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 5th day of November 2019 and the 8th day of May 2020, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Brian Samuel Dunbar.

The said Court finds that Brian Samuel Dunbar aged 75 years, late of Resthaven Mount Gambier, 24 Elizabeth Street, Mount Gambier, South Australia died at the Repatriation General Hospital, 216 Daws Road, Daw Park, South Australia on the 26th day of July 2016 as a result of pulmonary thromboembolus due to left calf deep vein thrombosis with contributing Influenza A infection and Parkinson's disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction, cause of death and reason for inquest

1.1. Brian Samuel Dunbar died at the Repatriation General Hospital (RGH) on 26 July 2016. He was 75 years of age. Dr Neil Langlois, a forensic pathologist at Forensic Science South Australia, conducted a post mortem examination of Mr Dunbar's remains. In his post mortem report[1] Dr Langlois expresses the opinion that the cause of Mr Dunbar's death was pulmonary thromboembolus due to left calf deep vein thrombosis with contributing Influenza A infection and Parkinson's disease. I find that to have been the cause of his death. A pulmonary thromboembolus is a blood clot that can originate in the deep veins of a person's leg. The blood clot can break away and enter the circulatory system of the lungs and cause sudden death. This is what occurred in respect of Mr Dunbar.

[1] Exhibit C2a

1.2. At the time of Mr Dunbar's death he was subject to an Inpatient Treatment Order (ITO) that had been imposed pursuant to the Mental Health Act 2009. Accordingly, his death was a death in custody for which an inquest into the cause and circumstances of his death was mandatory pursuant to the provisions of the Coroners Act 2003. These are the findings of that inquest.

2. Background

2.1. Mr Dunbar's personal history and decline in health are described in the statement of his wife, Mrs Coral Dunbar[2]. Mrs Dunbar states they were married for 51 years. For much of his younger life Mr Dunbar worked in the forestry industry in the south-east of the State. He operated machinery. He provided well for his family which included five children.

2.2. Several years prior to his death Mr Dunbar was diagnosed with Parkinson's disease by Dr Bimal Jayakody. The statement of Dr Jayakody was tendered to the inquest[3].

2.3. As well as the Parkinson's diagnosis, Mr Dunbar was also diagnosed with Alzheimer's dementia. Mrs Dunbar describes the difficulties associated with looking after her husband in light of these diagnoses.

2.4. In about May 2015 Mr Dunbar underwent six days of respite care in Boandik Lodge in Mount Gambier. It was not to his liking. Mrs Dunbar states that on one occasion he did not want to return to respite, but wanted to go to the football. He had taken off and was found, lost in confusion, some hours later. Mrs Dunbar states he would often take off and wander.

2.5. Mr Dunbar also spent some time in the Mount Gambier Hospital and in a Resthaven in that city. Mrs Dunbar outlines her husband's behaviour, some of which involved aggression that she says, and I am sure that this is so, was out of character for him. At one point he was also admitted to the RGH in Adelaide and was returned from there to Mount Gambier.

2.6. Eventually Mr Dunbar was again transferred under an ITO to the RGH in Adelaide where he ultimately died.

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[2] Exhibit C3
[3] Exhibit C8

3. Medical history

3.1. Dr Jayakody to whom I have referred is a general practitioner who practises in Mount Gambier. He commenced seeing Mr Dunbar in January 2015. Dr Jayakody states that Mr Dunbar had ongoing Alzheimer's disease as well as Parkinson's disease. Mr Dunbar's cognition deteriorated during the time Dr Jayakody was treating him. His behaviour was reportedly becoming more difficult to manage by family members. Mr Dunbar had become aggressive and was liable to wander. Dr Jayakody was not aware of any cardiac issues or circulatory issues with Mr Dunbar. It had not been established that he was suffering from a deep vein thrombosis.

3.2. Dr Jayakody states that Mr Dunbar was admitted into care when his behaviour became too difficult to manage. Dr Jayakody last saw Mr Dunbar on 15 April 2016. His presentation on that day involved worsening confusion and worsening Parkinson's tremors. Mr Dunbar was admitted to Resthaven soon after.

3.3. Ms Lisa Sutcliffe is the manager of Residential Services for Resthaven Mount Gambier. She provided a statement to the inquest[4]. Ms Sutcliffe states that Mr Dunbar was admitted to Resthaven on 7 June 2016. He had been transferred directly to that facility from the RGH via the Royal Flying Doctor Service. Ms Sutcliffe says that at first Mr Dunbar appeared to settle in. However, she describes certain incidents in relation to attempts to wander off and to enter other patients' rooms. At times Mr Dunbar exhibited aggression.

