



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 25th day of June 2020 and the 2nd day of November 2020, by the Coroner's Court of the said State, constituted of Brian Malcolm Nitschke, Deputy State Coroner, into the death of Graham Douglas Brown.

The said Court finds that Graham Douglas Brown aged 79 years, late of 28 Liddle Drive, Huntfield Heights, South Australia died at Noarlunga Hospital, Alexander Kelly Drive, Noarlunga Centre, South Australia on the 9th day of April 2019 as a result of combined cardiac, respiratory and renal failure as terminal events on a background of end stage dementia. The said Court finds that the circumstances of his death were as follows:

1. Introduction

- 1.1. Graham Douglas Brown was born on 11 June 1939 and died on 9 April 2019 at Noarlunga Hospital. He was 79 years of age.

2. Cause of death

- 2.1. A pathology review based upon Mr Brown's medical records and case notes was undertaken by Dr Iain McIntyre on 17 April 2019 in discussion with Dr John Gilbert, forensic pathologist, from Forensic Science South Australia¹. An autopsy was not recommended as the cause of death could be determined from the medical notes. In accordance with the review I find the cause of Mr Brown's death to have been combined cardiac, respiratory and renal failure as terminal events on a background of end stage dementia.

¹ Exhibit C2a

- 2.2. Dr McIntyre noted a significant medical history with advanced mixed pattern dementia with behavioural and psychological issues, depression, insulin dependent diabetes, ischaemic heart disease with coronary stenting, hypertension, obstructive sleep apnoea, chronic renal failure, Gilbert's disease, pulmonary embolus post knee replacement, bilateral total knee replacements, osteoarthritis, and falls.

3. Reason for Inquest

- 3.1. At the time of his death Mr Brown was subject to a Level 2 Inpatient Treatment Order (ITO) pursuant to section 25 of the Mental Health Act 2009. The Level 2 ITO was instituted by a psychiatrist, Dr Andrew Rosser, on 29 March 2019. As the ITO was still active at the time of Mr Brown's death, his was considered a death in custody and as such this is a mandatory Inquest pursuant to section 21 of Coroners Act 2003.

4. Background

- 4.1. Mr Brown had been cared for by his daughter, Trudy Bittner, during the last three years of his life. Mr Brown initially resided with his daughter and as his health deteriorated he was treated as an outpatient at the Repatriation General Hospital. On 11 August 2017 Mr Brown was diagnosed as suffering Alzheimer's dementia². From September 2017, he resided at Onkaparinga Lodge Aged Care Facility. Mr Brown developed aggression issues³. On 28 January 2019 following an aggressive episode Mr Brown was admitted to the Flinders Medical Centre. Tests were conducted and he was returned to Onkaparinga Lodge for one-on-one 24-hour care.
- 4.2. On 14 March 2019 Mr Brown was transferred to Myles Ward at Noarlunga Hospital so that his medication and behaviours could be attended to. Mr Brown was diabetic and required insulin. It could take up to four staff to administer his medication.⁴
- 4.3. On 24 March 2019 Mr Brown was examined by a medical practitioner, Dr Stephanie Wong, who issued a Level 1 ITO.⁵ On 25 March 2019 the Level 1 ITO was reviewed by psychiatrist, Dr Raja Hiremani. At this time, the order was confirmed.

² Exhibit C5

³ Exhibit C1a

⁴ Exhibit C3

⁵ Exhibit C7c

- 4.4. On 29 March 2019 Mr Brown was examined by psychiatrist, Dr Andrew Rosser, who instituted the Level 2 ITO.⁶ The Level 2 ITO was to expire on 10 May 2019.
- 4.5. From 6 April 2019 Mr Brown's health further deteriorated and at times he would refuse to eat. By that time, he was suffering end stage dementia and it was agreed with family that palliative care was appropriate.

5. Circumstances of Mr Brown's death

- 5.1. On 9 April 2019 Mr Brown's daughter, Ms Bittner, was advised Mr Brown had only a couple of days to live. Mr Brown was not having oral medication, insulin, or nutrition and had 'grunting' aspiration. He was given morphine for pain relief at 2:20pm and 8pm. Ms Bittner visited from 3pm to 7pm. Nurse Colbeck was present when Mr Brown took his last breath at 9:35pm. At 9:50pm Mr Brown was pronounced deceased by Dr Radcliff. Ms Bittner was called and informed her father had passed away.

6. Coronial investigation

- 6.1. Constable Ben Alexopoulos⁷ from Christies Beach SAPOL attended the Myles Ward at the Noarlunga Hospital at about 10:50pm on 9 April 2019 in relation to the death of Mr Brown. Constable Alexopoulos observed the body of Mr Brown and made other observations at the Noarlunga Hospital in accordance with standard procedures.
- 6.2. Brevet Sergeant Peter McGrade from the Southern District Criminal Investigation Branch of SAPOL investigated the (non-Police) death in custody of Mr Brown and prepared a comprehensive report for the State Coroner.⁸ Brevet Sergeant McGrade found nothing of concern during his involvement and investigation.

7. Conclusions

- 7.1. I have reviewed the statement of Mr Brown's daughter, Ms Bittner, and note that she does not raise any concerns in relation to the treatment of her father. Dr Desai, whose statement provided an overview of Mr Brown's care at the Noarlunga Hospital, indicates that Ms Bittner was well informed of her father's treatment and she was active in discussions regarding that treatment, including Mr Brown's end of life care.

⁶ Exhibit C7b

⁷ Exhibit C6

⁸ Exhibit C7a

7.2. I find that the care and treatment provided to Mr Brown during his admission to the Noarlunga Hospital was appropriate. I further find that the imposition of the Inpatient Treatment Orders was appropriate.

7.3. I have no need to make recommendations in relation to the death of Mr Brown.

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 2nd day of November, 2020.

Deputy State Coroner