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 5th day of February 2019 and the 15th day of April 2019, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Roger Curtin.

The said Court finds that Roger Curtin aged 63 years, late of 2/38 Weroona Avenue, Park Holme, South Australia died at the Repatriation General Hospital, 216 Daws Road, Daw Park, South Australia on the 1st day of September 2015 as a result of metastatic non-small cell lung carcinoma with chronic obstructive lung disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction, cause of death and reason for Inquest

1.1. Mr Roger Curtin was 63 years of age when he died at the Repatriation General Hospital (RGH) in Daw Park on 1 September 2015. A review of Mr Curtin's medical history was undertaken by Dr Iain McIntyre from Forensic Science South Australia. Dr McIntyre provided a report[1] to the Court in which he gave the cause of Mr Curtin's death as metastatic non-small cell lung carcinoma with chronic obstructive lung disease, and I so find.

1.2. At the time of his death Mr Curtin was subject to a Level 1 Inpatient Treatment Order (ITO) that had been imposed pursuant to the Mental Health Act 2009[2]. His death was therefore a death in custody within the meaning of the Coroners Act 2003 and this Inquest was held as required by section 21(1)(a) of that Act.

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1 Exhibit C2a
2 Exhibit C11b

2. Background and medical history

2.1. Mr Curtin had lived alone at Park Holme until he was admitted at the RGH on 14 August 2015 for management of his health condition. Mr Curtin had progressive metastatic non-small cell carcinoma with lymphangitis carcinomatosa and severe emphysema.

2.2. Mr Curtin commenced smoking cannabis excessively in 1972. In 1975 he was involved in a car accident and in the same year was diagnosed with schizophrenia. He received treatment at Glenside Hospital. He was admitted to the Flinders Medical Centre in 2013 and following a CT scan was diagnosed with primary pulmonary malignancy and contralateral pulmonary metastatic cancer in the right lower lobe.

2.3. In June 2014 he was referred to the Southern Adelaide Palliative Care Service and assigned to Dr Timothy To[3] at the RGH. In June 2015 he was admitted to the Flinders Medical Centre following sharp left chest pain. Scans reported a mass in the left upper lobe.

2.4. Prior to his admission he had been struggling at home with increasing confusion and breathlessness. On 14 August 2015 he was admitted to the RGH with increasing dyspnea and confusion. At the time he attended the hospital he was on several medications. He was treated for a chest infection to see if it would improve his breathing. Treatment included antibiotics and steroids. His behaviour was increasingly confused and agitated and his olanzapine was increased. He was also using opiates for pain relief.

2.5. Dr To was seeing Mr Curtin about three times per week and noted that his condition was challenging. He noted the non-small cell carcinoma with chronic dyspnea. The schizophrenia was generally well controlled. Dr To thought there was an exacerbation of chronic obstructive pulmonary disease with delirium. Dr To stated that Mr Curtin improved slightly through the week with careful management of his medication. However, between 29 and 30 August 2015, Mr Curtin's delirium escalated to a Code Black.

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[3] Exhibit C5

3. Mr Curtin's detention and decline in health

3.1. Between 14 and 30 August 2015 Mr Curtin was noted to be confused at times, going from pleasant and cooperative to agitated and uncooperative. He required more doses of morphine to maintain comfort with breathing. On 25 August 2015 he was found wandering the ward naked. On 28 August 2015 he was refusing medication, throwing water on the floor, pulling sheets off, shouting at nurses and telling them to call the police.

3.2. On 30 August 2015 he was seen by Dr Ramsay due to his behaviour the previous day. He was seen lying on the floor naked, pulling out his indwelling catheter, removing oxygen and requesting cannabis. By 8pm his behaviour had become worse and a Code Black was called. Mr Curtin was paranoid and delusional, threatening people and hitting out with a walking stick. Dr Miriam Cursaro placed Mr Curtin under an ITO. She also spoke with the on-call palliative care consultant, Dr Christou.

3.3. On 31 August 2015 Mr Curtin's behaviour had not improved. Dr To made a note that on 31 August 2015 Mr Curtin expressed the desire for minimal intervention. Dr To stated that from a prognosis perspective Mr Curtin had advanced and incurable cancer. His prognosis was measured in weeks prior to the delirium, however he became much worse as a result.

3.4. Dr Myhill, psychiatrist, provided a statement to the Court[4]. Dr Myhill had first met Mr Curtin on a home visit in September 2014. Dr Myhill set out the details of that assessment in her statement. She stated that Mr Curtin had significant past psychiatric history and had been admitted to Glenside Hospital in his twenties. He had a poor work history. Mr Curtin had become increasingly isolated and did not form any significant friendships.

3.5. Dr Myhill formed the impression that Mr Curtin was a very pleasant gentleman, albeit socially isolated with significant past psychiatric history and a life limiting illness. He presented no major psychiatric symptoms at that assessment. Dr Myhill did not have any further face to face contact with Mr Curtin until he was admitted to the RGH. But on 31 August 2015 Dr Myhill reviewed the ITO and confirmed the order. Dr Myhill

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[4] Exhibit C6

spoke to Dr To and agreed that sedation was necessary in order to manage the situation. Dr Myhill briefly reviewed Mr Curtin on 1 September 2015 prior to his death.

3.6. Emma Cranley, a registered nurse at the RGH, provided a statement to the Court[5]. She stated that at 8:45pm on 1 September 2015 she commenced her shift. At that time Mr Curtin was sedated and had access to pump action administering medication. Ms Cranley noted that at 11:40pm Mr Curtin's breathing had gone quiet. She checked and he did not have a pulse. She contacted Dr Tan who certified life extinct.

4. Conclusions

4.1. The SAPOL investigation report into Mr Curtin's death in custody[6] is extremely helpful and sets out summaries of the evidence. The conclusion in the report is that Mr Curtin's death was not suspicious and there was no deficiency in the care and attention afforded to Mr Curtin whilst detained at the RGH. Furthermore, his detention under the ITO was valid and appropriate. I have no hesitation in agreeing with the investigating officer's conclusion.

5. Recommendations

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

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

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

Seal the 15th day of April, 2019.

State Coroner

Inquest Number 3/2019 (1561/2015)

[5] Exhibit C4
[6] Exhibit C11