



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 6th day of October 2015, the 13th day of July 2016 and the 25th 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 William Thomas Kelbin.

The said Court finds that William Thomas Kelbin aged 81 years, late of 103 Ward Street, Whyalla, South Australia died at Whyalla Hospital and Health Services, Wood Terrace, Whyalla, South Australia on the 28th day of December 2012 as a result of gastrointestinal haemorrhage and multi-organ failure on a background of severe dementia. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

- 1.1. William Thomas Kelbin was 81 years of age when he died from natural causes on 28 December 2012 at the Whyalla Hospital. Mr Kelbin had a medical history that included diabetes, asbestosis, GORD, previous myocardial infarction, chronic cardiac failure and a total left hip replacement.
- 1.2. A pathology review was undertaken by Dr Iain McIntyre of Forensic Science SA. In his report¹ Dr McIntyre summarised Mr Kelbin's clinical circumstances prior to death and suggested that the cause of his death was gastrointestinal haemorrhage and multi-organ failure on a background of severe dementia. I have accepted Dr McIntyre's report in its entirety. I find that to have been the cause of Mr Kelbin's death.

¹ Exhibit C2a

2. Reason for Inquest and background

- 2.1. This was a mandatory Inquest due to the fact that Mr Kelbin died while under the detention imposed upon him by virtue of section 32 of the Guardianship and Administration Act 1993.
- 2.2. Until September 2012 Mr Kelbin lived independently in his own home in Whyalla. On 25 May 2012 he underwent a total left hip replacement at The Queen Elizabeth Hospital. That operation was successful and he discharged himself home on 26 June 2012.
- 2.3. As a follow-up to that operation on 11 July 2012 an occupational therapist visited him at home to assess him and his circumstances. She found him to be half-dressed, slightly unkempt and lacking in personal hygiene. Mr Kelbin was unable to provide the therapist with important information such as the name of his general practitioner or the number he should call if he had an emergency.
- 2.4. It was concluded that Mr Kelbin was a risk to himself due to limited demonstrated knowledge about dangerous household situations, medical emergencies and the way to contact emergency services. Further assessment was recommended and ultimately undertaken by consultant geriatrician Dr Lu Mykyta. Dr Mykyta conducted an assessment in Mr Kelbin's home and concluded that he had a memory impairment, paranoia and that he exhibited a complete lack of insight into his own needs and capabilities. It was further determined that he was neglecting significant health care needs, that he was at a high risk for falls and resulting injuries and that he had no-one to assist him with his daily living needs.
- 2.5. Dr Mykyta believed that the deceased was not able to make rational decisions about his health, safety and welfare. As a result Dr Mykyta recommended that the Guardianship Board be approached for a guardianship order with section 32 powers.
- 2.6. In early September 2012 Domiciliary Care workers who attended upon Mr Kelbin in his home became particularly concerned about his welfare. They noted that he had untreated sores on his legs from a heater and that his general wellbeing was poor. The workers transported him to the Whyalla Hospital where he was admitted. In light of

this admission and having regard to Dr Mykyta's assessment, a social worker at the hospital, Ms Courtney Huppertz, made an urgent application to the Guardianship Board on 6 September 2012. The application was considered urgent as Mr Kelbin was insisting on leaving the hospital and had a history of discharging himself against medical advice².

- 2.7. A Guardianship Board hearing was convened on 6 September 2012. On that day the Guardianship Board appointed the Public Advocate as full interim guardian. Additional powers were granted enabling the Public Advocate to determine where Mr Kelbin was to reside. In addition, an order was made that Mr Kelbin be detained in such place as the Public Advocate should determine. This was an interim order that would lapse at 3pm on 20 September 2012. Mr Kelbin was thereafter kept in the Whyalla Hospital.
- 2.8. Ms Bethany Jordan³ was the delegated guardian for Mr Kelbin. It was at her direction that Mr Kelbin remained in the Whyalla Hospital at least until such time as a full assessment of him could be undertaken. According to her statement she visited Mr Kelbin at the hospital on 11 September 2012 and met with members of his treating team. Mr Kelbin was difficult on this occasion expressing outrage at his circumstances and insisting that it was all a misunderstanding. He was insistent about returning home and that he did not need a guardian. He was also emphatic that his family should not be involved in this process. He also insisted that Domiciliary Care workers, who had largely been rejected by Mr Kelbin, were liars.
- 2.9. A review of the interim order was conducted by the Guardianship Board on 18 September 2012. Ms Jordan attended this hearing. At the hearing Mr Kelbin denied that he had any mental incapacity and insisted that he was managing well at home. There was some discussion about the risks that were presented to him within his home. On this date the Public Advocate was appointed as full guardian for Mr Kelbin. A further application for section 32 powers, including the power to detain in the place of residence, was dismissed.

