



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 26th day of April 2018, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Haralambos Maheras.

The said Court finds that Haralambos Maheras aged 74 years, late of Clements House, 200 Fosters Road, Oakden, South Australia died at Oakden, South Australia on the 15th day of May 2014 as a result of ischaemic heart disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

- 1.1. Haralambos Maheras was 74 years of age when he died at Clements House, Oakden on 15 May 2014. Clements House was a secure residential care facility operated pursuant to the Adelaide Metro Mental Health Directorate - Older Persons Mental Health Service. Mr Maheras suffered from severe dementia at a level that had been resistant to management within a conventional nursing home.
- 1.2. As at the time of his death Mr Maheras had been a resident at Clements House for approximately 9 months having moved into the facility on 7 August 2013. He had earlier been accommodated at Playford Village Baptist Care Nursing Home at Davoren Park (Playford Village) where unfortunately, due to the severity of his condition, his care needs could not adequately be met.
- 1.3. At the time of his death Mr Maheras was the subject of orders imposed by the Guardianship Board of South Australia pursuant to the Guardianship and Administration Act 1993 (the Act). One such order had been made pursuant to section

32 of the Act. The order authorised Mr Maheras' detention in his place of residence. He died at the Oakden facility while under detention. His death was therefore a death in custody in respect of which an Inquest into the cause and circumstances of his death was mandatory. These are the findings of that Inquest.

2. Cause of death

- 2.1. A post mortem examination of Mr Maheras' remains was carried out by Professor Roger Byard, a forensic pathologist at Forensic Science South Australia. Professor Byard's post mortem report¹ records Mr Maheras' previous medical history as including severe dementia, hypertension, hyperlipidaemia and osteoarthritis. The anatomical findings at post mortem included gyral atrophy of the brain, marked focal coronary artery atherosclerosis, congestion of the lungs, mild to moderate abdominal aortic atherosclerosis and liver fibrosis. Professor Byard determined and reported that the cause of Mr Maheras' death was ischaemic heart disease. In this regard Professor Byard reports that there was significant atherosclerotic narrowing of one of the three major epicardial coronary arteries. There were no other underlying organic diseases which could have caused or contributed to Mr Maheras' death. I find that the cause of Mr Maheras' death was ischaemic heart disease. In essence, Mr Maheras died of a heart attack.
- 2.2. Professor Byard found no evidence of significant trauma. This finding supports evidence gathered by police during the course of their investigation at the facility on the day of Mr Maheras' death.
- 2.3. I have examined photographs taken by investigating police of Mr Maheras in repose at the Clements House facility. Mr Maheras is situated lying on a bed. He is clothed in pyjama bottoms and a polo shirt. Photographs were taken of Mr Maheras' face in close-up as well as his arms, hands, lower legs and feet in close-up. There are also photographs of Mr Maheras' torso including his chest, side and back. Other than natural post mortem lividity to Mr Maheras' back and right hand side as can be seen in the photographs, there is no injury or blemish to any part of his body. Mr Maheras appears to have been well nourished. His room as depicted in the photographs is apparently clean and uncluttered. His clothing is neatly stacked in a wardrobe and drawers.

¹ Exhibit C2a

- 2.4. It can be seen both from Professor Byard's post mortem report and from other clinical evidence that Mr Maheras' death was sudden and not expected. This is naturally in keeping with the cause of death being an acute heart attack. I note that Mr Maheras did not have any previously diagnosed heart disease prior to death. As also will be seen, Mr Maheras' death was not witnessed. No person was present when he died. When located by facility staff at approximately 7:30am on the day in question Mr Maheras showed no signs of life, although his skin was still warm to the touch. As Mr Maheras was under a palliative care order as well as a not for resuscitation order, no resuscitative measures had been administered.

