



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 18th day of November 2016 and the 12th day of December 2017, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of John Francis Eugene Davis.

The said Court finds that John Francis Eugene Davis aged 88 years, late of Belalie Lodge, 1-7 Cumnock Street, Jamestown, South Australia died at Jamestown, South Australia on the 17th day of March 2013 as a result of pulmonary thromboembolism complicating ischaemic and hypertensive heart disease and chronic obstructive pulmonary disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

- 1.1. John Francis Eugene Davis was 88 years of age when he died on 17 March 2015 at the Belalie Lodge Nursing Home in Jamestown where he resided.
- 1.2. A post-mortem examination in respect of Mr Davis was undertaken by Dr John Gilbert, a forensic pathologist at Forensic Science South Australia. In his report Dr Gilbert expresses the cause of death as pulmonary thromboembolism complicating ischaemic and hypertensive heart disease and chronic obstructive pulmonary disease¹. I find that to have been the cause of Mr Davis' death.

2. Reason for Inquest

- 2.1. This Inquest was mandatory because Mr Davis' death was a death in custody. This was due to the fact that pursuant to orders of the Guardianship Board made under section 32

¹ Exhibit C3a

of the Guardianship and Administration Act 1993, Mr Davis was detained in his place of residence, namely Belalie Lodge. These orders had been sought by Mr Davis' sons, Mr William Davis and Mr Michael Davis, in light of their father's dementia. At the time that the orders were first sought and granted in 2014 Mr Davis was already a resident at Belalie Lodge. He had been a resident there since 2 December 2011. His condition had worsened to such a degree that he had no insight into person, place or time, and especially not in respect of his own frailties. On a number of occasions Mr Davis had been found wandering aimlessly within Jamestown. As a result, Mr Davis' sons sought orders that would enable Belalie Lodge staff to curtail his ability to leave the facility. On 2 February 2015 the Guardianship Board confirmed the section 32 order. The order was still in force at the time of Mr Davis' death on 17 March 2015. I find that the section 32 order was lawful and appropriate as was Mr Davis' detention pursuant to that order.

3. Mr Davis' medical history

- 3.1. Mr Davis had a medical history that included hypertension and ischaemic heart disease. He had suffered a heart attack in 1992. He also had a history of congestive cardiac failure, asthma, recurrent pneumonia, renal colic, recurrent urinary tract infections, gastroesophageal reflux disease and Alzheimer's dementia. On 29 January 2015 he had an admission to hospital for a suspected mini stroke. A decision was made not to investigate this and so he was returned to Belalie Lodge.
- 3.2. In the period leading up to Mr Davis' death his health had steadily declined due primarily to this age and his dementia. His health was monitored at Belalie Lodge by the attending general practitioner, Dr Graham Fitzclarenc.

4. The events of 17 March 2015

- 4.1. At 11:35am on 17 March 2015 Mr Davis was located standing in the corridor next to his room. He was naked. He was returned to his room where he was showered and then dressed. He was breathless and wheezy at this time and he was given Ventolin and an Atrovent inhaler. He appeared to be pale, glassy-eyed and seemed to be staring into space.

- 4.2. At 12pm observations were taken of Mr Davis. There was nothing particularly notable at that time. Mr Davis wanted to go for a walk, but after taking several steps found it difficult to continue. He was placed in a wheelchair, taken back to his room and transferred to bed. Once back in bed he began rubbing the left side of his chest, but denied any pain upon questioning. It was noted though that he was clammy and pale.
- 4.3. At 12:30pm further observations were taken. There was a slightly increased blood pressure and heart rate. Oxygen therapy was instituted and the attendance of the general practitioner was requested for a review. At 5:30pm that day Dr Fitzclarence attended and examined Mr Davis. Mr Davis' chest was clear. However, he was tachycardic and was experiencing atrial fibrillation. Dr Fitzclarence noted signs of peripheral cyanosis. Dr Fitzclarence requested that Mr Davis be placed on the list for further review on the following Thursday. Ten minute observations were instituted from that point.
- 4.4. At 6:05pm, which was shortly after Dr Fitzclarence's attendance, Mr Davis' call bell rang. A staff member attended and located Mr Davis slumped across his bed. He was unresponsive. Dr Fitzclarence was contacted but it was clear that Mr Davis had died. Dr Fitzclarence certified life extinct at 7:30pm.

5. Conclusions

- 5.1. I find that Mr Davis' detention under the Guardianship and Administration Act 1993 was at all times lawful. In fact he had been detained in the very facility in which he had been resident for some time prior to the imposition of the orders of the Guardianship Board.
- 5.2. I also find that Mr Davis' care while under detention at Belalie Lodge was appropriate. I have carefully examined the evidence collated by investigating police. I have also had regard to the helpful report of the investigating officer, Detective Brevet Sergeant Brenton Holmes. Mr Holmes has concluded that Mr Davis' detention was lawful and that his care was appropriate in all of the circumstances, conclusions with which this Court agrees. Indeed, Mr William Davis, one of Mr Davis' sons, has indicated in his witness statement² that he was '*more than happy with the level and standard of care*

² Exhibit C6

provided to Frank, my Dad, by Belalie Lodge'. Mr Davis died of natural causes. His detained status at Belalie Lodge did not in any way contribute to his death.

6. Recommendations

6.1. There are no recommendations made in respect of 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 12th day of December, 2017.

Deputy State Coroner