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 18th day of November 2016 and the 29th day of March 2018, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Colin Dean Black.

The said Court finds that Colin Dean Black aged 85 years, late of 201/18 McHarg Road, Happy Valley, South Australia died at the Repatriation General Hospital, 216 Daws Road, Daw Park, South Australia on the 19th day of March 2015 as a result of pneumonia on a background of end stage Alzheimer's disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. Colin Dean Black was 85 years of age when he died on 19 March 2015. He died from natural causes at the Repatriation General Hospital (the RGH) where he was a patient in Ward 18 which was a ward dedicated to persons with mental health issues and those who required aged or mental health care.

1.2. A pathology review conducted by Dr Iain McIntyre of Forensic Science South Australia and based upon Mr Black's longitudinal and recent medical history states that a cause of death could be determined from Mr Black's medical history with some certainty and that for that reason a post mortem examination was not necessary. Dr McIntyre states that the cause of Mr Black's death was pneumonia in a man with end stage Alzheimer's disease. In his review document[1] Dr McIntyre summarises that from December 2014 Mr Black was on a palliative care plan for end stage Alzheimer's dementia. He was

[1] Exhibit C2a

experiencing serious swallowing difficulties and falls. There was a steady decline with poor oral intake and a terminal respiratory failure due to pneumonia. I find that Mr Black's cause of death was pneumonia on a background of end stage Alzheimer's disease.

1.3. At the time of his death Mr Black was subject to a Level 2 Inpatient Treatment Order (ITO) that had been imposed pursuant to the Mental Health Act 2009. His death occurred whilst under the detention that an ITO imposes, the place of detention in this case being the RGH. His death was therefore a death in custody for which an inquest was mandatory. These are the findings of that inquest.

1.4. The deceased had initially been diagnosed with Alzheimer's dementia in 2009 following assessments by a geriatrician physician, Dr Spiliopoulou. Mr Black's medical history also included ischaemic heart disease and depression.

1.5. Mr Black's circumstances are described in the statement of his daughter Ms Susan Oliver[2]. It is clear from her statement that Mr Black had been a hard-working man throughout his life. He had been both resourceful and not afraid of change. Indeed, at the age of 55 years he had moved from one successful occupation to another, namely to that of a builder and renovator of houses. Ten years prior to his death he and his second wife moved into a retirement village. Mr Black had been a fit, healthy and active man prior to the Alzheimer's dementia diagnosis. I gather from Ms Oliver's statement that despite this diagnosis, Mr Black and his wife had lived independently. He was coherent until about October 2014. Ultimately his health deteriorated and he suffered mood swings. I should add here that this pattern of decline is very often seen in older men and women whose deaths are reported to the State Coroner, particularly in those who suffer from dementia. It is an unfortunate fact of life that this type of dementia can manifest itself in unpredictable and at times aggressive behaviour that is quite out of keeping with the person's previous character and personality. Unfortunately Mr Black exemplified this.

1.6. On the day of Mr Black's 85th birthday his wife had to go into hospital for a minor back operation. It was decided that for the period of his wife's recovery it was in Mr Black's best interests for him to be cared for in the Estia Nursing Home at Strathalbyn.

[2] Exhibit C4

By then Mr Black had reached a stage where he could only be left alone for short periods.

1.7. Mr Black moved into the Estia Nursing Home on 11 December 2014. Sedatives had been prescribed for Mr Black in anticipation of that move. When the sedation began to subside Mr Black's behaviour became disruptive and so it was decided that he could not suitably be accommodated at Estia.

1.8. Mr Black was taken to the Strathalbyn Hospital. A decision again was made to sedate him, and again he was accommodated at Estia. The nursing home was simply not equipped to deal with such a high dependency patient. This is no criticism of the facility. On 24 December 2014 Mr Black was transferred to Ward 18 at RGH. In March of the following year he would die in that ward but not before other relevant events had occurred in the intervening period including his discharge from the RGH and his ultimate readmission in circumstances that I will describe in a moment.

