



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 25th day of August 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 Barry John Matthews.

The said Court finds that Barry John Matthews aged 69 years, late of Linsell Lodge, 2 Cardigan Street, Angle Park, South Australia died at Angle Park, South Australia on the 21st day of February 2015 as a result of metastatic squamous cell carcinoma of the lung with chronic obstructive lung disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Barry John Matthews was 69 years of age when he died on 21 February 2015 at the Linsell Lodge aged care facility at Angle Park. His death was the subject of a pathology review undertaken by Dr Iain McIntyre of Forensic Science South Australia. The cause of death as described by Dr McIntyre in his report¹ was metastatic squamous cell carcinoma of the lung with chronic obstructive lung disease. I find that to have been the cause of Mr Matthews' death.

2. Reason for Inquest

2.1. On 13 March 2014 an interim guardianship and section 32 order pursuant to the Guardianship and Administration Act 1993 had been granted to the Public Advocate in respect of Mr Matthews. On 21 March 2014 the guardianship order was confirmed but

¹ Exhibit C2

the section 32 powers were revoked. However, on 7 January 2015 there was a further application for section 32 powers including the power of detention. Interim orders were granted at that time. On 19 January 2015 the special powers were confirmed. Thus at the time of Mr Matthews' death there was a guardianship order in place with special powers pursuant to section 32, including the power of detention, granted to the Public Advocate.

- 2.2. Mr Matthews' death was a death in custody. This was due to the fact that at the time of his death he was detained pursuant to the section 32 detention order to which I have referred. His place of detention as at the time of his death was Linsell Lodge. He died in that place. For those reasons a mandatory Inquest into the cause and circumstances of Mr Matthews' death was required. These are the findings of that Inquest.

3. Background

- 3.1. Mr Matthews had suffered from an intellectual disability from a very young age. Between the age of about five and seven years he was placed by his family into the care of Minda Home (Minda). His family had been unable to provide him with the level of care that was required.
- 3.2. Mr Matthews remained a resident of Minda until he was about 18 or 19 years of age. He then left Minda to live independently.
- 3.3. Mr Matthews never married and only had sporadic contact with his family.
- 3.4. Mr Matthews' intellectual disability meant that he frequently could not comprehend the events taking place around him. In his younger years this was manifested in inappropriate verbal and physical behaviour. In his later years for the most part the behaviour was verbal. Mr Matthews was a heavy smoker throughout his life.
- 3.5. In 2001 Mr Matthews was found by a worker from Uniting Care Wesley to be sleeping rough in the Port Adelaide area. This worker ultimately befriended Mr Matthews and assisted him to gain employment through Uniting Care Wesley. The worker also arranged accommodation for him in a Housing Trust flat at Pennington. Mr Matthews lived in that flat until his ultimate admission to hospital and eventual admission to the Linsell Lodge in early 2015.

4. Mr Matthews' decline in health

- 4.1. On 17 February 2014 Mr Matthews consulted his general practitioner regarding a cough and cold. Amoxil was prescribed. On 19 February 2014 he saw the same doctor because his symptoms were not resolving. The doctor determined that it was necessary for Mr Matthews to undergo a chest X-ray and blood tests. Although Mr Matthews was at first resistant to that course he eventually underwent the examinations. On 27 February 2014 he consulted the doctor regarding the results of the tests both of which revealed abnormalities. The cough had still not improved and so he was referred to the Queen Elizabeth Hospital (the QEH) for an inpatient review which Mr Matthews' doctor considered would provide the best possible opportunity to secure his compliance with recommended investigations and treatment.
- 4.2. On 12 March 2014 Mr Matthews was taken by ambulance to the QEH where he presented with shortness of breath, weight loss, a cough and a reported five week history of reduced exercise tolerance. He was admitted under the respiratory team. The QEH doctors felt that further investigation was warranted. Differential diagnoses of tuberculosis or cancer were made. Mr Matthews wanted to leave the hospital. The treating medical practitioners felt that he was not capable of making rational decisions about his situation. It was then that in the first instance a guardianship order and section 32 powers were applied for and granted. On 21 March 2014 the guardianship order was confirmed but the interim section 32 order was lifted.
- 4.3. Between 13 and 14 March 2014, while the section 32 orders were in place, Mr Matthews underwent a CT scan and bronchoscopy which revealed a large left lung mass. A diagnosis of small cell lung cancer was made. Mr Matthews was referred to the oncology department of the QEH. Upon that referral liaison between the treating team involved, the Office for the Public Advocate and Mr Matthews' friends and family took place. Mr Matthews was supported by the man whom he had befriended through Uniting Care Wesley in 2001 and by another friend who was a neighbour at the Pennington units. It was agreed that due to his intellectual disability Mr Matthews had little insight as to his diagnosis. He just wanted to go home. A decision was made that it was in Mr Matthews' best interests that he undergo chemotherapy. In the event the Public Advocate provided consent for this treatment pursuant to the powers granted under the existing guardianship order. Eventually Mr Matthews did become agreeable to that course.