3. Background and events leading to detention under the Act

- 3.1. Mr Maheras had been a market gardener and an active and productive man. He and his wife had been married for 53 years. They had five children. In about the year 2000 Mr Maheras retired to become a full-time carer for his wife who was an amputee and who had other health issues. She required a wheelchair for mobility. From about 2009 Mr Maheras started experiencing memory difficulties. In 2012 he was diagnosed with dementia which continued to worsen. As well, Mr Maheras was later diagnosed with major depression and anxiety, complications that can emerge as dementia worsens. His dementia manifested itself in behaviour that was quite out of keeping with his normal quiet character and which became difficult for his family members to manage.
- 3.2. Mr Maheras was referred to a geriatrician, Dr Chen Siang Peh. Dr Peh saw Mr Maheras on several occasions. It was while Mr Maheras was under Dr Peh's care that he was diagnosed with and treated for dementia and subsequently with major depression complicated by anxiety. Dr Peh last saw Mr Maheras in March 2013.
- 3.3. On 16 April 2013 at the family home an incident occurred in which Mr Maheras became aggressive towards his wife. Unfortunately both police and the South Australia Ambulance Service (SAAS) had to be called to provide assistance. At 8:40am that day SAAS ambulance officers took Mr Maheras into their care and control pursuant to section 56 of the Mental Health Act 2009. Mr Maheras was conveyed to the Lyell McEwin Hospital (LMH) where he was assessed and treated pursuant to section 14B of the Consent to Medical Treatment and Palliative Care Act 1995.
- 3.4. During Mr Maheras' admission at the LMH numerous code blacks were called due to his physical aggression and dementia related behaviour. In addition, Mr Maheras

exhibited a desire to leave the hospital. Mr Maheras had to be physically restrained for the protection of himself, staff and other patients.

- 3.5. Mr Michael Maheras was Mr Maheras' youngest child. Michael Maheras provided a comprehensive witness statement to investigating police. The statement describes his father's deterioration. It also describes his father's care at the hands of a number of entities including ultimately Clements House. A family decision was made that Michael Maheras be appointed his father's guardian². On 19 April 2013 a Guardianship Board hearing determined that an interim guardianship order containing section 32 powers should be granted to Michael Maheras. Michael Maheras' statement makes it clear that he understood that the effect of and need for the section 32 detention order was that his father had to be kept in secure care because without the order a hospital or other facility at which his father resided, or would reside, would not lawfully be able to prevent his father from leaving if he attempted to. On 3 May 2013 the Guardianship Board would confirm both Michael Maheras' appointment as his father's guardian as well as the section 32 detention powers.
- 3.6. Mr Maheras remained an inpatient at the LMH until 23 April 2013 when he was transferred to Playford Village. He remained in this facility until 14 June 2013 when he was transferred back to the LMH due to his deterioration and to the increased level of care that was now required but which could no longer be provided at Playford Village. During the weeks that Mr Maheras was resident at Playford Village he had displayed inconsistent behaviour. His dementia and resultant behaviour was noted generally to worsen. The statement of the clinical manager of that facility, Ms Jan Sheehan³, describes the particular difficulties associated with Mr Maheras' care. In his statement Michael Maheras states that he and his mother visited Mr Maheras every day. He adds that in his opinion Playford Village was a 'lovely facility' and that the staff were excellent.
- 3.7. Immediately upon Mr Maheras' transfer back to the LMH on 14 June 2013 he was placed on a Level 1 Inpatient Treatment Order (ITO) under the Mental Health Act. On 19 June 2013 a Level 2 ITO was implemented.

² Exhibit C9

³ Exhibit C8

- 3.8. Between 14 June 2013 and 7 August 2013 Mr Maheras remained a detained patient in LMH in ward 1H which was a secure ward in the hospital.
- 3.9. On 7 August 2013 Mr Maheras was transferred to Clements House at Oakden. While a resident at Clements House Mr Maheras remained under the guardianship and administration order and was subject to the section 32 detention powers contained within that order. This order and the section 32 powers remained in force until his death on 15 May 2014.
- 3.10. Michael Maheras indicates in his statement that at Clements House his father occupied a shared room with one other male resident. Initially he visited his father every day, and then on every other day alternating with a sister. In the event, for reasons that do not need to be described here, it became necessary for his visits to be restricted to about once a week. It is apparent from the Clements House clinical record that Mr Maheras' wife was a regular visitor despite her own disabilities.
- 3.11. Over the months following his admission to Clements House Mr Maheras' physical health remained relatively unchanged. However, his dementia and associated behaviours deteriorated. This deterioration, and the behaviour that it marked, is graphically documented on an almost daily basis within Mr Maheras' clinical record.
- 3.12. On 26 March 2014 Mr Maheras lost his balance and fell after he started running at the facility. The fall resulted in him sustaining a broken nose. That day he was taken to Modbury Hospital where clinical staff diagnosed the broken nose and cleared him of any other significant injury. He was returned to Clements House on the same day. Michael Maheras' statement makes it plain that Clements House staff made him aware of the incident in a timely manner. They told him that his father had been running and that they had attempted to stop him but that before they could catch him he fell on the outside pavers. This account of events is documented in detail in Mr Maheras' Clements House clinical record which I have read in full. I have also read the Modbury Hospital discharge summary. It records a history of a mechanical fall resulting in sustained bleeding from the nose and multiple superficial abrasions. A CT scan of the head revealed the nasal bone fracture. There was no intracranial bleed. It records that the patient was discharged back to his nursing home on the same day.

