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 Colin George Sinclair.

The said Court finds that Colin George Sinclair aged 68 years, late of Ian George Court, 2-10 First Street, Brompton, South Australia died at the Royal Adelaide Hospital, North Terrace, South Australia on the 10th day of May 2015 as a result of obstruction of airways by foodstuffs with contributing alcohol-related dementia. The said Court finds that the circumstances of his death were as follows:

1. <u>Introduction, reason for inquest and cause of death</u>

1.1. Mr Colin George Sinclair was born on 3 July 1946 and died on 10 May 2015 aged 68 years. His place of death was the Royal Adelaide Hospital (RAH). Prior to his admission to the RAH, Mr Sinclair had been residing at the Ian George Court care facility. He suffered from alcohol related dementia.

1.2. At the time of his death, Mr Sinclair was subject to a guardianship order with special powers pursuant to section 32 of the Guardianship and Administration Act 1993 (the Act). The order specified that Mr Sinclair be detained in such place as his guardians determined. That place was the Ian George Court. Mr Sinclair died after an incident at the Ian George Court in which his airway became obstructed with food. His death occurred as a result of that obstruction. Although Mr Sinclair eventually died at the RAH, the cause of that death had arisen at his place of detention. His death was not a natural death. All of this meant that his death was a death in custody in respect of

which an inquest into the cause and circumstances of that death was mandatory pursuant to the Coroners Act 2003.

1.3. Mr Sinclair's cause of death was determined by way of a pathology review conducted by Dr Cheryl Charlwood of Forensic Science South Australia on 14 March 2015. Dr Charlwood was able with some certainty to determine the cause of death from Mr Sinclair's medical records notes. She did not recommend an autopsy[1]. Dr Charlwood describes the cause of death as obstruction of airways by foodstuffs with contributing alcohol related dementia. I find that to have been the cause of Mr Sinclair's death.

2. Background and medical history

2.1. Mr Sinclair was born in Broken Hill, New South Wales and lived there throughout his childhood completing year 12 at Broken Hill High School. After completing school Mr Sinclair studied mining engineering at the University of New South Wales. After two years Mr Sinclair went on to obtain his pilot's licence and joined the Royal Australian Airforce on a scholarship. He remained in the Royal Australian Airforce from 1966 to 1978 during which time he was on active service. He then went on to work with the Department of Communications as a radio licence infringement officer for about 25 to 30 years before his retirement.

2.2. Mr Sinclair was the father of two children.

2.3. Mr Sinclair suffered from alcohol dependency from a young age. It is said that he had consumed alcohol every day from the age of 15. This adversely affected his personal relationships. He separated from his wife in 2008. It also adversely affected Mr Sinclair's health. Mr Sinclair's medical notes refer to a number of incidents involving alcohol related falls and they contain reports of increasingly impaired functional ability. He suffered from multiple bone fractures, osteoporosis, hypertension and hypercholesterolemia.

2.4. In 2012 Mr Sinclair was referred to neuropsychologist Dr Colin Field for assessment. He had been detained in the Repatriation Hospital during this time. Dr Field determined that Mr Sinclair's history of alcohol abuse and the resulting impairments fulfilled the criteria for Korsakoff's syndrome with significant amnestic syndrome and significant

[1] Exhibit C2a

decline in executive function. At this time Mr Sinclair was determined to have become so disabled by his disease that Guardianship Board orders were recommended.

2.5. The initial guardianship order was issued by the Guardianship Board of South Australia on 25 July 2012. This order appointed Mr Sinclair's son and the Public Advocate as his full guardians.

2.6. On 4 August 2012 an ACAT assessment was completed which recommended low level residential care. In October 2012 Mr Sinclair was placed at the Regency Green Aged Care facility which was a low level care placement. Mr Sinclair was able to come and go as he pleased from that facility and he frequently spent his days drinking at a nearby hotel. Due to repeated incidents of intoxicated behaviour, hiding alcohol in the gardens of the facility, repeated absconding, hoarding, non-compliance with medication and conflict with staff and residents, Mr Sinclair was unable to be accommodated at the Regency Green facility.

