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 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 Joseph McKenna.

The said Court finds that Joseph McKenna aged 83 years, late of Gleneagles Aged Care Facility, 1099 Grand Junction Road, Hope Valley, South Australia died at Hope Valley, South Australia on the 23rd day of November 2014 as a result of cholangiocarcinoma on a background of advanced dementia and ischaemic valvular and hypertensive heart disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Joseph McKenna was 83 years of age when he died on 23 November 2014 at the Gleneagles Aged Care Facility at Hope Valley (Gleneagles). His cause of death was established by way of a pathology review of Mr McKenna's clinical circumstances. No post mortem examination of Mr McKenna's remains was required. The review was undertaken by Dr Iain McIntyre of Forensic Science South Australia. The cause of death suggested by Dr McIntyre in his review report[1] is cholangiocarcinoma in a man with advanced dementia and ischaemic valvular and hypertensive heart disease. I have accepted Dr McIntyre's opinion and find that Mr McKenna's cause of death was cholangiocarcinoma on a background of advanced dementia and ischaemic valvular and hypertensive heart disease.

[1] Exhibit C2a

2. Reason for Inquest

2.1. At the time of his death Mr McKenna was the subject of detention pursuant to section 32 of the Guardianship and Administration Act 1993. His place of detention was Gleneagles. His death occurred in that place. This meant that Mr McKenna's death was a death in custody in respect of which an Inquest was mandatory. These are the findings of that Inquest.

3. Background and medical history

3.1. Mr McKenna had worked as a psychiatric clinical nurse at Hillcrest until retiring in 2001 at the age of 70. He had lived for many years in Valley View with his long-term partner, Ms Rachael Murphy. He had become a resident of Gleneagles on 5 November 2012 pursuant to the section 32 order of the Guardianship Board.

3.2. Mr McKenna had a medical history that included ischaemic heart disease, aortic stenosis and a stroke that had occurred in 2003. In July 2011 Ms Murphy consulted with his general practitioner in respect of concerns that she entertained about Mr McKenna's memory. As a result a CT scan was performed. Cerebral atrophy was detected. Following this diagnosis he remained at home where Ms Murphy acted as his carer.

3.3. On 30 January 2012 Mr McKenna was taken to the Lyell McEwin Hospital with shortness of breath. He was admitted to hospital where he was fitted with a cardiac pacemaker. Following his discharge and return home he became more frail and unsteady on his feet. Ms Murphy noticed further deterioration in his memory. Mr McKenna was admitted to Calvary Rehabilitation Hospital in Walkerville where he was reviewed by a geriatrician who diagnosed a significant cognitive impairment, vascular impairment and possible Alzheimer's dementia. Despite this diagnosis he returned to live at home from 10 March 2012 onwards.

3.4. By August 2012 Mr McKenna's condition had deteriorated to a point where he required greater care than his partner could provide at home. He was thus moved into the Valley View Nursing Home. Ms Murphy applied to the Guardianship Board seeking a guardianship order in relation to Mr McKenna. This was sought so that she could be granted control of his health care, accommodation and lifestyle decisions. She was

granted that order on 6 September 2012. The section 32 detention order would later be sought and imposed.

3.5. While a resident at the Valley View Nursing Home Mr McKenna was unsettled and difficult to manage. These circumstances led to two separate admissions to hospital for medication and behavioural management. These admissions respectively occurred on 22 September 2012 at the Lyell McEwin Hospital and on 27 September 2012 at the Royal Adelaide Hospital.

3.6. On 28 September 2012 Mr McKenna was assessed and a deterioration in his condition was identified. He was reportedly walking around the nursing home threatening staff and other residents with a walking stick. His behaviour led to another admission to hospital that day. He was sent to the Modbury Hospital where he remained until 5 November 2012. During this period of hospitalisation he was ultimately transferred from a medical ward to a geriatric specialty ward. Through this time Mr McKenna continually spoke about packing his bags and going home. He would actually pack his bags and appear as though he was going to leave the hospital.

3.7. Ultimately Mr McKenna did leave the Modbury Hospital through a fire exit. In so doing he set off an alarm. On another occasion he walked out of the hospital and caught a bus. This was after unsuccessful attempts had been made by staff to stop him leaving the hospital. He had become verbally and physically aggressive towards them.

4. Mr McKenna's detention at Gleneagles

4.1. Following these events Ms Murphy made a further application to the Guardianship Board that she be furnished with special powers pursuant to section 32 of the Guardianship and Administration Act that would include detention at her instigation. The order was sought and granted with Mr McKenna's safety in mind. The application was granted on 30 October 2012. The order was appropriate.

4.2. On 5 November 2012, pursuant to the section 32 order, Mr McKenna was moved to Gleneagles where he would remain until his death. Although he remained generally medically well from that point, in about December 2013 it was noticed that he started to lose weight and was seemingly becoming more unsteady on his feet and less mobile.

4.3. On 11 July 2014 following a diagnosis of anaemia Mr McKenna underwent a blood transfusion at Modbury Hospital. This led to a temporary improvement in his condition although he did continue to lose weight.

4.4. On 29 October 2014 Mr McKenna was taken to the Modbury Hospital where a liver scan was conducted. The scan revealed cholangiocarcinoma. Due to his age, his general frailty and his poor mental state, it was decided that active treatment was not to be given. Palliative care was to be the focus of his management with comfort care in the final stages.

4.5. On 6 November 2014 Mr McKenna was observed to deteriorate significantly due to an infection. Efforts to treat this were limited having regard to the palliative care regime that had been put in place.

4.6. At 5:30pm on 23 November 2014 Mr McKenna's condition worsened. He was struggling to breathe, was twitching and was providing a limited verbal response. He slipped into unconsciousness and died at 10:10pm with Ms Murphy and his nephew present.

5. <u>Coronial investigation</u>

5.1. As this was a death in custody the matter was investigated thoroughly by an experienced Detective, namely Detective Brevet Sergeant Michaela Nash of the Holden Hill Criminal Investigation Branch. In her extensive report Ms Nash has expressed a number of conclusions with which the Court agrees. They are that the circumstances surrounding Mr McKenna’s death are not suspicious and do not indicate the involvement of any third party. Furthermore, Detective Nash in consultation with Mr McKenna’s guardian, Ms Murphy, who was also his partner, stated that no concerns regarding Mr McKenna’s treatment at any stage were identified. Ms Murphy has indicated in her statement[2] that she was very happy with the staff and facilities at Gleneagles and with the manner in which they managed and treated Mr McKenna. The Court has no reason to conclude otherwise. Ms Nash indicates that in the course of her investigation she did not identify any deficiency in the care and attention afforded to Mr McKenna while he was at the Modbury Hospital or while detained at Gleneagles. Neither has this Court

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[2] Exhibit C1c

6. Conclusion

6.1. I find that Mr McKenna's detention pursuant to section 32 of the Guardianship and Administration Act 1993 was appropriate, had been imposed in his best interests and had no impact in relation to, or contributed to, his death.

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.

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Deputy State Coroner

Inquest Number 44/2016 (2049/2014)