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 July and the 30th day of April 2020, by the Coroner's Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of John Harold Benn.

The said Court finds that John Harold Benn aged 70 years, late of Oakden Clements House, 200 Fosters Road, Oakden, South Australia died at Oakden, South Australia on the 1st day of October 2015 as a result of ischaemic heart disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. John Harold Benn was 70 years of age when he died at Clements House, Oakden on 1 October 2015. A pathology review was undertaken by specialist forensic pathologist, Dr Stephen Wills, of Forensic Science South Australia. In his report Dr Wills stated 'with a reasonable degree of certainty' that Mr Benn's cause of death was ischaemic heart disease[1], and I so find.

2. Reason for inquest

2.1. At the time of his death, Mr Benn was subject to a Level 3 Inpatient Treatment Order (ITO) imposed by the Guardianship Board on 18 November 2014, which provided for his compulsory detention and mental health treatment. Mr Benn's death was therefore a death in custody as defined in section 3 of the Coroners Act 2003 and an inquest into the cause and circumstances of his death was mandatory, pursuant to section 21(1)(a) of that Act.

[1] Exhibit C2a

2.2. Ms Susan Goldeband is employed as a guardian/advocate by the Office of the Public Advocate. Ms Goldeband's statement[2] provides background information regarding Mr Benn and his detention history. She states Mr Benn was evicted from his Housing SA property at Naracoorte by the Residential Tenancies Tribunal on 25 July 2014. On 28 July 2014, the Guardianship Board appointed the Public Advocate as Interim Guardian with special powers pursuant to section 32 of the Guardianship and Administration Act 1993, which included a power to direct Mr Benn's place of residence and for persons involved in his care to use force as reasonably necessary for the purposes of ensuring proper medical treatment, day-to-day care and well-being.

2.3. On 15 August 2014 the order was varied following a review, so that the Public Advocate was a limited guardian for accommodation and lifestyle matters and the Public Trustee was appointed as administrator of Mr Benn's estate. Special powers pursuant to section 32(1) of the Guardianship and Administration Act 1993 continued to apply. These orders were to apply until revoked or varied, with a recommendation for review after three years.

2.4. On 21 August 2014 Mr Benn was transferred to the Repatriation General Hospital mental health ward for an assessment. At the same time, an ITO was imposed under the Mental Health Act 2009. This was reviewed as required.

2.5. On 21 October 2014 Mr Benn was transferred to Clements House, a long stay ward for elderly psychogeriatric patients at the Oakden Older Persons Mental Health Service (Oakden).

2.6. On 18 November 2014 a Level 3 ITO was imposed by the Guardianship Board for a period of 12 months. This provided for Mr Benn's compulsory detention and mental health treatment and remained in force at the time of his death on 1 October 2015.

3. Inquest by affidavit only

3.1. No interested party[3] sought to appear at the inquest and the matter proceeded by reference only to affidavits of witnesses and all the relevant documents, which were tendered. The delivery of this finding was postponed after Mr Benn's sister contacted the Coroners Court after the inquest, expressing certain concerns. After Ms Benn obtained legal representation those concerns were not pressed. In drawing conclusions

[2] Exhibit C6
[3] including Mr Benn's brother, Paul Benn and sister Cathryn Benn

in this matter, I am satisfied that the concerns initially raised by Ms Benn do not require further investigation or the attendance of any witness.

4. Background and medical history

4.1. Mr Benn never married and had no children. At the time of his death his parents were deceased.

4.2. For many years Mr Benn resided independently in South Australian Housing Trust accommodation at Naracoorte. In August 2013 he presented at the Royal Adelaide Hospital with confusion, and concerns were raised about his cognitive ability. He was diagnosed with delusional disorder. An MRI scan revealed moderate chronic small vessel ischaemia disease, a likely cause of his secondary diagnosis of dementia. Mr Benn was also recorded as suffering ischaemic heart disease and aortic stenosis, as well as hypothyroidism, hypertension and diabetes mellitus type 2.

4.3. In September 2013 Mr Benn was assessed by a psychiatrist and transferred to the Repatriation General Hospital (RGH) psychogeriatric ward, on an ITO due to his unwillingness to remain for further assessment. At the conclusion of assessments, the ITO was revoked and he was discharged from RGH to his home address.

4.4. On 27 June 2014 the Residential Tenancies Tribunal ruled that, due to the poor state of his Housing Trust property, his tenancy would be terminated. On 25 July 2014 Mr Benn was evicted from his property and rendered homeless.

4.5. On that day the Guardianship Board received an application for guardianship. An urgent interim hearing was held on 28 July 2014 and the Public Advocate was appointed as interim guardian with special powers pursuant to section 32 of the Guardianship and Administration Act 1993. This allowed for Mr Benn to be detained and to receive treatment at Naracoorte Hospital. Mr Benn remained in Naracoorte Hospital under the guardianship order until 21 August 2014 when he was transferred to the psychogeriatric ward at the RGH. A Level 1 ITO was made on that date. Attempts were then made to find a suitable facility to house Mr Benn. Unfortunately, this proved unsuccessful due to his challenging behaviours. On 21 October 2014 Mr Benn was transferred to Clements House.