4. Coronial investigation

- 4.1. During the course of the police investigation a number of witness statements were taken from persons associated with the care of Mr Maheras at Clements House. One such statement was from mental health nurse, Michael Henderson⁴. Mr Henderson's statements indicate that he began treating Mr Maheras on the day that Mr Maheras arrived at Clements House. Mr Henderson was aware that Mr Maheras, whom he referred to as 'Harry' in his statements, suffered from severe dementia. This condition resulted in dementia related behavioural issues which were regularly exhibited at Clements House. Mr Henderson was aware of the fall that caused a fracture to Mr Maheras' nose. He was aware that Mr Maheras had been reviewed by a doctor at the Modbury Hospital and that there were no ongoing issues surrounding the fall. That there were no adverse lasting consequences for Mr Maheras is borne out by the clinical record. It was Mr Henderson who found Mr Maheras deceased at about 7:30am on morning of his death. In his statements Mr Henderson explains that at the time of his death, Mr Maheras had been under palliative care and not for resuscitation orders. The existence of both orders was documented within Mr Maheras' clinical record at Clements House.
- 4.2. Dr Jennifer Lim⁵ was the doctor who certified Mr Maheras' life extinct on the morning of his death. Dr Lim had been Mr Maheras' treating practitioner since February 2014. She states that Mr Maheras' behavioural and psychological symptoms were such that his dementia had been too difficult to manage in a conventional nursing home. However, his behaviour had been reasonably well controlled in Clements House by medication and through the efforts of nursing staff. Dr Lim describes Mr Maheras' treatment and medication regime while at Clements House. Dr Lim's statement asserts that she saw Mr Maheras, whom she also refers to as 'Harry', every day as she was the resident medical officer on his ward. Dr Lim indicates that Mr Maheras had a treating psychiatrist who was Dr Patrick Flynn. The only matter of note that Dr Lim raises in her statements is the fact that Mr Maheras had been taking the drug clonazepam long-term to manage his agitation. However, his dosage was decreased by Dr Flynn on 22 April 2014 as Mr Maheras was noted to be sleepy during the day. During a clinical review meeting on 13 May 2014 the nurses at Clements House indicated that

⁴ Exhibits C1b and C1c

⁵ Exhibit C5

Mr Maheras was noted to be drowsy and dozing off during the day. As a result a decision was made to cease clonazepam. The nursing staff had been satisfied with Mr Maheras' behaviour and so clonazepam was ceased.

4.3. I return to the statement of Mr Michael Maheras. In his statement he indicates that around Easter 2014, at a time when his sisters were over from Melbourne, one of the Clements House staff spoke to him and his sisters about their father's care. In particular they were asked to consider what should occur in the event that Mr Maheras was no longer able to eat or had deteriorated further, and whether they wanted him to be resuscitated. Michael Maheras indicated that a decision was made that if their father reached that stage they did not want him to be resuscitated. As a result the necessary documentation was completed. Thus the fact that no resuscitative measures were put in place when Mr Maheras was found collapsed in his bed on the morning of his death was in accordance with his family's wishes.

4.4. Michael Maheras last saw his father approximately a week before he died. There was nothing unusual or different about him on that occasion. Michael Maheras was informed by Clements House staff of his father's death on the day of his death.

4.5. In his statement Michael Maheras indicates that his father's death came as a complete shock to him. It is true that Mr Maheras' death was sudden and unexpected and that he died from a previously undiagnosed disease of the heart. Michael Maheras states as follows:

'My family and I did not have any concerns about the care or treatment provided to my father whilst he was at Clements House.'

4.6. As to the circumstances of Mr Maheras' death I have already referred to the fact that it was mental health nurse Mr Henderson who discovered that Mr Maheras had died. This discovery was made at about 7:30am on the morning in question. At that time Mr Henderson entered the room to check Mr Maheras' co-occupant. In the process of doing this he noticed that Mr Maheras appeared to be discoloured, was lying on his side facing slightly downward and that his legs were facing towards the floor. His lower torso was hanging off the end of the bed from his side to his leg. Mr Henderson could not locate a pulse.