2.7. At first, Mr Sinclair's guardians were unable to agree on the need to utilise section 32 detention powers under the Act, nor agree on a suitable alternative placement. However, on 28 January 2013 section 32 directions were issued following Mr Sinclair's refusal to cooperate with the arrangements for transferral to Regis Burnside facility.

2.8. In November and December 2013 Mr Sinclair was referred to the Exceptional Needs Unit which is a multidisciplinary service that assists persons with complex case management needs. On 28 January 2014 Mr Sinclair was transferred to a secure placement at Ian George Court. Ian George Court is a high level care facility which provided constant care and supervision. Mr Sinclair was accommodated there until his death.

2.9. Reviews of the orders took place at the appropriate intervals. The most recent review preceding Mr Sinclair's death occurred on 22 January 2015 when the Guardianship Board agreed to continue Mr Sinclair on limited joint order for a further twelve months. No further variation was sought. I find that Mr Sinclair's detention was lawful and appropriate in the circumstances given his state of cognitive decline resulting from his dementia related disease.

3. The circumstances leading to Mr Sinclair's death

3.1. From 16 January 2015 Mr Sinclair's treating doctor, Dr Rosario Carfora, entertained concerns about the manner in which Mr Sinclair was eating[2]. Both on 16 January and 19 March 2015 staff at the care facility reported that Mr Sinclair had experienced profuse sweating while eating followed by episodes of vagueness. These episodes only lasted a few minutes before completely resolving. Dr Carfora thought that this might be related to a transient ischaemic attack otherwise known as a mini stroke.

3.2. Dr Carfora also queried seizures. As there had only been two incidents at this time, Dr Carfora did not seek to investigate any further. On 2 February 2015 at the request of Ian George Court staff, Mr Sinclair underwent a speech pathology review. The review was performed by Adelaide Speech Pathology. This was undertaken due to concerns expressed by staff that Mr Sinclair was not chewing his food prior to swallowing and was placing too much food into his mouth at meal times. The speech pathologist's report determined that the issue with Mr Sinclair's eating was cognitive, that it was linked to his dementia and was not mechanical.

3.3. On 2 February 2015 Corinne Shawcross[3], a Clinical Nurse at Ian George, completed a short functional assessment for Mr Sinclair which included advice on his diet. Mr Sinclair's diet was recommended to consist of soft textured food cut into bite-size or smaller than bite-size pieces, or of the approximate size of a 10 cent piece. He was also required to have one-on-one supervision during meal times which was to ensure that Mr Sinclair could be prompted to chew before swallowing. Staff were also required to monitor Mr Sinclair's room on a daily basis as he had a tendency to hoard food and other items. In accordance with those observations a folder in the kitchen contained directions regarding Mr Sinclair's special dietary requirements and the short functional assessment.

3.4. Mr Sinclair's issues with eating did continue. On four separate occasions between 2 February and 3 May 2015 staff observed Mr Sinclair to be stuffing too much food into his mouth. On 19 April 2015 he also appeared to be sweating while eating.

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[2] Exhibit C15
[3] Exhibits C14 and C14a

4. Mr Sinclair's collapse and death

4.1. On 10 May 2015 Mr Sinclair was served his evening meal which consisted of soup and then sausages and vegetables cut up into 10 cent size pieces. During the meal staff observed that Mr Sinclair was stuffing food in his mouth. He was reminded by staff to chew his food slowly but he did not cooperate. Staff removed his plate so he could not continue eating. Mr Sinclair then started to cough and appeared red and sweaty. He was directed by staff to spit out his food. He walked away from the dining room and then collapsed in the corridor. Staff attempted to dislodge the food from his throat with back blows but were unsuccessful. CPR was commenced by nursing staff and oxygen was administered.

4.2. Ambulance crews attended and found that Mr Sinclair's airways were totally obstructed. The food was removed prior to intubation. The ambulance crew noted that Mr Sinclair was in asystolic cardiac arrest. He was transferred to the Royal Adelaide Hospital (RAH) for resuscitation. He was admitted to the RAH at 6:47pm. Although circulation was initially restored after efforts at resuscitation, Mr Sinclair went on to suffer a further cardiac arrest and was pronounced deceased at 7:05pm.

