.
- 3.8. There were concerns about Mr Bannister absconding from the hospital so a nurse special was instituted. At about 8:30pm on his day of admission Mr Bannister did attempt to leave the hospital and a code black was called. He was ultimately found by security officers in an aggressive state and it took considerable effort to restrain him so that he could be dealt with by medical staff.
- 3.9. A level 1 Inpatient Treatment Order was instituted and this was confirmed the following day by a psychiatrist. Mr Bannister made further attempts to leave the hospital between 1 February 2014 and his discharge on 22 April 2014 to the Monreith Aged Care Facility at Toorak Gardens.
- 3.10. While he was in hospital Mrs Bannister applied to the Guardianship Board for orders under the Guardianship and Administration Act 1993. The orders were made, and included provisions empowering her to direct where he must be and reside

4. Mr Bannister's decline in health and ultimate death

- 4.1. Mrs Bannister expressed her wishes to the staff that in the event of a cardiac or respiratory collapse she did not wish for Mr Bannister to be resuscitated and only wanted palliative care for him in the meantime. Mr Bannister experienced more episodes of aggression and agitation whilst a resident at Monreith. His overall health declined over the months and he became unsteady on his feet and required assistance with feeding.
- 4.2. Comfort care commenced for Mr Bannister on 9 October 2014. He was having difficulty swallowing and all of his oral medications were ceased on that day.
- 4.3. On 1 November 2014 Mr Bannister became unrousable. He was not responding to verbal or physical stimuli and his death was imminent. Mr Bannister's daughter attended at Monreith and sat with her father until he died at 7pm on 2 November 2014. Life was declared extinct at 11:36pm by a locum doctor who attended in response to the incident.

5. Recommendations

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

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

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

Seal the 5th day of September, 2016.

State Coroner

Inquest Number 35/2016 (1918/2014)