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 24th day of September 2019 and the 29th day of October 2019, by the Coroner's Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of Graham Ashton Pemberton.

The said Court finds that Graham Ashton Pemberton aged 87 years, late of 30 McMahon Road, Morphett Vale, South Australia died at the Repatriation General Hospital, 216 Daws Road, Daw Park, South Australia on the 5th day of February 2016 as a result of aspiration pneumonia, urinary tract infection and general inanition complicating advanced Alzheimer's dementia. The said Court finds that the circumstances of his death were as follows:

1. Reason for inquest

1.1. It is mandatory, pursuant to section 21(1)(a) of the Coroners Act 2003 (the Act) for the Coroners Court to hold an inquest into the death of a person, where that person's death is a 'death in custody', as defined in section 3 of the Act.

1.2. 'Death in custody' is defined in the Act to include a death 'while the person was being detained in any place within the State under any Act or law by a person authorised to do so under any Act or law of the State.'

1.3. At the time of his death on 5 February 2016, Mr Graham Ashton Pemberton was detained at the Repatriation General Hospital under the authority of a Level 2 Inpatient Treatment Order (ITO) under the Mental Health Act 2009.

1.4. Mr Pemberton's death was a 'death in custody' for the purposes of the Act and an inquest into his death is required to be undertaken.

2. Pathology review

2.1. Following Mr Pemberton's death, a pathology review was undertaken at Forensic Science South Australia by Dr Iain McIntyre, in consultation with forensic pathologist Dr John Gilbert[1]. I have accepted, as the cause of death, the opinion provided upon that review, namely that Mr Pemberton died of aspiration pneumonia, urinary tract infection and general inanition complicating advanced Alzheimer's dementia.

3. Background

3.1. Graham Ashton Pemberton was born in Adelaide on 23 October 1929. He was later married to Laurel Kay Pemberton, for 46 years until his death. During the majority of their married life they lived in Perth, and they had one child, Christopher. Mr Pemberton was a loyal husband and hard-working man, who was forced to retire earlier than he wished to, when the engineering company for which he worked failed in 1990. The couple returned to live in Adelaide. Mr Pemberton became devoted to voluntary work, most notably for the Daw House Hospice Foundation. I am informed that he was keenly interested in social issues, often writing to politicians regarding matters of benefit to the community. He enjoyed keeping birds, reading, listening to classical music and spending time in his shed or gardening with his wife.

4. Medical history

4.1. In 2011, Mr Pemberton was diagnosed with Alzheimer's type dementia. He suffered increasingly from memory loss. Mrs Pemberton was attentive to her husband's domestic and medical needs and sustained his care at home for as long as possible. Mr Pemberton's condition caused his behaviour to deteriorate dramatically in the last year of his life. In that year, his home and medical care became increasingly complex.

4.2. Mr Pemberton had a history of prostate enlargement with urinary flow problems and he had declined surgical intervention in the past. Urinary problems were to become a feature of subsequent hospital admissions.

[1] Exhibit C2a

4.3. Mr Pemberton presented to the Flinders Medical Centre on four occasions in 2015. On the first occasion, he was referred by his general practitioner after suffering chest pain and vomiting. On the second, he was suffering dehydration, diarrhoea and vomiting. On the third occasion, he was admitted after a fall. At home, he had been becoming more agitated and aggressive, as well as sleeping very poorly, and he often prevented Mrs Pemberton from sleeping.

4.4. A geriatrician, Dr Flynn, suggested an elective admission to Flinders Medical Centre, with aims to optimise Mr Pemberton's medications so he would be more settled and able to be cared for at home, and to give Mrs Pemberton a break whilst he was in hospital. Mrs Pemberton was, by then, very concerned about the side-effects of antidepressants and then antipsychotic drugs, which had been prescribed due to her husband's deteriorating behaviour.

4.5. Mr Pemberton was admitted to the Flinders Medical Centre 2 November 2015. He had one-on-one nursing as he was quite agitated and was at risk of wandering or leaving the hospital. Over some days, he was trialled on different medications and doses, to manage his agitation without excessive drowsiness.

4.6. 'Code black' alerts were called, due to his aggravated and aggressive behaviour, on 3 November and 5 November 2015. Mr Pemberton was diagnosed with and treated for pneumonia.

4.7. On 6 November 2015 a blood test showed a deterioration of his kidney function. A urinary catheter was inserted and a large quantity of urine was drained, but it was necessary to remove the catheter because Mr Pemberton tried to pull it out, and he was considered likely again to attempt to do so. The next day it was ascertained he was dehydrated and a catheter was again inserted, so that he could be given intravenous fluids, and his fluids in and out could be measured. The catheter was soon removed but had to be reinserted on 9 November 2015 due to increased urinary retention. He also had difficulty swallowing, and was placed on a soft diet.

