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 18th day of June and the 18th day of December 2020, by the Coroner's Court of the said State, constituted of Ian Lansell White, Deputy State Coroner, into the death of Gary Desmond Frost.

The said Court finds that Gary Desmond Frost aged 57 years, late of 12 King George Avenue, Brighton, South Australia died at the Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 14th day of February 2019 as a result of right acute subdural haematoma following a fall. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Gary Desmond Frost was born on 10 February 1962. He died at the Flinders Medical Centre[1] on 14 February 2019 aged 57 years.

1.2. A pathology review based on Mr Frost's medical records was conducted by Dr Iain McIntyre from Forensic Science South Australia on 21 February 2019.[2] Dr McIntyre found that Mr Frost had died from a right acute subdural haematoma following a fall. I accept Dr McIntyre's finding as Mr Frost's cause of death.

2. Reason for inquest

2.1. At the time of his death Mr Frost was subject to a special powers order issued pursuant to Section 32 of the Guardianship and Administration Act 1993. This order was made

[1] FMC

[2] Exhibit C1a

due to the decline in his health. At the time of the fall leading to his death, Mr Frost was in the lawful custody of Minda Incorporated.[3] His death is to be treated as a death in custody as defined in the Coroners Act 2003.[4] As he was subject to a detention order at the time of his death this is a mandatory inquest pursuant to Section 21(1)(a) of the Act.

3. **Background**

3.1. Mr Frost's personal background has been provided by Maria Darby, Senior Manager Quality and Governance at Minda. Mr Frost was born into a farming family at Kadina.[5] He initially lived on the farm with his parents and sister. Due to his intellectual disability he became a resident of Minda at North Brighton from 24 March 1969 when he was aged seven. Mr Frost's parents were active in his life, but were unable to provide some of the supports he required. Mr Frost could access the special school at Minda at a time when such a facility was not available at Kadina. Mr Frost would return home to visit his family and his family would frequently visit him. Mr Frost was an active child at Minda. He lived in various houses and was in Hodge House for over 20 years. After he finished school Mr Frost worked in the laundry at Minda.

3.2. In 2011 Mr Frost moved into supported accommodation overseen by Minda at Brooklawn Close, Mitchell Park. Until mid-2017 Mr Frost was relatively independent, being able to care for himself to some degree. At that time staff from Minda reported a change in his overall demeanour. Mr Frost began to refuse to go to work and eventually stopped completely. A support plan was devised in November 2017. At this time Mr Frost had increased anxiety, was having difficulty verbalising, started showing aggression, and had some limitations on travelling home. As a result Mr Frost's elderly mother had to drive from Kadina to visit him.

3.3. During 2018 Mr Frost's behaviour continued to worsen requiring police and ambulance attendance on occasion. The aggression was out of character for him. He also became incontinent during that time. In 2018 Mr Frost was relocated to the Pat Kaufman Centre, Minda's aged care in-house residence. There were further incidents at that location. In December 2018 it was suspected Mr Frost had frontal lobe dementia. Various meetings were held between interested parties regarding Mr Frost's

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[3] Minda
[4] 'The Act'
[5] Exhibit C4

accommodation and assistance. Concerns were raised about changes to his gait and falls.

3.4. Following a further behaviour related admission to the FMC, Mr Frost was discharged on 14 January 2019 to the Acacia Unit at Murdoch House. That unit had no other residents and Mr Frost was given one-on-one attention.

4. Mr Frost's guardianship

4.1. In 1998 the Guardianship Board appointed a staff member at Minda as Mr Frost's delegate.[6] His parents remained as his informal decision makers until a special powers order was made in December 2018 by the South Australian Civil and Administrative Tribunal[7] pursuant to Section 32 of the Guardianship and Administration Act 1993. The specific order for residency, detention and treatment was required to move Mr Frost to a more secure facility. The order was made on 3 December 2018 with an expiry date of 24 December 2018. Mr Frost's now 87-year-old mother was listed as his interim guardian.

4.2. On 19 December 2018 a guardianship hearing was held. The guardianship order was amended appointing Mr Frost's relatives, including his mother, as guardians. It had a recommended review date of 17 December 2021. Special orders were made for residence, detention, treatment and care which enable such force as is necessary to be used to ensure proper medical treatment.

5. Mr Frost's medical history

5.1. Mr Frost had a significant medical history. The pathology review noted a history of intellectual disability, schizophrenia, dementia, hypertension, oropharyngeal dysphagia and recurrent falls.[8]

5.2. During the last few weeks of his life Mr Frost had several falls.[9] Some of the falls required attendance at the FMC.[10] He was at times wearing a helmet but would

[6] Exhibit C5
[7] SACAT
[8] Exhibit C1a
[9] Exhibit C4
[10] Exhibit C3

sometimes remove it.[11] A psychologist was consulted about the use of a helmet as it could be considered a restraint.

