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 30th day of April and the 28th day of May 2020, by the Coroner's Court of the said State, constituted of Simon James Smart, Deputy State Coroner, into the death of John Maxwell Loudon.

The said Court finds that John Maxwell Loudon aged 83 years, late of Helping Hand, 2 The Strand, Mawson Lakes, South Australia died at the Lyell McEwin Health Service, Haydown Road, Elizabeth Vale, South Australia on the 25th day of April 2017 as a result of aspiration pneumonia on a background of dysphagia and advanced Alzheimer's disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. John Maxwell Loudon was born on 29 August 1933 and died at the Lyell McEwin Health Service (LMHS) on 25 April 2017 aged 83 years. Mr Loudon's body was identified by his daughter, Ms Angela De Silva[1].

1.2. The cause of Mr Loudon's death was determined by Dr Iain McIntyre of Forensic Science South Australia following a review of Mr Loudon's medical case notes and clinical history. In his pathology review report[2], Dr Iain McIntyre provides the cause of death as aspiration pneumonia in a man with dysphagia and advanced Alzheimer's disease, and I so find.

[1] Exhibit C1a
[2] Exhibit C2a

2. Reason for Inquest

2.1. Mr Loudon's death was the subject of a mandatory inquest pursuant to the Coroners Act 2003 as there was reason to believe a possible cause of death arose, or may have arisen, while Mr Loudon was the subject of an Inpatient Treatment Order (ITO).

2.2. At the time of Mr Loudon's death the ITO had been revoked[3], however a review of the LMHS medical records indicates that his treating team suspected aspiration pneumonia as a possible cause for his physical deterioration, and this was at a time prior to the revocation of the ITO.

2.3. Mr Loudon's death therefore falls within the definition of 'death in custody' pursuant to the section 3(1) of the Coroner Act 2003 which states:

> 'death in custody means the death of a person where there is reason to believe that the death occurred, or the cause of death, or a possible cause of death, arose, or may have arisen, while the person was being detained in any place within the State under any Act or law.'

3. Background

3.1. There is little information about Mr Loudon's personal history. Statements have been obtained from health workers as have medical case notes.

3.2. Mr Loudon was born in Scotland. He immigrated to Australia in 1962 and had three children, all of whom live in Adelaide. Mr Loudon was divorced and, prior to his admission to the Helping Hand aged care facility, lived with his friend Mavis[4].

3.3. Mr Loudon was moved to Helping Hand due to several difficulties. He was becoming forgetful and was trying to do things that he was not capable of doing. He failed to recognise family or friends that he had not seen for a while. He would often become frustrated and his difficult behaviour would escalate at night. It was clear to his family that he required care in a safe environment. Prior to his admission to Helping Hand Mr Loudon did not have any other services involved in his care.

3.4. The Helping Hand case notes reveal Mr Loudon was assessed for suitability to reside at the facility with the knowledge and assistance of two of his children.

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[3] Mr Loudon's Inpatient Treatment Order was revoked on 20 April 2017

[4] Exhibit C9, Helping Hand case notes

4. Helping Hand

4.1. On 16 January 2017 Mr Loudon was admitted to the Helping Hand aged care facility in Mawson Lakes. He was 82 years old. Mr Loudon's care plan is set out in the statement of Ms Claire Stone who is the Residential Services Manager[5].

4.2. At the time of admission Mr Loudon had been diagnosed with dementia, diabetes, prostate cancer and transient cerebral ischemic attacks. He also had history of treated pancreatic carcinoma.

4.3. Mr Loudon's behaviour continued to deteriorate at Helping Hand. He was uncooperative and resistant to showering and toileting. He would wander around secure areas, abscond into the car park, physically threaten staff and walk uninvited into other residents' rooms. He regularly wandered around the nursing home at night, resisting returning to his room.

4.4. Mr Loudon also suffered from short term memory loss, disorientation and had severe cognitive impairment. His mood would fluctuate. He showed symptoms of depression and anxiety. Mr Loudon was prescribed numerous medications for his many comorbidities. The full details of his medication regime are included in the statement of Ms Stone[6].