3.4. On 1 July 2016 Mr Dunbar was transferred to the Mount Gambier Hospital. By that stage his behaviour had become too difficult to manage. Mr Dunbar was returned to Resthaven. However, later that same evening he was exhibiting apparent paranoia and so was returned to the Mount Gambier Hospital.

4. Inpatient Treatment Orders are imposed

4.1. On 5 July 2016 a Level 1 ITO was imposed on Mr Dunbar at the Mount Gambier Hospital. On 8 July 2016 Mr Dunbar was transferred to the RGH in Adelaide. He was still at that time subject to the ITO.

[4] Exhibit C7

4.2. Dr Michael Page was a consultant psychiatrist at the RGH. He provided a statement to the inquest[5]. Dr Page had seen Mr Dunbar on an earlier occasion. The initial Level 1 ITO remained in force until 12 July 2016. Dr Page examined Mr Dunbar on that day. Dr Page formed the view that a further ITO was appropriate, particularly due to Mr Dunbar's dementia with symptoms of aggression and paranoia. Thus Dr Page imposed a Level 2 ITO which would have expired on 23 August 2016 but for Mr Dunbar's death.

4.3. In his statement Dr Page describes the medication regime that he employed in an attempt to manage Mr Dunbar's behaviour. Dr Page states that on 18 July 2016 a medical assessment showed Mr Dunbar was experiencing respiratory difficulties. The possibility that he was suffering from pneumonia was considered.

4.4. On 19 July 2016 there was a MET call in respect of Mr Dunbar. He was assessed as possibly having hospital acquired pneumonia. His behaviour was no longer agitated. Dr Page decided Mr Dunbar could be transferred to the medical team.

4.5. In his statement[6] Dr Isuru Sirisinghe noted that on 21 July 2016 Mr Dunbar's nasal swabs came back as positive for Influenza A. His antibiotics were ceased and his steroid treatment was slowly tapered. Due to his Influenza A Mr Dunbar was isolated. Dr Sirisinghe states that on 26 July 2016 Mr Dunbar was more mobile and seemed to be recovering well. He had been seen by a consultant and the decision was made to transfer him back to his original ward.

4.6. Prior to that transfer a physiotherapist was asked to see Mr Dunbar. He was taken for a walk and upon returning to his room he suddenly coughed, made a gurgling sound and collapsed. He did not sustain a fall as the staff were able to hold him. Dr Sirisinghe was in the vicinity when the MET call was made. Mr Dunbar had no pulse. Although CPR was commenced it was ceased as he was listed as not for CPR. The suddenness of Mr Dunbar's collapse and death is quite in keeping with the cause ultimately established at his post mortem examination.

4.7. Dr Sirisinghe certified life extinct at 3.30pm on 26 July 2016.

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[5] Exhibit C6
[6] Exhibit C5

5. Conclusions

5.1. The circumstances of Mr Dunbar's death were thoroughly investigated by Detective Brevet Sergeant Jonathon Barber of the Southern District Criminal Investigation Branch of SAPOL. In his report[7] Mr Barber expresses the conclusions that Mr Dunbar's detention pursuant to the Level 2 ITO imposed by Dr Page was lawfully imposed and that the treatment that Mr Dunbar underwent at the RGH during the course of the detention was appropriate in the circumstances. Having examined the evidence for myself I have come to the same conclusions.

5.2. Mr Dunbar's detention pursuant to the Level 2 ITO did not contribute to his death. The origin of the deep vein thrombosis within Mr Dunbar's calf cannot be identified. Mr Dunbar appeared to be recovering from the Influenza A virus at the time of his death. In his post mortem report the forensic pathologist, Dr Langlois, stated that it is to be acknowledged that a pulmonary thromboembolism that originates from a deep vein thrombosis within the calf can occur spontaneously without an obvious initiating cause. However, he points out that in this case Mr Dunbar's reduced mobility due to Parkinson's disease may have been a factor in the sustaining of the deep vein thrombosis. Infection with the Influenza A virus, resulting in bronchitis, may also have been a factor as infection may increase the tendency of blood to clot and illness may further reduce mobility.

5.3. In my opinion Mr Dunbar's detention under the Mental Health Act did not contribute to his death. Mr Dunbar's death could not have been prevented.

6. Recommendations

6.1. I have no recommendations to make in this matter.

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 8th day of May, 2020.

Deputy State Coroner

[7] Exhibit C12a