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 11th day of March 2016 and the 8th day of February 2018, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Leon McLaren Brown.

The said Court finds that Leon McLaren Brown aged 94 years, late of Salisbury Private Nursing Home, 147 Frost Road, Salisbury, South Australia died at Salisbury, South Australia on the 5th day of April 2014 as a result of general inanition on a background of advanced dementia. The said Court finds that the circumstances of his death were as follows:

1. Introduction, cause of death and reason for Inquest

1.1. On 5 April 2014 Leon McLaren Brown, aged 94 years, died at the Salisbury Private Nursing Home (the facility). On 14 April 2014 a pathology review based upon Mr Brown's clinical history was undertaken by Dr Iain McIntyre of Forensic Science South Australia. In that review Dr McIntyre suggested that a post mortem examination was not necessary and that the cause of Mr Brown's death could be established as general inanition in a man with advanced dementia[1]. I accept that evidence and find that Mr Brown's cause of death was general inanition on a background of advanced dementia.

1.2. Mr Brown's death was a death in custody due to the fact that at the time of his death he was subject to the detention imposed pursuant to an order of the Guardianship Board of South Australia made under section 32 of the Guardianship and Administration Act

[1] Exhibit C2a

1993 (the Act). He was detained at the facility described above. He died at that facility. For all of those reasons an Inquest into the cause and circumstances of Mr Brown's death was mandatory. These are the findings of that Inquest.

2. Background and admission to the facility

2.1. Until early 2014 Mr Brown had been residing independently in his own home. On 17 January 2014 Mr Brown was admitted to hospital with a sore neck following multiple falls over the previous few weeks. Mr Brown had been experiencing falls and bouts of incontinence. In 2006 he had been diagnosed with Parkinson's disease by his general practitioner. This had been contributing, in part, to his falls. The general practitioner had personally attended at Mr Brown's home and it was clear that Mr Brown could no longer live alone.

2.2. Hospital notes record Mr Brown's refusal to use his four-wheeled walker and to participate in an ACAT assessment. On 28 January 2014 he was discharged home. The neck pain had been diagnosed as muscular in origin.

2.3. On 3 February 2014 Mr Brown was conveyed by ambulance to the Modbury Hospital following more falls. The ambulance case card indicates that Mr Brown had been reported as having fallen at about 1pm, but that he had not depressed his medic alert button to request assistance until 12:23am the following morning. Other than a skin tear on his left forearm there were no visible injuries on Mr Brown. No acute fractures were found. His medications were altered because it was considered that they may have contributed to his lack of balance and therefore to his falls.

2.4. Mr Brown was refusing to accept that he was no longer capable of looking after himself at home and he was adamant that he would return to his home upon discharge from hospital.

2.5. In July 2013 Mr Brown's son, Mr Trevor Brown, had been granted an Enduring Power of Attorney in respect of his father. He and his sister, Ms Yvonne Chapman, were also enduring guardians by virtue of an Enduring Power of Guardianship that had been executed in 2013. On 20 February 2014 they jointly applied to the Guardianship Board for orders pursuant to section 32 of the Act. On 7 March 2014 orders were made by the Guardianship Board. They included that Mr Brown's guardians would be Trevor and Yvonne Chapman and that he would reside and be detained at such place as the

guardians from time to time think fit. The orders were to remain in effect for six months with a recommendation that they be reviewed on or before 6 September 2014. With the order in place Mr Brown's children made arrangements for him to be moved to the facility.

2.6. On 11 March 2014 Mr Brown was discharged from the Modbury Hospital and admitted to the facility. He remained a resident there until his death only a matter of weeks later. During the period of residence at the facility Mr Brown was treated on five occasions by Dr Ching Thim Chow, a general practitioner. He was noted to be suffering from type 2 diabetes, prostate cancer and dementia. For most of his admission Mr Brown refused food and fluids and would only eat and drink after considerable encouragement from nursing staff. This pattern of refusal was well documented within Mr Brown's clinical record.

2.7. The staff at the nursing home monitored his food and fluid intake carefully. Consideration was given to the insertion of a PEG tube to ensure adequate feeding. However, this measure was not considered to be appropriate for Mr Brown given his age, his comorbidities and the fact that he had previously expressed the desire that he did not want active measures to be taken to prolong his life. Mr Brown's wishes in this regard had been documented within the Enduring Power of Guardianship that had been executed in 2013.

2.8. On 5 April 2014 a nursing check revealed that Mr Brown was cold to the touch, was experiencing laboured breathing and had an undetectable pulse at wrist and elbow. The ambulance service was called and they observed that Mr Brown was cool to the touch and had a shallow breathing pattern.

2.9. Mr Brown's family members were contacted by phone. They advised that Mr Brown's wishes and their wishes were for him not to be resuscitated or be provided with any life saving measures. There is no question but that this course was appropriate. Mr Brown was then moved to a palliative care room at the facility. Further observations were conducted over the next few hours. Mr Brown remained unconscious with an undetectable blood pressure. Morphine was administered for pain relief.

2.10. At about 12:13pm it was considered that all signs of life were absent and that Mr Brown had died.

3. Conclusions

3.1. The orders imposed by the Guardianship Board were appropriately applied for and granted. Mr Brown did not experience any insufficiency of care at the facility. His detention at the facility did not contribute to his death. His death was not preventable. I am reinforced in these conclusions by the thorough investigation and report of the investigating police officer, Detective Brevet Sergeant Daniel Nelligan of the Elizabeth CIB, who came to the same conclusions.

4. Recommendations

4.1. The Court does not make any recommendation consequent upon these findings.

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 8th day of February, 2018.

Deputy State Coroner