



## FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 25<sup>th</sup> day of November 2015 and the 1<sup>st</sup> day of September 2016, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Antonio Corbo.*

*The said Court finds that Antonio Corbo aged 90 years, late of Aldersgate Aged Care, 160 OG Road, Felixstow, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 11<sup>th</sup> day of September 2013 as a result of bowel obstruction leading to acute renal failure, sepsis and respiratory failure . The said Court finds that the circumstances of his death were as follows:*

### **1. Introduction and reason for Inquest**

- 1.1. Antonio Corbo, aged 90 years, died at the Royal Adelaide Hospital (the RAH) on 11 September 2013.
- 1.2. At the time of his death Mr Corbo was the subject of an order pursuant to section 32 of the Guardianship and Administration Act 1993 that mandated his detention. For that reason this Inquest was considered mandatory. There was no other reason why an Inquest was indicated in this case. Mr Corbo died of natural causes in keeping with his medical history and advanced years.

### **2. Cause of death**

- 2.1. Dr Philip Britten-Jones, an emergency practitioner at the RAH Emergency Department, has indicated in a coronial medical deposition that in his opinion Mr Corbo's cause of death was bowel obstruction leading to acute renal failure, sepsis, respiratory failure

and death<sup>1</sup>. I find that the cause of Mr Corbo's death was bowel obstruction leading to acute renal failure, sepsis and respiratory failure.

### **3. Background and circumstances leading to Mr Corbo's death**

- 3.1. Mr Corbo's medical history included advanced dementia, prostate cancer, atrial fibrillation, stroke with left-sided middle cerebral artery territory infarct, chronic subdural haematoma, chronic left-sided exudative effusions, high blood pressure, chronic cardiac failure, cardiac pacemaker for heart block, chronic renal failure, high cholesterol and previous appendectomy.
- 3.2. On 18 June 2013 Mr Corbo was admitted to the Royal Adelaide Hospital from home with gait disturbance and chronic renal impairment. During this admission he developed pneumonia due to immobility. He was discharged from the Royal Adelaide Hospital on 3 July 2013 after his daughter signed a discharge against medical advice form on his behalf, due to the distress he was in at being hospitalised.
- 3.3. However, on 5 July 2013 Mr Corbo was re-admitted to the Royal Adelaide Hospital with increased dyspnoea and exacerbation of chronic cardiac failure. Testing and assessment during this admission revealed vascular-type dementia. His family were advised that he was no longer considered to have capacity to make medical decisions for himself.
- 3.4. As a result of this diagnosis Mr Corbo's family made an application to the Guardianship Board for full guardianship of him. They did this with the assistance of a social worker from the Royal Adelaide Hospital.
- 3.5. A Guardianship Board hearing was conducted on 29 July 2013. A guardianship and administration order was granted to Ms Elda Corbo, the daughter of Mr Corbo. The orders included an order which specified section 32 powers that mandated his detention. These orders were to remain in full force and effect until reviewed or revoked. A review was recommended on or before 12 February 2014.
- 3.6. An ACAT assessment was undertaken in relation to Mr Corbo's needs outside of hospital. As a result, a place was found at Aldersgate Aged Care Facility. Mr Corbo

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<sup>1</sup> Exhibit C12

was ultimately transferred to the facility and he took up residence there on 3 September 2013.

- 3.7. On 9 September 2013 Mr Corbo experienced a coffee ground vomit. The following day he complained of severe abdominal pain for which he was transferred to the Royal Adelaide Hospital where he would remain until he died on 11 September 2013.
- 3.8. Notes from the admission examination of Mr Corbo at the Royal Adelaide Hospital on 10 September 2013 revealed a temperature of 35.5° C, a heart rate of 135 beats per minute, a respiratory rate of 32 and a blood pressure of 79/58. His oxygen saturations were only 90% on 10 litres of oxygen via a mask. Mr Corbo was alert but confused. He was noted to have poor perfusion to his peripheries. His abdomen, which was tense, showed diffuse peritonism. His lungs exhibited diminished breath sounds and the presence of crepitation. Mr Corbo had a raised white cell count, a raised creatinine and an elevated troponin. A CT scan of his abdomen revealed a closed loop bowel obstruction plus free fluid in his abdomen with the assessment being a likely bowel obstruction secondary to adhesions from previous surgery. He was considered to be in a critically unwell state.
- 3.9. Liaison was conducted between the medical team and Mr Corbo's family. It was considered that he was unlikely to survive any surgical intervention. A decision was therefore made to institute comfort care only. Mr Corbo died at approximately 7:30am on 11 September 2013. Dr Philip Britten-Jones completed the death report to the coroner on the same day.

#### **4. Conclusion**

- 4.1. There is no suggestion that Mr Corbo's care at the Aldersgate facility and the Royal Adelaide Hospital was anything other than adequate. Mr Corbo's circumstances of detention had no bearing on his decline and death.
- 4.2. In her comprehensive covering report the investigating SAPOL officer, Detective Senior Constable First Class Amanda Thompson of the Special Crimes Investigation Branch, has stated in essence that investigations into deaths involving section 32 powers of detention under the Guardianship and Administration Act 1993 are in general unduly

resource intensive and therefore unduly burdensome. Once again, it is hard to disagree, and this case exemplifies all of that, yet again. Once again the issue is referred to the Attorney-General. I also refer the matter to the Minister for Police.

**5. Recommendations**

5.1. I make no recommendations based on Mr Corbo's level of care.

*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 1<sup>st</sup> day of September, 2016.*

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*Deputy State Coroner*