5.3. Mr Frost's first presentation to the FMC for a fall was on 24 January 2019. On that occasion he had fallen backward, hitting his head on a door frame. He did not lose consciousness, but sustained a 2cm superficial laceration on top of his head and a full thickness 8cm laceration to the back of his head. This wound was stapled. His neurological examination was normal.

5.4. Mr Frost next attended the FMC on 29 January 2019 following a fall at 7am whilst trying to get out of bed. He had no loss of consciousness, but required attention to a wound on his left temple. A CT scan was performed but there was no evidence of brain injury. Mr Frost was discharged.

5.5. On 8 February 2019 Mr Frost was admitted to the FMC following a fall where he fell backwards hitting the back of his head on the ground. He did not lose consciousness. He suffered a laceration to the back of his head where it had previously been stapled. A neurological assessment found no issues. Mr Frost was discharged.

5.6. On 10 February 2019 Mr Frost had two further falls in the morning with a head strike to a wall causing an extension of his scalp wound. He was under 24-hour care but was difficult to manage.[12] Mr Frost was assessed in the short stay unit and released. He had no neurological deficits. It was determined a CT scan was not required. The decision to conduct a CT scan is a considered one. It is noted that performing CT scans on patients with an intellectual disability or behavioural disturbance is challenging. A review of the case of Mr Frost found the approach taken was reasonable.[13]

5.7. On 11 February 2019 Mr Frost was sitting on the edge of a couch when he fell over backwards. When falling Mr Frost struck his head against a wall and a concrete floor. He was wearing a helmet at the time but it was dislodged by his fall. He was unconscious as a result and was sent to the FMC.

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[11] Exhibit C3, paragraph 26
[12] Exhibit C4, paragraph 7
[13] Exhibit C4, paragraph 8

6. Mr Frost's final admission

6.1. At the FMC, Mr Frost was found to have unequal, non-reactive pupils and was in a deep state of unconsciousness, in a coma, with decerebrate posturing. His condition was indicative of a severe brain injury.[14] A CT scan was performed which displayed a large acute right subdural haematoma with 15mm midline shift and bilateral uncal herniation. A neurological assessment determined Mr Frost's outlook was grim. The pressure on the brain stem caused Mr Frost to be in a coma and vegetative state. It was considered surgery, namely a craniotomy to remove the clot, would not assist survival. Drs Vrodos and Treddan had a discussion with Mr Frost's family advising them that they did not support active surgical treatment. In consultation with family a decision was made to provide palliative care.

6.2. At 9:35am on 12 February 2019 there was a further discussion between treating staff as to Mr Frost's condition. Mr Frost remained unconscious and non-responsive to painful stimuli. The decision to palliate was confirmed. Mr Frost received supportive care with no intervention and he passed away on 14 February 2019.

7. Review of treatment

7.1. Associate Professor Andrew Blyth reviewed Mr Frost's treatment at the FMC. Associate Professor Blyth is the Network Clinical Director of the Emergency Department at the FMC. He reviewed Mr Frost's case considering the history of falls and the use of CT scans. He considered the bleed which led to death and noted it was most likely the result of Mr Frost's last fall. He considered the tragic outcome difficult to prevent.[15] No medication was administered, nor was it necessary as vomiting or severe pain were not present.[16] Associate Professor Blyth considered discharge communications were completely appropriate.[17]

8. Coronial investigation

8.1. Due to Mr Frost's death being a death in custody, an investigation was conducted by SAPOL. Senior Constable Lynda Crisp[18] attended the FMC at about midday on 15 February 2019 in relation to the death of Mr Frost. Senior Constable Crisp observed

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[14] Exhibit C2
[15] Exhibit C4, paragraph 11
[16] Exhibit C4, paragraph 14
[17] Exhibit C4, paragraph 16
[18] Exhibit C6

the body of Mr Frost and made other observations in accordance with standard procedures.

8.2. Detective Brevet Sergeant Sherri-Anne Modra investigated the death in custody of Mr Frost and prepared a comprehensive report[19]. Nothing of concern was noted during her investigation in relation to both Mr Frost's accommodation at Minda or the care and treatment provided at the FMC.

8.3. No matters were raised by Mr Frost's next of kin. It is apparent that Mr Frost's mother was kept aware of Mr Frost's health issues and treatment. Mrs Frost was present at the inquest with her daughter Sharon Lawrence and her son-in-law Brian Lawrence. Their presence is a clear indication of how much they loved and were proud of the late Mr Gary Frost.

9. Conclusions

9.1. I find that Mr Frost's care, both in a supported facility and at hospital, was the best it could be in the circumstances of his failing health. Mr Frost's care and treatment at the FMC was appropriate. His death was expected due to the serious injury that occurred following his last fall.

9.2. I further find that Mr Frost was in lawful custody at the time of his death.

10. Recommendations

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

Key Words: Death in Custody; Natural Causes; Section 32 Powers

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

Seal the 18th day of December, 2020.

Deputy State Coroner

Inquest Number 64/2020 (0309/2019)

[19] Exhibit C7