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 27th day of November 2018 and the 30th day of April 2019, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Allen Henry Franklin.

The said Court finds that Allen Henry Franklin aged 83 years, late of 70 Penna Road, Macclesfield, South Australia died at the Repatriation General Hospital, 216 Daws Road, Daw Park, South Australia on the 19th day of November 2015 as a result of aspiration pneumonia and delirium complicating surgery for left total knee replacement on a background of dementia and ischaemic heart disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction, reason for Inquest and cause of death

1.1. Allen Henry Franklin was 83 years old when he died on 19 November 2015 at the Repatriation General Hospital. At the time of Mr Franklin's death he was subject to a Level 2 Inpatient Treatment Order (ITO). The order had been imposed pursuant to the Mental Health Act 2009. Accordingly, Mr Franklin's death was a death in custody within the meaning of that expression in the Coroners Act 2003 and this inquest was held as required by section 21(1)(a) of that Act.

1.2. Mr Franklin's death followed elective surgery for replacement of his left knee. The cause of death, as determined by a pathology review conducted by Dr Ian McIntyre of the Forensic Science Centre South Australia on 15 October 2015[1], was aspiration

[1] Exhibit C2a

pneumonia and delirium complicating surgery for the left total knee replacement on a background of dementia and ischaemic heart disease, and I so find.

2. Background and medical history

2.1. Mr Franklin's wife had died some years previously. Leading up to his death Mr Franklin lived on his 38 acre property at Macclesfield where he had been cared for by his adult daughter, Janene, for 3½ years. Mr Franklin had been suffering left knee pain since about 2007 and regularly consulted his general practitioner at the Mount Barker Medical Clinic for this complaint over the years before his death. Mr Franklin's previous medical history included treatment for ischaemic heart disease, carcinoma of the bladder, prostate cancer, hypertension and osteoarthritis.

2.2. Mr Franklin also had a history of memory loss and dementia dating from 2012. Mr Franklin's daughter was required to care for him for this reason. Although he could shower and mostly toilet himself, his disease meant that he would forget to eat and could not maintain his house independently.

2.3. Mr Franklin's knee complaint was quite debilitating. He could hardly walk and had experienced falls as a result of his knee giving away. Mr Franklin was referred to orthopaedic surgeon, Dr Brian Wallace, in 2013. Dr Wallace performed an arthroscopy at the Mount Barker Hospital. This showed advanced degenerative changes in the medial compartment of Mr Franklin's knee. Although he recovered from that surgery, Mr Franklin continued to experience knee pain. Mr Franklin continued to consult his general practitioner.

2.4. In February 2014 there was discussion regarding the risks of a total knee replacement noting that they might outweigh the benefits. In May 2014 Mr Franklin was referred to geriatrician, Dr Bruno Franchi. Dr Franchi noted in his letter to Mr Franklin's general practitioner that:

> 'Unless his knee pain is extreme, avoiding general anaesthetic is imperative. There is an almost certain possibility he'll develop a post-operative delirium after having a general anaesthetic.'

2.5. Mr Franklin's osteoarthritis pain and limited mobility continued. He was referred to knee surgeon, Dr Jonathon Cabot, in July 2014. Following Dr Cabot's review Mr Franklin was placed on a waiting list to have the full knee replacement surgery at

the Repatriation General Hospital. Mr Franklin was anxious to have the operation done and he was very much looking forward to it. In the lead up to the operation Janene Franklin said:

> 'It was explained to the family that there were risks associated with the surgery, including an escalation of the dementia if he was required to have a general anaesthetic'.

The family were told that the operation would take place under an epidural block and sedation and a general anaesthetic would be avoided unless absolutely necessary.

3. Mr Franklin's decline and detention

3.1. On 12 October 2015 Mr Franklin was admitted to the Repatriation General Hospital and the surgery was performed by Drs Ranawat and Sampson. There were no complications. The surgery was conducted under spinal anaesthesia and general anaesthesia was avoided. Not long after the operation it was noticed that Mr Franklin had suffered a decline in his cognitive function and cognitive state. He became agitated and aggressive which was out of character for him. This was diagnosed as delirium. Mr Franklin would engage in reckless behaviours including trying to pull his drip out of his arm and take off his bandages, and he tried to get out of bed to go home post-surgery. His management, because of this, was consistently difficult.

3.2. Between 12 and 21 October 2015 Mr Franklin's cognitive function never fully recovered. There were many code black medical emergencies called during this time for acute episodes of behavioural disturbance and aggression.

3.3. On 21 October 2015 an ITO was instituted by Dr Daniel George to facilitate nursing care. Mr Franklin required shackles on his arms and legs for treatment, and his daughter describes this as 'horrible but necessary'.

3.4. The delirium and behaviour disturbance did not improve despite various strategies for pharmaceutical intervention. Management of medication, nutrition and hygiene was difficult and a Level 2 ITO was initiated by Dr Richard Weeks on 28 October 2015.

3.5. On 3 November 2015 a chest X-ray was performed which showed changes of chronic obstructive lung disease with hyperinflated lungs. On 15 November 2015 Mr Franklin was noted to be refusing foods and fluids. The following day, 16 November 2015, he developed a moist cough with hypoxia, fever and shortness of breath and was diagnosed

with having aspiration pneumonia. Intravenous antibiotics were commenced. Members of Mr Franklin's family were informed of Mr Franklin's poor prognosis and on 17 November 2015 they decided on a palliative approach and that was then adopted.

3.6. As I have said, Mr Franklin died on 19 November 2015.

4. Conclusion

4.1. The effects of the post-operative delirium were rapid and unfortunate. Given that Mr Franklin continued to be an ongoing risk to himself and others with multiple records of aggression and assaults, and behaviour to compromise his treatment, both the imposition and the later confirmation of the ITO were, in my opinion, appropriate and necessary.

4.2. As to the question of whether the total knee replacement surgery was appropriate in the circumstances, an opinion was sought from Professor Cade, Emeritus Consultant in Intensive Care at the Royal Melbourne Hospital. In Professor Cade's opinion the surgery was, on balance, appropriate and reasonable in the circumstances. Whilst general anaesthesia for major surgery can contribute to cognitive decline in elderly patients, alternate anaesthetic techniques were adopted in this case, namely spinal anaesthetic. Professor Cade said that in his opinion the optimal technique for surgery was adopted in Mr Franklin's case. Professor Cade commented that the risk/benefit analysis for the operation was properly considered and the overall care for Mr Franklin by his multidisciplinary team was appropriate.

4.3. 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 30th day of November, 2019.

State Coroner