



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 Augustine Durham Rayner.

The said Court finds that Augustine Durham Rayner aged 88 years, late of 9a Fisher Street, Norwood, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 9th day of March 2015 as a result of bilateral acute bronchopneumonia on a background of chronic obstructive airways disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

- 1.1. Augustine Durham Rayner was 88 years old when he died on 9 March 2015 at the Royal Adelaide Hospital.
- 1.2. An autopsy was performed by Dr Karen Heath of Forensic Science South Australia. Dr Heath's report¹ gave the cause of death as bilateral acute bronchopneumonia on a background of chronic obstructive airways disease, and I so find.

2. Reason for Inquest

- 2.1. At the time of his death Mr Rayner was the subject of a Level 2 Inpatient Treatment Order under the Mental Health Act 2009 which had been imposed by Dr Paul Davis on 27 February 2015. Mr Rayner's death was therefore a death in custody within the

¹ Exhibit C2b

meaning of that expression in the Coroners Act 2003 and this Inquest was held as required by section 21(1)(a) of that Act.

3. Medical History

- 3.1. The relevant medical history with respect to Mr Rayner is that he was an ex-smoker, had suffered from chronic obstructive pulmonary disease and had a long history of mental health issues, from approximately 1950, when he was diagnosed with chronic schizophrenia.

4. Background

- 4.1. Mr Rayner emigrated from Melbourne to London with his family in 1929. He served in the British Army during World War II. In the aftermath of World War II he began showing signs of chronic schizophrenia and required hospitalisation. In 1956 at 30 years of age he moved back to Australia with his parents. Over the ensuing 20 years he received intermittent treatment at the Northfield Mental Hospital and Glenside Hospital.
- 4.2. In 1976 his parents died and he moved into a unit in the Norwood area. At that stage Mr Rayner regularly attended Glenside Hospital for depot medication and experienced a relatively stable period of mental health for the next 10 to 12 years. In 1988 he ceased taking his medication and his mental health appeared to remain relatively stable until the early 2000s.
- 4.3. In 2002 a treating general practitioner referred him to Eastern ACIS with a view to recommencing his depot medication and in 2010 it was reported that his mental health had been fairly stable as he had been compliant. In 2011 Mr Rayner experienced an onset of paranoia and began to isolate himself from his mental health workers and the family member who he had remained close to in Australia. An assessment was undertaken but it was not felt that he was detainable at that time. Eastern Mental Health continued to monitor his wellbeing.
- 4.4. Eastern Mental Health experienced difficulty managing Mr Rayner as on occasion he would not allow them access to his home and would not engage with workers. On 20 February 2015 he was found by ambulance officers at a bus stop on North East Road at Hampstead Gardens. He was unkempt. He was incontinent of faeces and it was

believed he was homeless. The ambulance officers conveyed him to the Royal Adelaide Hospital and he was admitted.

5. Mr Rayner's detention to the Royal Adelaide Hospital

- 5.1. On 21 February 2015 he was detained on a Level 1 Inpatient Treatment Order due to his refusal for any medical intervention and his aggression towards staff, including an attempt to strangle one of the doctors who was trying to attend to him. On 27 February 2015 Dr Paul Davis invoked a Level 2 Inpatient Treatment Order as Mr Rayner's behaviour continued to be disorganised and abusive.
- 5.2. Mr Rayner was considered for admission to a psychiatric ward, however that required medical clearance before he could be accepted.
- 5.3. On 9 March 2015 it was noted in the Royal Adelaide Hospital casenotes² that at 10:45am Mr Rayner was medically stable and awaiting a psychiatric bed to become available. At 11:50am it was noted that Mr Rayner was alert, but agitated and abusive. He remained in bed and requested the blinds remain drawn and staff not enter the room. At 12:50pm a code blue was called by nursing staff who found him unresponsive. CPR was commenced, but it was unsuccessful and at 1:13pm his life was declared extinct.
- 5.4. There was some surprise in regards to Mr Rayner's death, however it is clear from Dr Heath's post-mortem report that Mr Rayner suffered from significant bronchopneumonia and airways disease.

6. Conclusion

- 6.1. There were significant efforts made during the course of Mr Rayner's life to control his schizophrenia and, for the most part, he was relatively compliant with his medication. Towards the end of his life his mental health deteriorated and he was sadly found in poor condition on the streets. The staff at the Royal Adelaide Hospital attempted to resolve the issues surrounding Mr Rayner's mental and physical health, but he ultimately succumbed to his lung disease.
- 6.2. I find that the order for detention under the Mental Health Act 2009 was lawful and appropriate and that the medical treatment provided to Mr Rayner was also appropriate.

² Exhibit C19

7. Recommendations

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

Key Words: Death in Custody; Inpatient Treatment Order

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

Seal the 19th day of April, 2017.

State Coroner

Inquest Number 55/2016 (0410/2015)