



## FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 31<sup>st</sup> day of October 2018 and the 5<sup>th</sup> day of November 2018, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Mervyn Eric Size.*

*The said Court finds that Mervyn Eric Size aged 77 years, late of 23 Stokes Road, Karoonda, South Australia died at the Repatriation General Hospital, 216 Daws Road, Daw Park, South Australia on the 13<sup>th</sup> day of November 2016 as a result of multi organ failure due to general inanition on a background of end-stage Alzheimer's dementia. The said Court finds that the circumstances of his death were as follows:*

### **1. Reason for inquest and cause of death**

- 1.1. Mervyn Eric Size was 77 years old when he died on 13 November 2016 at the Repatriation General Hospital at Daw Park (the Repat). He died of natural causes.
- 1.2. At the time of Mr Size's death he was subject to a Level 2 Inpatient Treatment Order (ITO) that had been imposed pursuant to the Mental Health Act 2009. Accordingly, Mr Size's death was deemed to be a death in custody in respect of which an inquest into the cause and circumstances of his death was mandatory pursuant to the provisions of the Coroners Act 2003. These are the findings of that inquest.
- 1.3. The cause of Mr Size's death was established by way of a review conducted by Dr Iain McIntyre of Forensic Science South Australia. Dr McIntyre's analysis was based upon a review of Mr Size's medical case notes and clinical history. He advised that a post mortem examination of Mr Size's remains was not necessary in order to establish the cause of death. In his report Dr McIntyre expresses the cause of death as '*multi-organ*

*failure due to general inanition in a man with end stage Alzheimer's dementia*<sup>1</sup>. I accept Dr McIntyre's evidence as contained in his report. I find that the cause of Mr Size's death was multi-organ failure due to general inanition on a background of end-stage Alzheimer's dementia.

## **2. Background and medical history**

- 2.1. Mr Size died from the debilitating effects of dementia. In the period before his death Mr Size displayed symptoms and behaviours that are typical manifestations of the illness but which were not in keeping with his usual demeanour. The illness that ultimately claimed Mr Size's life, and the custodial circumstances that pertained at his death, which were solely due to that illness, are naturally no reflection upon the good character that he had displayed during his life. Mr Size had lived in Karoonda with his wife of 52 years. He had lived a productive life and had been engaged in his community. Mr and Mrs Size had raised three children. In her statement<sup>2</sup> Mrs Size describes her husband as a devoted father and a man who was patient and kind. Mr Size's son, Gregory<sup>3</sup>, describes his father as having possessed a huge work ethic and says that he was a person who in essence had always maintained his composure. Among other skills he was a self-taught mechanic. Mr Size was also an accomplished musician who for most of his life played the trumpet in bands and who was given the honour of playing the bugle at ANZAC services for which he received a citation from the Returned & Services League.
- 2.2. One of Mr Size's general medical practitioners at Karoonda, Dr Gregory Crafter, describes Mr Size as a lovely man who was never 'cranky' until he experienced dementia. Dr Crafter states that his deterioration from the effects of dementia was rapid and unfortunate.
- 2.3. After they were married Mr Size joined his wife's family's farm machinery business which they ran and eventually took over. The business was ultimately handed over to their eldest son in 2006. During their working life, and even after they retired from the family business, Mr and Mrs Size both drove the school bus for the local area. According to Gregory Size, his father drove the school bus for something of the order of 40 years.

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<sup>1</sup> Exhibit C2a

<sup>2</sup> Exhibit C4

<sup>3</sup> Exhibit C1b

- 2.4. Mr Size had generally been of good health in his adult life with complaints of vasculitis and a collapsed disc in his back. He suffered from hypertension for which he was medicated. Mrs Size describes an initial diagnosis of dementia being made in 2013 by Dr Kneebone whom he had consulted for vasculitis. For approximately two years prior to that Mrs Size had entertained suspicions of dementia due to her husband's forgetfulness and a lack of confidence when driving.
- 2.5. In September 2016, at the suggestion of Dr Peter Joyner, Mr Size was admitted to the Karoonda Hospital. Dr Joyner was of the view that Mrs Size needed respite from caring for her husband. Mr Size was then transferred to Flinders Medical Centre. Following a sharp decline in both his cognitive and medical health, Mr Size was admitted to the Repat where a little less than two months later he died.

