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 14th day of September 2016 and the 19th day of April 2017, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Kumana Boogar.

The said Court finds that Kumana Boogar aged 42 years, late of 7 Bowcher Street, Salisbury, South Australia died at Salisbury, South Australia on the 28th day of February 2015 as a result of sudden unexpected death in epilepsy. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Kumana Boogar was 42 years of age when he died at his home in Salisbury on Saturday, 28 February 2015.

1.2. An autopsy was carried out by Dr Stephen Wills, a forensic pathologist at Forensic Science South Australia, who gave the cause of death as sudden unexpected death in epilepsy, and I so find. Dr Wills commented in his report:

> 'Taking all the findings into consideration it is my opinion this gentleman has died as a result of complications of epilepsy and may be classified as the sudden unexpected death in epilepsy (SUDEP). This is defined as the sudden, unexpected, non-traumatic, non-drowning death in an individual with epilepsy, witnessed or unwitnessed, in which post mortem examination does not reveal an anatomic or toxicological cause for the death. Specialist examination of his brain revealed findings in keeping with lack of oxygen and/or nutrients to the brain which can be accounted for by a period of seizure activity prior to death.' [1]

[1] Exhibit C2a, page 2

2. Reason for Inquest

2.1. At the time of his death Kumana was subject to orders under the Guardianship and Administration Act 1993. The orders required Kumana to be and remain in a particular place and consequently he was, for legal purposes, under detention when he died. His was therefore a death in custody within the meaning of that expression under the Coroners Act 2003 and this Inquest was held as required by section 21(1)(a) of that Act.

3. Background

3.1. Kumana was originally from Yalata. On 13 April 2013 he was arrested on three counts of aggravated indecent assault and one count of indecent behaviour with allegations that he had exposed himself to three females under the age of 12 and forced them to touch his genitals. The community became very angry in relation to those allegations and there were concerns for his safety within the Yalata community.

3.2. Kumana began engaging in risk taking behaviour and was not adhering to bail conditions that were placed upon him as a result of his arrest. In light of this he was moved to Adelaide on 24 March 2014 and into the house at Salisbury where he was accommodated until his death under the care of InComPro Incorporated. InComPro provides services to Aboriginal people, organisations and communities within South Australia.

3.3. At the time of his death Kumana was living alone with 'round the clock' carers who were present to assist him.

4. Medical history

4.1. Kumana was a double-leg amputee due to an incident where he sustained severe burns to his legs. He also suffered burns to his hands leaving one of them deformed. Kumana therefore had significant physical difficulties. He was wheelchair bound and had a longstanding diagnosis of epilepsy. He had problems with alcohol abuse and had been known to use inhalants earlier in life.

4.2. Kumana was on a number of medications for his conditions including Carbamazepine which is an anticonvulsant and analgesic, diazepam for anxiety relief, sertraline for depression, sodium valproate for his epilepsy and thiamine hydrochloride which is a vitamin supplement.

4.3. It was reported that he was managing quite well in his accommodation and with the assistance of carers. His alcohol and cigarette intake was monitored by the carers and these items were locked away to avoid overindulgence. His medications were regularly administered to him as prescribed and his personal care was improved through their assistance.

4.4. Kumana was known by the carers to have small seizures on a semi-regular basis. His carers were usually able to handle these by simply reassuring Kumana and monitoring him through the seizure and for a period of time afterwards. There were three shifts that would work with him. There would be one shift from morning until late afternoon, one from late afternoon into night and then an overnight shift. There was another InComPro property located next door with another set of carers that could be called upon for support. Kumana had a friendship with the gentleman residing at that property.

5. The events leading to Kumana's death

5.1. James Knox was one of Kumana's carers. According to his statement[2] he attended for his shift at 8:30am and was receiving his handover from the overnight carer. The night had been uneventful and Kumana had already been next door and shared breakfast with the resident at that property and had returned home. He was now sleeping on a mattress in the lounge room of his home which was where he usually slept.

5.2. During the handover process Mr Knox began to hear Kumana making noises. He went to check on him and found him on the mattress having a seizure. He described it as not being particularly violent, with only small jolts and shaking. Mr Knox had seen Kumana have many seizures and this one was at the mild end of the scale. Mr Knox reassured Kumana and monitored him during the seizure which lasted for about 30 seconds.

5.3. Following the seizure Mr Knox rolled Kumana onto his side and made him comfortable. Kumana made some coughing and grunting noises which Mr Knox termed as typical of what happens after his seizures. Mr Knox checked his breathing and it seemed fine. He sat with Kumana and checked him again a few minutes later by touching him on the shoulder and verbally reassuring him and Kumana again coughed and grunted and appeared to be breathing satisfactorily.

[2] Exhibit C6

5.4. A short time later Mr Knox again touched him on the shoulder and verbally reassured him, however this time something was different. Kumana was not breathing. Mr Knox immediately sought help from the carer in the property next door and they called emergency services and began CPR. Ambulance officers attended, but despite resuscitative efforts from both the carers and ambulance officers, Kumana died.

6. Conclusion

6.1. I find that Kumana's custody was lawful and appropriate and that the care provided to Kumana prior to his death was proper and suitable in the circumstances.

7. Recommendations

7.1. I have no recommendations to make in this matter.

Key Words: Death in Custody; Section 32 Powers; Epilepsy

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 19th day of April, 2017.

State Coroner