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 20th day of November 2018 and the 12th day of June 2019, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Robert Boyd Cheetham.

The said Court finds that Robert Boyd Cheetham aged 84 years, late of 96/328 Fullarton Road, Fullarton, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 6th day of October 2015 as a result of dilated cardiomyopathy with cardiomegaly due to pulmonary hypertension and valvular and ischaemic heart disease with atrial septal defect. The said Court finds that the circumstances of his death were as follows:

1. Introduction, reason for inquest and cause of death

1.1. Robert Boyd Cheetham was 84 years old when he died on 6 October 2015 at the Royal Adelaide Hospital. At the time of Mr Cheetham'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 Cheetham's death was 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.

1.2. The cause of Mr Cheetham's death was determined by a post-mortem examination conducted by Dr Cheryl Charlwood of the Forensic Science Centre South Australia on 15 October 2015. Dr Charlwood's report described the cause of death as dilated cardiomyopathy with cardiomegaly due to pulmonary hypertension and valvular and

ischaemic heart disease with atrial septal defect[1]. I find that to have been the cause of Mr Cheetham's death.

1.3. Other principal findings at autopsy included that there were no significant injuries, there were marked cardiomegaly and cardiac dilation including myocardial fibrosis, focal moderate to severe coronary artery atheroma, marked right ventricular hypotrophy, atrial septal defect, valvular dilation, chronic obstructive pulmonary disease and pulmonary oedema, pleural and pericardial effusions, peripheral oedema, ascites, granular and thin kidneys and nodular fibrous liver.

2. Background and medical history

2.1. Mr Cheetham had no known living relatives. He was born in Sydney in New South Wales and had moved to Adelaide in about 2001 where he experienced a period of homelessness. Mr Cheetham was provided with independent housing in Fullarton, but continued to rely on staff at the Hutt Street Day Centre, which is a service for homeless people, to check on his welfare and to assist around his home.

2.2. Mr Cheetham's prior medical history comprised serious heart and lung conditions including congestive cardiac failure and pulmonary hypertension, atrial septal defect and tricuspid valve regurgitation. He suffered from chronic obstructive pulmonary disease and type one respiratory failure.

2.3. His treatment history had been complicated by his long-standing mental health issues. Mr Cheetham suffered from chronic paranoid schizophrenia with cognitive impairment. He had many psychiatric admissions, mainly at Glenside Hospital, but also at Ward 18 of the Repatriation General Hospital. Mr Cheetham was known to be non-compliant with medication.

3. The events leading to Mr Cheetham's detention

3.1. On 1 September 2015 Mr Cheetham was found at his home address in Fullarton by the Hutt Street Centre staff to be in a poor state of health. He had shortness of breath. There were blood stains on the floor of his unit. The South Australian Ambulance Service attended and conveyed Mr Cheetham to the Royal Adelaide Hospital where he

[1] Exhibit C3a

was treated for congestive cardiac failure exacerbation secondary to advanced pulmonary hypertension and valvular heart disease.

3.2. On 2 September 2015 Mr Cheetham's prognosis for recovery was considered to be very poor. A resuscitation plan was instituted with Mr Cheetham electing to be *'not for resuscitation'*. This admission was complicated by pneumonia and haematuria due to traumatic removal of his indwelling catheter.

3.3. At the time of his discharge on 22 September 2015 medical staff realised that Mr Cheetham was no longer able to care for himself due to a significant decline in cognitive impairment. Arrangements were made for his placement in a nursing home. Unfortunately Mr Cheetham exhibited a determination to leave the nursing home and to return to his previous place of abode. Therefore, on the afternoon of 22 September 2015 a decision was made to return Mr Cheetham to hospital where he was placed on a Level 1 ITO by Dr Andrew Burch. This was due to his serious medical conditions, poor insight and his inability to care for himself. He had only been outside of the hospital for a number of hours before his behaviour required his return to hospital.

3.4. On 23 September 2015 the Level 1 ITO was confirmed by psychiatrist Dr Davis. The confirmation of the ITO meant that Mr Cheetham remained at the Royal Adelaide Hospital. Mr Cheetham's cognitive impairment did not improve during the course of his detention at the Royal Adelaide Hospital. On 29 September 2015 consultant psychiatrist Dr Jonathon Symon deemed continuing detention necessary. As a result, Dr Symon placed Mr Cheetham on the Level 2 ITO. Mr Cheetham died while subject to that ITO.

3.5. On 6 October 2015 nurse Simi Devassy found Mr Cheetham slumped in the chair next to his bed. He received immediate medical treatment but this was not successful. Mr Cheetham was pronounced deceased by Dr Burch at 3:25pm on that day.

4. The coronial investigation

4.1. The circumstances of Mr Cheetham's death were investigated by SAPOL on behalf of the State Coroner. The report of Detective Brevet Sergeant Peter Graves sets out in

detail the timeline of events concerning Mr Cheetham including his diagnosis and the occasion of his death[2].

4.2. Detective Brevet Sergeant Graves expresses the opinion that the care and treatment of Mr Cheetham by the Royal Adelaide Hospital where he had been detained and died was appropriate. He concluded that the detention was lawful and appropriate given that Mr Cheetham presented as:

> '… a man in turmoil, cognitively impaired, unable to attend to his own care, all symptoms that were intensified by chronic poor health … detention was the only option open to medical staff who acted in the deceased's best interest. There was no less restrictive means to address the many problems that the deceased had. '

I agree with the observations made by Detective Brevet Sergeant Graves.

5. Conclusion

5.1. I find that Mr Cheetham's detention pursuant to the Level 1 and Level 2 ITOs was lawful and appropriate.

5.2. I find that Mr Cheetham died of natural causes due to the progression of his chronic medical comorbidities. There is no suggestion that his detained status contributed to his death. I have no need to make any recommendations 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 12th day of June, 2019.

Deputy State Coroner

[2] Exhibit C13