² Exhibit C5a, page 2

³ Exhibit C5a

- 2.10. On 20 September 2012 Mr Kelbin discharged himself from hospital and returned home. In her statement Ms Jordan explains that she believed that in accordance with the principles contained within the Guardianship and Administration Act 1993, she was obligated to respect Mr Kelbin's current wishes and that she should grant him a trial period of living in his own home. Domiciliary Care attempted to engage with him at home. At times he refused their help and, with limited exceptions, would not let services into the premises. Mr Kelbin would allow into his home one particular Domiciliary Care worker and a physiotherapist. Monitoring of his condition and his self-management continued as best it could through those two persons. It was around this time that it became apparent that another male person had been residing at Mr Kelbin's premises. It was said that this person would slam the door on services.
- 2.11. During the trial period to which I have referred, Ms Jordan received correspondence from a clinical nurse at Domiciliary Care advising her that staff had been refused entry into Mr Kelbin's home. Domiciliary Care staff had reported to Ms Jordan that Mr Kelbin's living conditions were filthy. In addition it was said that Mr Kelbin had dismissed his general practitioner. Over the next weeks Mr Kelbin's health deteriorated.
- 2.12. On 3 October 2012 a Domiciliary Care worker noted that Mr Kelbin had a distended stomach. He reported that he had not used his bowels for a week. He had not eaten anything that day. Mr Kelbin consulted Dr Cyril Monteiro on 4 October 2012⁴. Dr Monteiro referred Mr Kelbin for an ultrasound at the Whyalla Hospital. He next saw Mr Kelbin on 13 October 2012 in relation to the investigations from the previous appointment. Dr Monteiro states that Mr Kelbin was admitted to hospital. He was admitted to the Whyalla Hospital with a pleural effusion on 16 October 2012.
- 2.13. On 4 October 2012 Mr Kelbin's guardian, the Public Advocate, requested a further Guardianship Board hearing concerning Mr Kelbin. A hearing was scheduled for 22 October 2012.
- 2.14. However, on 20 October 2012 the male associate of Mr Kelbin attended at the hospital to visit Mr Kelbin and in the course of that visit they went outside to have a cigarette

⁴ Exhibit C8a

and failed to return. Mr Kelbin was still absent from the hospital on 22 October 2012 on which day the Guardianship Board hearing was scheduled. The hearing proceeded and the Public Advocate, as guardian for Mr Kelbin, was granted section 32 powers including the power of detention.

- 2.15. Following this, Ms Jordan, who believed that Mr Kelbin was critically ill and whose desire was that Mr Kelbin be returned to the Whyalla Hospital where she wanted him again to be detained, filed a missing person's report with South Australia Police. On 23 October 2012 Mr Kelbin was located in Moonta with his male associate. He was taken to the Wallaroo Hospital pending transfer to Whyalla Hospital. Mr Kelbin was transported by the Royal Flying Doctor Service at 9pm on 23 October 2012 to Whyalla.
- 2.16. Mr Kelbin remained in the Whyalla Hospital until his death on 28 December 2012. While in hospital efforts were made to treat Mr Kelbin's physical conditions. At times he was resistant to treatment. He was aggressive, abusive and disruptive towards staff and other patients. Naturally this rendered the administration of care as problematic. Mr Kelbin's clinical course and decline are summarised in the pathology review of Dr McIntyre as follows:

'On 23/10/12 he was admitted under a s.32 order from the Guardianship Board. He was demented and had been exhibiting verbal aggression, significant weight loss and anaemia deemed to be from blood loss in the gastrointestinal tract. Blood transfusions were given to correct the anaemia. Investigations were not deemed appropriate as he had severe heart failure and he himself refused any endoscopic procedures. He also had bilateral leg ulcers which were dressed. Swallowing difficulties were also a problem and he continued to lose weight in hospital. He became increasingly confused and his cardiac failure worsened. He then had several hematemesis, further deteriorated into multi-organ failure and death.'

I accept Dr McIntyre's analysis.

- 2.17. Efforts to assist Mr Kelbin's physical health continued until it became apparent that these were futile and comfort measures were instituted on 26 December 2012. Mr Kelbin died in his sleep at 1:30am on 28 December 2012.

3. Conclusions

- 3.1. I find that Mr Kelbin's detention was lawful. His custodial circumstances did not contribute to his death.
- 3.2. Mr Kelbin died of natural causes.

4. Recommendations

4.1. I do not make any 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 25th day of August, 2017.

Deputy State Coroner

Inquest Number 19/2015 (2152/2012)