5. Mr Benn's admission and care at Clements House

5.1. Dr Wheatley, who was a resident medical officer at Clements House, stated[4] that the ongoing care of Mr Benn was discussed fortnightly. He was highly resistant to any interpersonal care. He was very selective, on the basis of shape and colour, about the medications he would take. He had significant dementia, diagnosed previously, and considered to be a mix of vascular and Alzheimer's. He also had ischaemic heart disease and a history of diabetes, hypertension, hypothyroidism and back pain. Mr Benn was receiving numerous medication for his various conditions.

5.2. Dr Patrick Flynn, a psychiatrist at Clements House stated[5] that Mr Benn was transferred to Clements House upon referral from the acute psychogeriatric ward at the RGH. He saw Mr Benn soon after his admission on 21 October 2014. He was difficult to manage and was often threatening, loud and demanding. His hygiene was poor, he refused to shower and he was incontinent. Interventions by staff would usually be met with resistance. He was often aggressive and he would hit staff.

5.3. Dr Flynn requested that Mr Benn be placed on a Level 3 ITO, as he required ongoing treatment at a specific psychogeriatric facility because of his persistent delusional beliefs, his lack of insight, his intermittent aggressive behaviour and his inability to manage independently outside the facility. Mr Benn was not willing to stay voluntarily at Clements House and he required specialist nursing care because of his behaviour and non-compliance with treatment.

5.4. When Dr Flynn saw Mr Benn in September 2015, he appeared a little less disruptive.

5.5. Dr Flynn stated that although Mr Benn's death was sudden, he was not in good health and he tended not to care for his diet or other matters that were high risk issues in cardiovascular disease.

5.6. When Dr Wheatley last saw Mr Benn on 29 September 2015 she completed a mental examination, and concluded that his cognitive function was declining. A plan was considered for Mr Benn to be discharged to a generic aged care facility, without a treatment order. There was however a limitation to achieving this, due to Mr Benn's behaviour. He was reluctant to have his care needs attended to, specifically relating to his hygiene and was also very combative.

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[4] Exhibit C4a
[5] Exhibit C5

6. Events on the day prior to Mr Benn's death

6.1. On 30 September 2015, at about 6:45am, Mr Benn was found on the floor beside his bed, stating he could not remember what had happened. No signs of bruising were found.[6]

6.2. During that day Mr Benn was subject to neurological observations which were satisfactory and stable. However, he was observed to be very quiet and was eating and drinking very slowly. A nursing note at 3:45pm states 'Motor retardation evident at times e.g. feeding himself, leaning to the right' but that his observations remained satisfactory.[7]

6.3. That evening, as recorded at 7 pm, Mr Benn complained of right shoulder pain which he said was limiting his movement. A physiotherapy referral was arranged.[8]

6.4. A locum doctor attended Mr Benn at about midnight on 30 September 2015.[9] Details of the attendance are recorded in clinical report of Dr Azhar Shabbir, of the National Home Doctor Service. Upon examination, the following was noted:

> 'Alert and well, afebrile, stable observation, moving all joints, no discomfort, BL (bilateral) shoulders. No deformity, no swelling. FROM (full range of motion) at both shoulder. Weight-bearing. Nil else of note on exam.'

The doctor's diagnosis was 'Likely mechanical fall'. The doctor advised that Mr Benn should be observed, and in the event of ongoing concern regarding shoulder pain, he should be reviewed again to consider for X-ray.

6.5. There is nothing in the evidence to suggest that Mr Benn was treated inadequately or inappropriately on the day prior to his death.

7. Events of 1 October 2015

7.1. On the morning of 1 October 2015, enrolled nurse Alexandra Zerella[10] was assisting patients, including Mr Benn, with breakfast in the communal meal room. Ms Zerella had been caring for Mr Benn for more than two years and had a good rapport with him. Clinical nurse Edward Lynch also observed Mr Benn eating his breakfast.

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[6] Exhibit C15, Lyell McEwin Health Service case notes
[7] Exhibit C15
[8] Exhibit C15
[9] recorded in nursing note, Exhibit 15
[10] Statement, Exhibit C3

7.2. Mr Benn asked Ms Zerella to watch his breakfast whilst he went to the toilet, stating that he would return to finish it. A short time later she heard a noise and saw Mr Benn collapsed on the floor in the corridor. A code blue alarm was called. Mr Lynch was among those who attended immediately. Mr Benn was given oxygen, a defibrillator was deployed and CPR was performed. South Australian Ambulance Service personnel also attended. Despite all appropriate efforts, Mr Benn could not be revived.

8. Police investigation

The death in custody of Mr Benn was carefully and thoroughly investigated by Detective Senior Constable Antony Barile[11], who provided a report of his investigation[12]. This report is a comprehensive account of all relevant documents and circumstances, including many to which it is not necessary here to refer. The investigator concluded, properly in my opinion, that the care of Mr Benn during his detention at the Repatriation General Hospital between August and October 2014 was appropriate, as was his later care at Clements House.

9. Conclusion

9.1. I find that Mr Benn's detention under the Mental Health Act 2009 was lawful and appropriate and had no bearing on his death. I find that the care he received whilst at Clements House was appropriate in the circumstances. I make no recommendations in this matter.

Key Words: Death in Custody; Inpatient Treatment Order; Oakden

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

Seal the 30th day of April, 2020.

State Coroner

[11] Now Detective Brevet Sergeant
[12] Exhibit C10a