4.5. Dr Martin Ooi, a general practitioner from the Marden Medical Clinic, reviewed Mr Loudon at Helping Hand. Dr Ooi states that Mr Loudon had significant behavioural and psychological symptoms of dementia[7]. On 11 April 2017 Dementia Support Australia was consulted regarding incidents of physical and verbal threats.

4.6. On 13 April 2017 Older Persons Mental Health was contacted to review Mr Loudon's behavioural issues. Helping Hand was advised to contact SAAS immediately and to send Mr Loudon for review at hospital if there were risks due to his behaviour. Due to his unpredictable episodes of physical and verbal aggression towards staff, arrangements were made to transfer him to a facility which had the capacity to care for him. On 15 April 2017 he was transferred to LMHS following an episode of physical aggression towards a staff member.

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[5] Exhibit C6, Statement of Ms Claire Stone
[6] Exhibit C6
[7] Exhibit C5

4.7. Helping Hand followed up on Mr Loudon's progress with LMHS but received no response until 26 April 2017 when they were informed by his daughter that he had passed away.

5. Lyell McEwin Health Service

5.1. Dr Sujeeve, psychiatrist and Clinical Director of the Northern Mental Health Service, provided a statement to the Court wherein he details Mr Loudon's admission to the LMHS and the imposition of the Level 1 ITO[8].

5.2. Dr Sujeeve states that on 15 April 2017 Mr Loudon was brought to the LMHS Emergency Department as there were reports of behavioural changes. Mr Loudon had become quite aggressive and it was reported he had tried to strangle his daughter.

5.3. Dr Sujeeve states that behavioural changes are common in people with Alzheimer's and dementia. Mr Loudon was seen by the geriatric team who hoped to address his physical state and delirium.

5.4. Due to his aggressive behaviour on the ward there were a number of 'code blacks'[9]. On 17 April 2017 he was deemed to be a risk to himself and others and was placed on a Level 1 ITO by Dr Rubaiyat Rimi[10]. On 18 April 2017 Mr Loudon was seen by senior consultant psychiatrist, Dr Fiona Hawker, who confirmed the ITO. Dr Hawker was of the opinion that Mr Loudon presented with an exacerbation of his Alzheimer's and dementia. This was due to his behaviour and his refusal to take his medication. Dr Hawker consulted with Mr Loudon's daughter and recommended an application be made to the Guardianship Board seeking section 32 powers.

5.5. Dr Sujeeve states that Mr Loudon deteriorated physically. There were multiple meetings with the medical team and family. It was decided that a palliative approach was the most appropriate course. On 20 April 2017 Mr Loudon was seen by consultant psychogeriatrician, Dr Asha Chitrarasu, who revoked the ITO following assessment. Mr Loudon remained a voluntary patient until his death on 25 April 2017.

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[8] Exhibit C4

[9] A Code Black is a request for urgent/emergency assistance made by staff who believe that their safety, or that of the patient and/or other people, is at risk

[10] Exhibit C8a

5.6. Registered Nurse Danika Spilsbury provided a statement to the Court detailing Mr Loudon's final hours on 25 April 2017[11]. Mr Loudon was regularly checked by medical staff and administered pain relief. He passed away at 6:05pm.

6. Coronial investigation

6.1. On 26 April 2017 South Australia Police commenced an investigation into Mr Loudon's death. Constable Shaun Rowe attended Lyell McEwin Hospital and provided a statement to the Court setting out a brief chronology of events[12].

6.2. Brevet Sergeant Timothy Nguyen was appointed as the investigating officer in relation to the coronial death in custody investigation. Brevet Sergeant Nguyen provided a detailed report to the State Coroner[13].

7. Conclusions

7.1. I find that the treatment and care provided to Mr Loudon at Helping Hand and the Lyell McEwin Health Service was appropriate[14].

7.2. There were no suspicious circumstances surrounding the death of Mr Loudon and no third-party involvement. Mr Loudon's next of kin have not expressed any concerns in relation to his care.

8. Recommendations

8.1. I make no recommendations pursuant to section 25(2) of the Coroners Act 2003.

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 28th day of May, 2020.

Deputy State Coroner

[11] Exhibit C3
[12] Exhibit C7
[13] Exhibit C8
[14] Final Report Non-Police death in custody Page 18.