### **3. The circumstances leading to Mr Size's death**

- 3.1. Between 2013 and 2015 there had been a noticeable decline in Mr Size's cognitive function with memory loss, confusion and a tendency to wander. He underwent MRI testing which ultimately confirmed a diagnosis of Alzheimer's dementia.
- 3.2. Mr Size became increasingly difficult to manage in the home setting. As indicated earlier, he was ultimately admitted to Karoonda Hospital for respite. At around this time a referral was also made to the Geriatric Management Unit at Flinders Medical Centre.
- 3.3. On 5 October 2016 Mr Size was transferred to the Flinders Medical Centre in an agitated state and was apparently unsteady on his feet. He was ultimately settled with oxazepam.
- 3.4. Between 8 and 12 October 2016 a number of emergency codes were called due to Mr Size's behaviour. At 6:10pm on 12 October 2016 a Level 1 ITO was imposed on Mr Size by Dr Emily Kilner. The underlying basis of the ITO, as expressed in the relevant documentation, was that Mr Size had a mental illness, that he required treatment for his own protection and that there was no less restrictive means than an ITO of ensuring appropriate treatment. In my opinion the imposition of the Level 1 ITO was lawful and appropriate.
- 3.5. The following day Dr Rene Pols, psychiatrist, examined Mr Size and confirmed the Level 1 ITO. In my opinion the confirmation was also both lawful and appropriate.

The confirmation of the ITO meant that Mr Size was at that time detained at the Flinders Medical Centre.

- 3.6. On 17 October 2016 Mr Size was transferred, still under detention, to the Repat. At this time the Level 1 ITO was still current. He was examined the following day by Dr Christopher Veale who was satisfied that grounds for the order to continue existed. As a result Dr Veale imposed a Level 2 ITO. In the normal course of events this order would have expired on 28 November 2016 and Mr Size's detention under the Mental Health Act would then have been considered afresh. However, Mr Size died on 13 November 2016.
- 3.7. Between 18 October 2016 and 8 November 2016 Mr Size experienced a significant decline in his cognitive and medical health. He was often confused and at times was non-compliant with treatment. He was also noticed to be having difficulty eating. An assessment by a speech pathologist resulted in Mr Size being commenced on a minced diet.
- 3.8. An indwelling catheter was inserted when it was noticed that Mr Size's bladder was becoming distended. On 9 November 2016 it was noticed that there was blood in Mr Size's urine. Palliative care was discussed with Mr Size's family. As a consequence comfort care was agreed upon. A morphine and midazolam regime was implemented.
- 3.9. As indicated, on 13 November 2016 Mr Size died during the currency of the Level 2 ITO. His death was not unexpected. Gregory Size states that it had been clear for some weeks that his father's body was shutting down and that his death was imminent.

#### **4. The investigation into Mr Size's death and the Court's conclusions**

- 4.1. The circumstances of Mr Size's death were thoroughly investigated by the police on behalf of the State Coroner. Tendered to the Court was the comprehensive report of Senior Constable Mark Bentley of Murray Bridge police<sup>4</sup>. The report sets out in considerable detail a timeline of events between 2013, when Mr Size was diagnosed with dementia, and the occasion of his death in 2016. The conclusions expressed by Senior Constable Bentley in his report are that the care of the deceased at the Repat where Mr Size had been detained and ultimately died was more than appropriate. Secondly, Senior Constable Bentley has concluded that the Level 2 ITO, during the

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<sup>4</sup> Exhibit C10a

currency of which Mr Size died, was valid and appropriate. Having carefully considered the evidence presented to the Court I agree with those conclusions and I so find.

- 4.2. I would add the following. In his witness statement, Mr Size's son Gregory had this to say about the standard of care that was provided to his father at the Repatriation General Hospital:

'The people and the care at the Repat was phenomenal. They genuinely cared about the patients there and seemed to understand the job and have an appreciation that most of their patients don't leave there alive, it's their last port of call. I felt I could always call them and get an update. They understood the disease well.'

And:

'It was clear for the last couple of weeks of dad's life that his body was shutting down and his death was imminent. It was a matter of being around him and making him as comfortable as possible. There was nothing suspicious about his passing away as it was completely expected. I felt blessed and reassured that dad spent his final days at the Repat because they were true professionals in how they cared for him.'

- 4.3. Mrs Margaret Size, Mr Size's wife, had the following to say about the standard of care at the Repat:

'The staff at the Repat provided respectful, caring and compassionate care at all times to Merv and to the rest of the family as well. They always discussed his treatment with the family before taking any action.'

## 5. **Recommendations**

- 5.1. I have no recommendations to make in this matter.

*Key Words: Death in Custody; Natural Causes, Inpatient Treatment Order*

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

*Seal the 5<sup>th</sup> day of November, 2018.*

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*Deputy State Coroner*