



## FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 1<sup>st</sup> day of July 2016 and the 25<sup>th</sup> day of August 2017, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Geoffrey Neil Allen.*

*The said Court finds that Geoffrey Neil Allen aged 84 years, late of Monreith Aged Care Facility, 401 Portrush Road, Toorak Gardens, South Australia died at Toorak Gardens, South Australia on the 18<sup>th</sup> day of September 2014 as a result of multi-organ failure due to general inanition due to end-stage dementia. The said Court finds that the circumstances of his death were as follows:*

### **1. Introduction and cause of death**

1.1. Geoffrey Neil Allen died on 18 September 2014 at the Monreith Aged Care facility (Monreith) in Toorak Gardens. He was 84 years of age at the time of his death. A pathology review conducted by Dr Karen Heath, a forensic pathologist at Forensic Science South Australia, and based on Mr Allen's recent and longitudinal medical history, determined that his cause of death was multi-organ failure due to general inanition due to end-stage dementia. Mr Allen's general practitioner, Dr Iain McIntyre, concurs with that opinion<sup>1</sup>. I find that to have been the cause of Mr Allen's death.

### **2. Background and reason for Inquest**

2.1. Mr Allen had a medical history including dementia, depression, hypotension and cardiomyopathy. He was diagnosed with benign prostatic hyperplasia with recurrent urinary tract infection and underwent laser surgery for a prostatectomy in August 2013.

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<sup>1</sup> Exhibit C2a

- 2.2. In 2009 Mr Allen was diagnosed with vascular dementia. His family reported that they witnessed a steady decline in his condition after that time. On 14 February 2013 police located Mr Allen wandering in the suburb of Beaumont. He was in a confused state and was taken to the Royal Adelaide Hospital. Police checks also revealed a report of his wandering in Glossop in the Riverland.
- 2.3. At the Royal Adelaide Hospital (RAH) Mr Allen was assessed as suffering from delirium and dehydration and was treated accordingly. He would remain in the Royal Adelaide Hospital until his admission to Monreith on 8 July 2013. In March 2013 following Mr Allen's admission to the RAH, a guardianship and administration order with special powers under section 32 of the Guardianship and Administration Act 1993 was jointly applied for by Mr Allen's daughters and his son-in-law. Orders were granted to those three persons on 5 April 2013. The section 32 powers that were granted on that occasion included a power to impose detention in Mr Allen's place of residence. On 27 August 2013 an administration order was revoked but the guardianship order and the special powers pursuant section 32 power of detention remained in full force and effect. Further reviews and confirmation of those orders were undertaken on 29 November 2013 and 9 December 2013. As a consequence of the series of orders of the Guardianship Board, Mr Allen would be detained at Monreith until his death. His death was therefore a death in custody as defined within the Coroners Act 2003. Accordingly, this was a mandatory Inquest. These are the findings of that Inquest.
- 2.4. On 8 July 2013 Mr Allen was admitted to Monreith. On admission Mr Allen experienced behavioural difficulties. Mr Allen suffered from a particular recurring delusion that drove some of this behaviour. Strategies were developed in consultation with the Dementia Behaviour Management Advisory Service of Alzheimer's SA in an attempt to manage this issue.
- 2.5. In December 2013 end of life directives were completed in conjunction with Mr Allen's family and a decision was made that he was not to be resuscitated.
- 2.6. On 9 May 2014 Mr Allen returned a score of 7 out of 30 on a mini-mental examination, meaning that he had little comprehension about what was going on around him.
- 2.7. Mr Allen was prone to falls and numerous strategies were employed in an endeavour to prevent these. A number of risk assessments for falls were conducted. Including among the fall prevention strategies was the provision of a walker. However, the

walker had limited benefit as Mr Allen was prone to forget to use it. His bed was lowered to minimise falls and a rail was erected at the side of his bed. A pressure mat was placed on the floor in order to alert staff if he rose from bed or fell from it. Mr Allen experienced a number of falls between 2 and 9 September 2014 with no significant injury. However, he was admitted to the RAH as a precautionary measure.

### **3. Mr Allen's decline and subsequent passing**

- 3.1. Staff at Monreith noted that Mr Allen seemed to age very quickly towards the end of August 2014. From the weekend of 13 September 2014 Mr Allen was incapable of receiving fluids or medications. He remained in a deep unconscious state until his death five days later on 18 September 2014. He was kept as comfortable as possible by staff during those last days.
- 3.2. Ms Katherine Ruth Heijkoop<sup>2</sup> is a daughter of the deceased, Mr Allen and was one of the guardians appointed pursuant to the orders of the Guardianship Board. In Ms Heijkoop's statement she describes some of the history and detail connected with her father's decline. In relation to the care that was provided to her father at Monreith, she states that she found the staff at Monreith to be very caring and professional. She asserts that staff kept the members of her family well-informed of any issues concerning their father's wellbeing or in relation to any adverse incidents. Indeed, Ms Heijkoop describes one particular staff member, whom I infer was registered nurse Mary Dunstan, as a saint. Ms Heijkoop asserts that she and her family had agreed that their father should not be resuscitated and that they had accepted that he was dying.
- 3.3. The investigating officer, Detective Senior Constable First Class Richard Power of SAPOL, concluded that there was no deficiency in the care and attention afforded to Mr Allen while detained in the Monreith Aged Care facility. I have no reason to differ from that conclusion.

### **4. Conclusions**

- 4.1. I find that Mr Allen's detention at Monreith was at all times lawful.
- 4.2. Mr Allen's custodial circumstances had no bearing on his death.

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<sup>2</sup> Exhibit C1b

**5. Recommendations**

5.1. There are no recommendations in this matter.

*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 25<sup>th</sup> day of August, 2017.*

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*Deputy State Coroner*

Inquest Number 40/2016 (1643/2014)