



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 May 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 Alfred Henry Cooper.

The said Court finds that Alfred Henry Cooper aged 94 years, late of Trevu House Nursing Home, 19 Dawkins Avenue, Willaston, South Australia died at Willaston, South Australia on the 6th day of July 2014 as a result of pneumonia 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. Mr Alfred Henry Cooper, aged 94, died on Sunday 6 July 2014 at the Trevu House Nursing Home at Willaston.
- 1.2. A pathology review undertaken by Dr Iain McIntyre of Forensic Science South Australia, as discussed with Associate Professor Neil Langlois, a forensic pathologist at FSSA, and based upon an examination of Mr Cooper's recent clinical history, states that in Dr McIntyre's opinion the cause of Mr Cooper's death was pneumonia in a man with severe dementia. I accept Dr McIntyre's opinion.
- 1.3. I find that the cause of Mr Cooper's death was pneumonia on a background of severe dementia.

2. Reason for Inquest

- 2.1. At the time of his death Mr Cooper was subject to detention pursuant to an order made by the Guardianship Board of South Australia under section 32 of the Guardianship and

Administration Act 1993. As a result of that order Mr Cooper was detained at Trevu House where he resided. He died at that facility. Accordingly, Mr Cooper's death was a death in custody in respect of which a mandatory Inquest was required. These are the findings of that Inquest.

3. Background

- 3.1. Mr Cooper's productive life and decline in old age is poignantly described in the statement of his daughter, Ms Annette Maxine Broughton. Ms Broughton signed two witness statements for the Court¹. Ms Broughton indicates in her statement² that in 2006 she and her siblings started to notice some changes in Mr Cooper's behaviour. In due course they became concerned about his driving in particular. In 2011 Mr Cooper had been found wandering the street naked. His subsequent hospitalisation in Port Pirie where his mental health was tested resulted in the view being taken that Mr Cooper was no longer capable of living by himself. He had also become quite frail by that time.
- 3.2. In the event orders were sought and granted from the Guardianship Board of South Australia, including the power of detention in Mr Cooper's place of residence. Such an order has the objective, in the interests of the person's safety, of preventing the person from leaving the facility in which they are accommodated. In his thorough investigation report, the investigating police officer, Detective Simon Carpenter, has indicated that despite the recommendations made by the Board that the detention orders be reviewed during their currency, the orders were still in force as of the date of Mr Cooper's death. I agree with Detective Carpenter's assessment that the failure for those orders to be reviewed had no impact on their validity. I also tend to think that by the time of Mr Cooper's final decline, the orders were no longer necessary. However, it is plain that whether or not the orders were still in place, the issue of their currency or validity had no bearing on Mr Cooper's circumstances, nor on his death. According to the statement of Ms Broughton, at no time after the orders were made did her father attempt to leave the hospital or any of the nursing homes that he lived in.
- 3.3. Mr Cooper moved into the Trevu House facility in March 2012. He remained there until he died in July 2014. Ms Broughton described some concern that from time to time she had entertained that her father may not have been receiving sufficient sustenance and nutrition. She visited her father almost every day and would regularly

¹ Exhibits C1b and C1c

² Exhibit C1c

take food into him. She indicates in her statement that the question of his nutrition existed in the six months prior to his death. During this time Mr Cooper was bedridden and incapable of feeding himself. Ms Broughton had an impression that the Trevu House facility was not particularly well-staffed.

4. Mr Cooper's decline in health and ultimate death

- 4.1. From the outset of Mr Cooper's accommodation at Trevu House he was looked after by Dr David London whose practice was situated at the Gawler Medical Clinic. He would see Mr Cooper generally about once a month and sometimes more frequently. According to the statement of Dr London³, Mr Cooper suffered from a number serious illnesses including progressive dementia, osteoarthritis, hearing loss and was prone to infection. His health clearly declined quite quickly. During the two years that Dr London treated Mr Cooper his dementia symptoms were becoming progressively worse and he experienced bouts of minor chest and urinary infections. Dr London confirms that Mr Cooper was basically bedridden for the last few months of his life. He last saw Mr Cooper on 2 July 2014 when his overall condition was declining. At that time Dr London felt that comfort care was more important at that stage of his life.
- 4.2. On 5 July 2014 Mr Cooper was seen by Dr London's colleague, Dr John Salagaris. Dr Salagaris identified a serious decline in Mr Cooper's health over the past two days. Mr Cooper was febrile and resisting oral intake of food and fluid. He formed the view that noises within Mr Cooper's lung indicated that he was suffering from an overwhelming respiratory sepsis. Dr Salagaris determined that antibiotics would not be effective and so prescribed palliative medications only.
- 4.3. At 7:10am the following morning, namely Sunday 6 July 2014, Mr Cooper passed away.
- 4.4. Tendered to the Court was the statement of Ms Vanessa Slape⁴ who was the Facility Care Manager at Trevu House at the time with which this Inquest is concerned. She indicates that Trevu House was funded to accommodate 45 care residents. As far as staff was concerned the facility conducted three shifts comprising a morning shift staffed by one registered nurse, one enrolled nurse and seven carers. The afternoon shift was staffed by one registered nurse and four carers. The night shift was staffed by one registered nurse and two carers. Ms Slape first encountered Mr Cooper in 2014.

³ Exhibit C4

⁴ Exhibit C3

Ms Slape describes Mr Cooper's time at Trevu House in the period from May to July of 2014. Her observations are based on the Trevu House clinical records. She observes that Mr Cooper was unable to recall recent events and was in fact unable to participate in a mini-mental examination due to severe impairment. Ms Slape indicates that Mr Cooper's weight loss was noted. A weight loss chart was commenced for Mr Cooper. He required full care from nursing and care staff to perform his activities of daily living. This included assistance from staff to eat and drink. A choking episode was documented which prompted a speech pathology referral. Naturally such an issue would not have helped in maintaining nutrition.

5. Conclusion

- 5.1. I have already referred to the investigation conducted by Detective Carpenter of SAPOL. In respect of the issue as to whether the care and treatment of Mr Cooper had been appropriate whilst at Trevu House, Detective Carpenter concluded that the matter of Mr Cooper's weight loss was not something that contributed to his death. I agree with that conclusion. The decline of Mr Cooper and his apparent limited oral intake is quite typical of that seen in many persons whose life is coming to an end, particularly in those afflicted with the extremely debilitating condition of dementia.
- 5.2. To my mind neither Mr Cooper's circumstances of detention nor his residence within the Trevu House facility pursuant to that detention contributed to his death.

6. Recommendations

- 6.1. There are no 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 8th day of February, 2018.

Deputy State Coroner