



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 16th day of December 2016 and the 30th day of May 2017, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of David Michael McKeever.

The said Court finds that David Michael McKeever aged 69 years, late of Ibis Care Edenfield, 20-36 Gardenia Drive, Parafield Gardens, South Australia died at Parafield Gardens, South Australia on the 29th day of June 2015 as a result of aspiration pneumonia on a background of ischaemic heart disease and diabetes. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

- 1.1. David Michael McKeever was 69 years of age when he died on 29 June 2015 at Edenfield Family Care (Ibis Care Edenfield), Parafield Gardens where he had been a resident. Following his death a pathology review was conducted by Dr Iain McIntyre of Forensic Science South Australia. On the basis of Dr McIntyre's report I find the cause of death to be aspiration pneumonia on a background of ischaemic heart disease and diabetes.

2. Reason for Inquest

- 2.1. On 30 September 2014 the Guardianship Board granted an interim guardianship and administration order with provision as to detention, pursuant to section 32 of the Guardianship and Administration Act 1993. These orders had been sought due to Mr McKeever's declining cognitive state and his steadfast belief that he could remain at home without assistance. He was delirious, failing to comply with medication

regimes, engaging in risk-taking behaviour and was considered not to have the capacity to make decisions about his living situation and day to day care.

- 2.2. On 10 October 2014 the board granted the orders in full. With the assistance of his lawyer Mr McKeever appealed the decision of the Guardianship Board on a number of procedural fairness bases, including that he had not had the opportunity to appear before the Board himself, nor had the opportunity to cross-examine persons involved in that hearing. He also argued that he did not need the intervention of the guardian or an administrator as he was perfectly capable of looking after himself and his affairs.
- 2.3. On 2 March 2015 the appeal was heard in the District Court before Judge Tilmouth and on 13 March 2015 Judge Tilmouth upheld the appeal. He remitted the matter back to the Guardianship Board for full consideration on the merits under section 42F of the District Court Act 1991. He further ordered that in the meantime the guardianship and administration orders were to remain in effect. The orders were still in effect at the time of Mr McKeever's death. Therefore, Mr McKeever's death was a death in custody within the meaning of that expression in the Coroners Act 2003, and this Inquest was held as required by section 21(1)(a) of that Act and for no other reason.

3. Background

- 3.1. Mr McKeever's medical history includes ischaemic heart disease with bypass surgery in 2012, diabetes type 2 with peripheral neuropathy, hypertension, dementia with a cognitive impairment and obesity. Mr McKeever's diabetes was poorly controlled.
- 3.2. On 22 September 2014 he was taken from home to the Lyell McEwin Health Service by South Australia Ambulance after he was found wandering in his garden in a confused state.
- 3.3. On 24 September 2014 he was transferred to the Geriatric Evaluation and Management Unit at the Modbury Hospital for further cognitive assessments. He made numerous attempts to abscond and return home. He was detained on a Level 1 Inpatient Treatment Order under section 21 of the Mental Health Act 2009 due to delirium, cognitive impairment and being a risk to himself. He underwent extensive cognitive testing and was diagnosed with frontal dementia with behavioural and psychological symptoms, and was assessed as not having the capacity or insight to understand his medical management decisions. There were considerable concerns about his ability to

comply with the medication regime, his capacity for risk-taking behaviours and his general safety if he were to live alone.

- 3.4. In light of this, and with the help of the staff at Modbury Hospital, Mr McKeever's daughter applied to the Guardianship Board for the orders referred to earlier in this finding.
- 3.5. On 5 December 2014 Mr McKeever was transferred from the Modbury Hospital to high level care at Edenfield Family Care. Between December 2014 and June 2015 his medical condition deteriorated. He had numerous falls, was resistant to carers, refused medications and was described by his attending general practitioner as very difficult to care for.
- 3.6. On 24 June 2015 at approximately 4am he was transferred to the Lyell McEwin Health Service with vomiting. He had become breathless and had developed a fever. He was admitted with a diagnosis of aspiration pneumonia. Intravenous antibiotics were administered for 24 hours. Mr McKeever had no response to these and, in consultation with Ms McKeever, it was decided that he would be for palliative care only from that point.
- 3.7. Mr McKeever was discharged back to Edenfield on 25 June 2015 for palliative care. His condition continued to decline and he died on 29 June 2015.

4. Conclusion

- 4.1. I find Mr McKeever's detention was lawful and that he received appropriate care.

5. Recommendations

- 5.1. I have no recommendations to make in this matter.

Key Words: Death in Custody; Section 32 Powers

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 30th day of May, 2017.

State Coroner