1.9. Upon his admission to the RGH in December 2014 Mr Black was placed on a Level 1 ITO. This order was required as a result of Mr Black's agitated behaviour at Estia and was based upon the need to protect him. The order was clearly warranted. That order remained in force for 7 days. Following that period, and for similar reasons, it was considered necessary for a Level 2 ITO to be imposed. This occurred on 31 December 2014. The Level 2 ITO was also warranted.

1.10. On 14 January 2015 an application was made for a Level 3 ITO. As a matter of law, at that time a Level 3 ITO was required to be imposed by the Guardianship Board of South Australia. This application was made to the Board and the order was duly approved and authorised on 29 January 2015 with an expiry date of 28 July 2015. The order was imposed lawfully and appropriately.

1.11. During Mr Black's admission and treatment at the RGH he responded favourably. It was decided that he would benefit from a less restrictive environment and treatment regime so he was considered suitable for placement in a nursing home without detention under the Mental Health Act 2009. Indeed, detention under that Act could not have been lawfully executed in a nursing home.

1.12. On 23 February 2015 application was made for revocation of the Level 3 ITO. This was due to the fact that Mr Black had been accepted for a bed at the St Basil's Nursing

Home in Christie Downs. The Guardianship Board duly approved the revocation of the Level 3 ITO.

1.13. On 24 February 2015 the deceased was discharged to St Basil's Nursing Home with a view to a palliative care approach to his treatment.

1.14. Unfortunately within a few days Mr Black's agitated behaviour at St Basil's meant that he had to be taken to the Flinders Medical Centre. On 26 February 2015 this occurred and he was again placed, appropriately, on a Level 1 ITO. That day he was transferred to Ward 18 at the RGH. On this occasion he would remain detained within that ward until the day of his death. In the meantime the Level 1 ITO became a Level 2 ITO and it was while he was subject to that ITO that Mr Black died.

1.15. In August 2010 the deceased had granted Enduring Power of Guardianship to his wife and to Ms Susan Oliver. This document had stipulated that in the event that Mr Black's health deteriorated to the point of irreversible incontinence and immobility, he did not wish to have any lifesaving or life prolonging medical intervention. Instead, the deceased had requested the best standards of palliative care. Due to a number of episodes of non-responsiveness and marked decline in his physical health and due to the palliative care approach, it was decided that Mr Black would be deemed not for resuscitation and not for any unnecessary medical investigations, the focus of care being on comfort and palliation for his end stage degenerative condition.

1.16. A detailed investigation was conducted by police in relation to Mr Black's treatment at the RGH during the weeks prior to his death. It is not necessary to mention all of the detail. The decline was very typical of that seen in the elderly when afflicted with end stage dementia. There were falls and a diminishing of Mr Black's capacity to understand what was happening or where he was. Serious swallowing difficulties were encountered and a terminal respiratory failure and infection ensued. His comfort was managed with morphine for pain and other medication for respiratory secretions.

1.17. On 19 March 2015 Mr Black passed away. He was still under the Level 2 ITO which had appropriately been imposed.

1.18. The very detailed report of the investigating officer, Senior Constable First Class Darrin Widdrington of the South Coast Criminal Investigation Branch, has expressed a conclusion that Mr Black received the appropriate level of care and supervision while

in hospital. I note that Ms Oliver asserts in her statement that the RGH provided excellent care for her father's health and resulting behavioural problems. There is no reason to think otherwise. Mr Black's health care was of an appropriate standard.

1.19. I agree with the conclusions of the Investigating Officer and find that Mr Black's detention under the Mental Health Act was at all times lawful and appropriate and that his detained status did not in any way contribute to his death. On the contrary it ensured that Mr Black received the best of care.

1.20. There are no recommendations to be made in this matter.

Key Words: Death in Custody; Natural Causes; Inpatient Treatment Order

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 29th day of March, 2018.

Deputy State Coroner