5. Conclusions

5.1. Although Mr Sinclair had demonstrated issues with eating and swallowing prior to his death, those issues had been assessed by a speech pathologist to be linked to his cognitive decline rather than to any medical condition. The Ian George Court facility therefore made adjustments to Mr Sinclair's diet accordingly and he was required to be supervised during meal times. Although this was something that Mr Sinclair was often resistant to, supervision nonetheless did continue and in the instance leading to Mr Sinclair's death his food was taken away by staff when his eating behaviour was identified as dangerous. Regrettably, the unfortunate choking event occurred despite the action taken by staff.

5.2. The report of the investigating officer Brevet Sergeant Elaine McGilchrist of SAPOL was tendered to the Court[4]. The report sets out in detail the timeline of events concerning Mr Sinclair including those events relating to his diagnoses and the events surrounding his death. Ms McGilchrist has expressed a number of conclusions

[4] Exhibit C19

including that Mr Sinclair's detention pursuant to section 32 of the Act was appropriate. I agree with that conclusion.

5.3. Ms McGilchrist's report identifies a policy issue at the Ian George Court care facility. Brevet Sergeant McGilchrist suggests that residents who have a short functional assessment or care plan in place due to feeding or swallowing issues and require supervision by staff during mealtimes should be placed together in the same area of the dining room, perhaps at the same table, so that in the event of a staff shortage or low staff numbers staff will be better able to supervise high-risk residents. This may allow for earlier intervention by staff if another resident chokes on food. This is a possible risk management strategy that I draw to the attention of the manager of Ian George Court.

5.4. There is no evidence that Mr Sinclair's death resulted from or was contributed to by any lack of appropriate care.

5.5. There is one further matter regarding Mr Sinclair's attempted resuscitation that should be mentioned. When South Australia Ambulance Service (SAAS) paramedics attended at the scene they discovered that Mr Sinclair's airway was blocked with a great deal of food, including large pieces of sausage. Paramedics initially performed suction in order to remove some of the foodstuff from Mr Sinclair's mouth and airway. This appears only to have been partially successful. Attempts made by a Rescue and Retrieval Paramedic to intubate Mr Sinclair and to clear his airway failed as there was simply too much food blocking his airway. It was only at the second attempt that intubation was successful in clearing Mr Sinclair's airway, but this was only the case after the paramedic had to push some of the food that was blocking his airway into Mr Sinclair's lungs. Only then did Mr Sinclair apparently begin to respond to resuscitation.

5.6. The further statement of Ms Shawcross to whom I have referred[5] indicates that the nursing staff at the Ian George Court facility receive first aid training annually and that as part of that training they receive instruction in relation to CPR and the management of choking incidents. The statement of Ms Shawcross indicates that at the time of the incident involving Mr Sinclair oxygen equipment and suction equipment were available in the facility and that the nursing staff would have been aware of its location and aware of its manner of use. While oxygen and CPR appear to have been administered by the

[5] Exhibit C14a

facility's nursing staff in the first instance, I have seen no evidence of the use of any of the suction equipment that would have been available for attempted resuscitation prior to the arrival of SAAS paramedics. Attempts to dislodge any food that may have been blocking Mr Sinclair's airway were administered by back blows. The statement of one carer suggests that Mr Sinclair's airway was thought to have been cleared, but plainly this was not the case as evidenced by the observations of SAAS paramedics after their arrival. However, it is clear from the statements of the paramedics that even if the staff at the facility had employed suction it is highly unlikely that it would have been successful. I make this observation because the efforts of the paramedics were successful only after they were able to intubate Mr Sinclair by forcing the blockage into his lungs.

5.7. Mr Sinclair appears to have had an unmanageable habit of putting too much food in his mouth when eating. I do not believe that his death was preventable.

6. Recommendations

6.1. There are no recommendations in this matter.

Key Words: Death in Custody; Section 32 Powers; Choking

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 12th day of June, 2019.

Deputy State Coroner