- 4.4. On 31 March 2014 Mr Matthews was discharged home after having undergone his first round of chemotherapy. The plan was for him to receive hospital at home care and have regular blood testing. The Office for the Public Advocate arranged an aged care assessment for him in an endeavour to secure further services such as cleaning and home care. The friends whom I have mentioned also assisted Mr Matthews around his home.
- 4.5. On 6 April 2014 Mr Matthews was returned to the QEH due to the development of febrile neutropenia from chemotherapy treatment. Chest X-rays that were administered showed that the cancer had actually reduced in size at that time.
- 4.6. From 14 to 16 April 2014 Mr Matthews underwent his second round of chemotherapy. From 6 May to 27 May 2014 he underwent his final two rounds of chemotherapy. CT scans demonstrated a further reduction in the size of the cancer. Mr Matthews' weight had also improved. In June and then again in August 2014 Mr Matthews was reviewed at the QEH. His cancer appeared to have further reduced in size and he was receiving ongoing daily living assistance in his home.
- 4.7. However, on 17 October 2014 Mr Matthews was found on the floor at home by his neighbour. He had been unable to move and had been incontinent. He was conveyed to the QEH by ambulance. On this occasion a CT scan of his brain revealed multiple brain metastases. He was commenced on dexamethasone to reduce the swelling associated with those metastases.
- 4.8. On 3 November 2014 Mr Matthews was discharged home after four brain radiotherapy sessions. He again received domestic support through services and friends and family. However, on 7 January 2015 when Mr Matthews' doctor conducted a home visit, he was found to be clearly unwell. His breathing and heart rate were rapid and he had a productive cough. The doctor was concerned that he had developed a chest infection and so he referred him back to hospital. It was at this time that a further urgent application was made to the Guardianship Board with regard to implementing section 32 powers of detention. This was due to the fact that Mr Matthews was reluctant to go to or remain in hospital. The urgent application was brought by the Office of the Public Advocate and interim orders were made so as to enable his hospitalisation.
- 4.9. On admission to hospital on this occasion Mr Matthews underwent a chest X-ray which revealed that the mass in the left chest had increased in size. From that point he was

admitted under the palliative care team. Mr Matthews remained generally resistant towards care and towards any suggestion that he had to stay in hospital. Ultimately the section 32 detention orders were confirmed. Mr Matthews was spoken to regarding resuscitation plans. He indicated that he did not want to live as a vegetable and that if CPR was required he did not want to be resuscitated.

- 4.10. Ultimately a place was secured for Mr Matthews at Linsell Lodge. On 6 February 2015 he moved to that facility. The section 32 detention remained in place. Mr Matthews continued with dexamethasone for ongoing reduction in brain swelling. Haloperidol was also introduced in an effort to control some of his erratic outbursts and behaviour. There were instances of uncooperative behaviour throughout his stay. He refused many of the services that were offered to him at the facility. He continued to smoke throughout this period.
- 4.11. On 17 February 2015 Mr Matthews was examined at Linsell Lodge by a visiting general practitioner. He was found to have a moist, chesty cough with decreased oxygen saturations. He was commenced on Augmentin Duo Forte due to the suspicion that he had a chest infection. Over the course of the evening of 21 February 2015 it was clear that Mr Matthews was having trouble breathing. Nurses attended to him and increased his oxygen delivery incrementally over time until it was at a level of 15 litres. However, he still struggled to breathe. At 10:40pm on that day he died at the facility in the presence of nursing staff.

5. **Coronial investigation**

- 5.1. I should pass comment on the excellence of the police investigation in relation to Mr Matthews' death. The investigation was overseen by Senior Constable Matthew Legge of the Western Adelaide Criminal Investigation Branch. Senior Constable Legge's investigation and report of that investigation² is as extensive and as thorough as I have seen in respect of a matter such as this. I also agree with the conclusions that Senior Constable Legge has expressed in his report.
- 5.2. Senior Constable Legge concluded that Mr Matthews' treatment at the various locations at which his care was administered was of a satisfactory standard. The only blemish in care that Senior Constable Legge identified was the fact that in the three days prior to Mr Matthews' death at the Linsell Lodge he was not administered the prescribed

² Exhibit C19

dexamethasone medication. Staff at the facility identified this omission on the day of Mr Matthews' death. A locum doctor was called in on that day to review Mr Matthews and his medication chart. It was determined that he could be recommenced on the medication the following day. However, Mr Matthews died a short time later. A statement was taken from Dr Rachel Roberts-Thomson³ who was Mr Matthews' specialist treating doctor at the QEH for his lung cancer. It was this medical practitioner who had commenced the deceased on dexamethasone. Dr Roberts-Thomson has stated that the dexamethasone was not prescribed for the purpose of treating the cancer itself, but for assisting in the alleviation of side effects of chemotherapy treatment and with the swelling associated with brain metastases. The medication would also assist in alleviating and treating shortness of breath. Dr Roberts-Thomson has stated that the deceased missing three doses of this medication was unlikely to have significantly impacted on his prognosis given the diagnosis and progression of his terminal cancer. I accept that evidence. In any event a plan had been in place to gradually wean Mr Matthews off that medication as it can have long-term side effects. I agree with the conclusion reached by Senior Constable Legge that this did not contribute to Mr Matthews' death.

6. Conclusion

- 6.1. I find that Mr Matthews' detention was at all times lawful and appropriate and that it did not contribute to his death. On the contrary, it ensured that he was properly cared for and suitably accommodated at all material times.

7. Recommendations

- 7.1. There are no recommendations to be made in this matter.

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

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

Seal the 26th day of April, 2018.

Deputy State Coroner

³ Exhibit C12