4.8. By 11 November 2015 Mr Pemberton was sleeping well, appeared to be recovering from his pneumonia and was swallowing and eating satisfactorily. His catheter was removed, but it was noted that his bladder volume would require careful monitoring.

4.9. On 11 November 2015 Mr Pemberton was transferred from Flinders Medical Centre to the Repatriation General Hospital in the Geriatric Evaluation and Management (GEM) ward. As it transpired, he was to remain there until 29 December 2015, when he was discharged to residential care at Onkaparinga Lodge. During this stay in the GEM ward he suffered delirium and worsening cognitive failure. A catheter was necessary due to recurrent urinary retention and urinary infections. He fluctuated between resting calmly, and periods of irritable and erratic behaviour. He often tried to pull and touch everything in reach, including his catheter. He frequently stayed awake all night and on the following day would fluctuate between drowsy, and alert with agitated states. At times, he did not recognise his wife.

4.10. At discharge on 29 December 2015 to Onkaparinga Lodge, an in-dwelling catheter was left in place, but on 31 December 2015 Mr Pemberton was admitted to Noarlunga Hospital after trying to remove it, causing bleeding and trauma to his urethra. In the next week, he was discharged from and later readmitted to hospital, for similar reasons, on two further occasions.

4.11. On 8 January 2016 Mr Pemberton was transferred to geriatric team care at the Repatriation General Hospital with one-to-one special nursing care to manage risks of falls and catheter removal.

4.12. On 13 January 2016, he was transferred to the dementia ward for closer monitoring and management of his behaviour generally, and ongoing night-time agitation.

4.13. On 14 January 2016, a suprapubic catheter was inserted under anaesthetic. It was then necessary to put mittens on Mr Pemberton's hands to prevent him trying to pull it out. There were continuing efforts to manage his distress and pain with medications. He was not eating well and was no longer able to swallow safely, so intravenous fluids were administered.

4.14. By 21 January 2016 he was showing signs of urinary tract infection and pneumonia, which were treated with antibiotics.

4.15. By 27 January 2016, despite intravenous antibiotics and hydration, there was no clinical improvement, physical or cognitive, in Mr Pemberton's condition. For some time, his agitation had been either unmanageable or controlled only with sedation. Palliative options were discussed with Mrs Pemberton.

4.16. By 4 February 2016 it was clear, upon review, that only palliative care was indicated, and on 5 February 2016 at 6:20pm Mr Pemberton passed away peacefully, in the presence of his wife and her sister.

5. Inpatient Treatment Orders

5.1. The first Inpatient Treatment Order was imposed by Dr Daniel Chahine on 17 January 2016.

5.2. As required by law, it was reviewed within 24 hours by a psychiatrist, Dr Blood, who confirmed the order on 18 January 2016. By this stage, Mr Pemberton's mental state was extremely poor, he was extremely agitated and was unable to give coherent answers to any of Dr Blood's questions. She diagnosed Alzheimer's disease with agitation possibly reflecting post-operative delirium. She assessed that he was unable to comprehend his surroundings or his health issues and did not have the capacity to make any decisions in relation to his own health.

5.3. On 22 January 2016, Dr Blood again assessed Mr Pemberton and was satisfied that he posed a risk to himself, through his continued attempts to remove his catheter, which in turn required restraints, and so, for the same clinical reasons, Dr Blood imposed a Level 2 Inpatient Treatment Order.

6. Coronial investigation

6.1. An investigation of Mr Pemberton's death in custody was undertaken on behalf of the State Coroner by Brevet Sergeant Childs, whose report was received in evidence[2].

6.2. The investigator raised an issue of whether Mrs Pemberton was given, as soon as practicable, copies of the Level 1 and then the Level 2 Inpatient Treatment Orders, and the statement of rights issued with respect to each order, as respectively required by sections 23[3] and 27[4] of the Mental Health Act 2009.

6.3. The evidence presented in the inquest was not sufficient to enable me to make findings as to those matters. However, if these provisions were not properly complied with,

[2] Exhibit C8a
[3] in the case of the Level 1 Inpatient Treatment Order
[4] in the case of the Level 2 Inpatient Treatment Order

such non-compliance did not affect the appropriateness of those orders being made and could not have affected the progression of Mr Pemberton's illness.

7. Conclusions

7.1. I find that the care provided to Mr Pemberton during the last three months of his life was appropriate.

7.2. I find Mr Pemberton's death was not preventable.

7.3. I find that the Inpatient Treatment Orders imposed upon Mr Pemberton were necessary and were lawfully imposed.

8. Recommendations

8.1. I make no recommendations following Mr Pemberton's death.

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 29th day of October, 2019.

State Coroner