- 4.7. Mr Maheras had last been seen alive by an enrolled nurse, Ms Alexandra Zerella⁶, at approximately 6:50am that morning. At that time she had walked into the room. She observed that both Mr Maheras and his co-occupant had been asleep. She had watched Mr Maheras' chest rise and fall. He was sleeping on his back. She did not wake him. At 7:30am she was notified that Mr Maheras had died.
- 4.8. It is apparent and I find that Mr Maheras died between 6:50am and 7:30am on the morning of Thursday 15 May 2014.
- 4.9. Police attended the Clements House facility on the morning of Mr Maheras' death. I received in evidence a number of statements from attending police officers. I have already referred to the photographs that were taken by police. A Criminal Investigation Branch Detective and a crime scene investigator attended. Uniformed officers also attended. Observations were made of Mr Maheras' body by police. Around the immediate area of his body there were no signs of a struggle. The deceased had no defensive wounds. It was the opinion of Constable Danielle Kerin⁷, a uniformed police officer who attended, that Mr Maheras died in unexpected but non-suspicious circumstances. The CIB Detective, Mr Sean Willdin⁸, conducted detailed observations of the deceased's head, back, chest, legs and arm. There were no signs of injuries or marks and there were no suspicious features. The deceased's face was clean with no discharge or fluids observed. There were no signs of forced entry to his room or of trauma to the deceased. Detective Willdin expresses the opinion that there were no suspicious circumstances surrounding Mr Maheras' death. Detective Willdin postulates that from the position in which the deceased had been located, he had been in the process of getting into or out of bed and was seated on the side of the bed. To my mind this is a conclusion that is available from the evidence. It is supported by the observations of the nurse Mr Henderson.
- 4.10. Mr Maheras' death was further investigated by Detective Brevet Sergeant Michaela Nash of the Holden Hill Criminal Investigation Branch. Detective Nash compiled a thorough, informative and helpful investigation report⁹. She investigated a number of

⁶ Exhibit C4

⁷ Exhibits C11 and C11a

⁸ Exhibit C12

⁹ Exhibit C14

issues, one of which was naturally whether the care and treatment of the deceased whilst at Clements House was appropriate. I set out Detective Nash's conclusions in this regard:

'Throughout the deceased's admission at Clements House, he continued to be resistive towards treatment or care by staff. He was also reported to display antisocial behaviour and attempted to run away from staff whilst he was at the facility. He was visited by family but would often become distressed and difficult to settle by staff, which resulted in the family reducing the times they visited.

In relation to the Palliative Care Plan that was in place whilst at Clements House, I deem that this was appropriate. A Palliative Care Order/Treatment Plan is in relation to the wishes for treatment by a patient (or there (sic) carer) during the end stages of their life to prevent ongoing pain and suffering. These treatment orders do not have any impact on Section 32 orders and do no (sic) replace these orders as they serve different purposes.

I deem the admission and subsequent care of the deceased during his stay at Clements House was more than appropriate.'

5. Conclusions

- 5.1. I agree with the above conclusion of Detective Brevet Sergeant Nash. I have thoroughly examined the clinical record relating to Mr Maheras that was maintained at the Clements House facility. There is nothing within it that gives rise to any concern in respect of the quality of Mr Maheras' care. There is no evidence of any maltreatment or neglect. Members of Mr Maheras' family regularly visited him. I have been unable to find within the record any adverse matter of significance that Mr Maheras' family drew to the attention of staff.
- 5.2. To my mind there was nothing unusual or defective about the care provided to Mr Maheras at the Clements House facility. His death was not caused by nor contributed to by any deficiency in care. Indeed, no deficiency in care has been identified. His fall on 26 March 2014 and the consequent broken nose did not contribute to his death. The fall was documented, was the subject of immediate medical intervention and was promptly notified to Mr Maheras' family.
- 5.3. The fact that Mr Maheras was detained within this facility also did not contribute to his death. His detention in that facility was appropriate in that it was clear, as evidenced by the statement of Ms Sheehan¹⁰, the Clinical Manager of the Playford Village facility, that he could not satisfactorily be managed within a conventional nursing home.

¹⁰ Exhibit C8

Having regard to the nature of Mr Maheras' severe dementia and the manifestations of it in terms of his behaviour as documented with the Clements House records, I am not surprised at that conclusion.

6. Recommendations

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

Key Words: Death in Custody; Section 32 Powers; Natural Causes; Oakden Aged Care

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

Seal the 26th day of April, 2018.

Deputy State Coroner