



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 28th day of May and the 12th day of October 2020, by the Coroner's Court of the said State, constituted of Simon James Smart, Deputy State Coroner, into the death of Henri Martinus Bernardus Mansvelders.

The said Court finds that Henri Martinus Bernardus Mansvelders aged 79 years, late of 36 Ridgeway Drive, Bellevue Heights, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 17th day of June 2017 as a result of atherosclerotic right internal carotid artery occlusion with resultant ischaemia and infarction of greater than 50% of the right middle cerebral artery territory. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

- 1.1. Henri Martinus Bernardus Mansvelders, known as Harry, was born on 19 May 1938 and died on 17 June 2017 at Royal Adelaide Hospital on North Terrace. He was 79 years of age.
- 1.2. A 'Death Report to Coroner - Medical Practitioner's Deposition' was completed by medical intern, Dr Alexander Stevanovici. In that document Dr Stevanovici has provided a suggested cause of death of atherosclerotic right internal carotid artery occlusion with resultant ischaemia and infraction of greater than 50% of the right middle cerebral artery territory.¹ I find that to have been the cause of Mr Mansvelders' death. No pathology review or post mortem was conducted and Mr Mansvelders' death was expected as a consequence of his stroke.

¹ Death Report to Exhibit Coroner Medical Practitioner's Deposition

2. **Reason for inquest**

- 2.1. This was a mandatory inquest pursuant to section 21(1)(a) of the Coroners Act 2003 as Mr Mansvelders was subject to an Inpatient Treatment Order (ITO) at the time he suffered the stroke that resulted in his death.
- 2.2. A Level 1 ITO was imposed pursuant to section 21 of the Mental Health Act 2009 by Dr Andrew Taylor at 9:45pm on 8 June 2017 following Mr Mansvelders' admission to the Flinders Medical Centre (FMC). The ITO was for a period of seven days and was due to expire at 7pm on 15 June 2017.²
- 2.3. The ITO was instituted as a result of an assessment that Mr Mansvelders was at risk of harming himself following an expression of suicidal ideation.³ Mr Mansvelders had contacted his stepson in Queensland and threatened to harm himself if his wife left him. Mr Mansvelders' son contacted South Australia Police who attended the home address of Mr Mansvelders. Upon their attendance police spoke with Mr Mansvelders who was visibly upset. He indicated to police that he had contemplated suicide in the previous couple of days.⁴
- 2.4. At about 1pm on 8 June 2017 attending police detained Mr Mansvelders under section 57 of the Mental Health Act 2009. He was conveyed to the FMC Emergency Department where he was admitted into their care. He was compliant and happy that police were there to assist him.⁵
- 2.5. At approximately 10pm Mr Mansvelders absconded from the FMC. Police were notified and attended at his home address at 10:47pm. At that time the house appeared unoccupied, however approximately ten minutes later lights were turned on at the premises. Police entered the house through an unlocked garage door and located Mr Mansvelders hiding within the premises. He was again detained by police and transferred back to the FMC without incident.⁶
- 2.6. On 9 June 2017 Mr Mansvelders was transferred from the FMC to the Repatriation General Hospital where he was placed in a locked ward. On 10 June 2017

² Exhibit C11b

³ Exhibit C5, Statement of Roman Onilov, [11] and [15]

⁴ Exhibit C7, Statement of David Jowsey, [6]

⁵ Exhibit C8, Statement of David Milsom, [4]

⁶ Exhibit C8, Statement of David Milsom, [5]-[6]

Mr Mansvelders was found slumped on the floor and subsequent investigations revealed he had suffered a stroke.⁷

- 2.7. On 15 June 2017 the ITO was allowed to lapse after Mr Mansvelders was reviewed by consultant psychiatrist Roman Onilov. Dr Onilov found Mr Mansvelders in a severe unresponsive state and was unable to make a meaningful psychiatric assessment as Mr Mansvelders was in a non-verbal state. There was no indication his condition was going to improve.⁸ Mr Mansvelders passed away on 17 June 2017.
- 2.8. Although the ITO was not in place at the time of Mr Mansvelders' death, section 3 of the Coroners Act 2003 defines a death in custody to include when the cause of death, or a possible cause of death, 'arose or may have arisen while a person was in custody'. In this matter the critical event, the stroke that led to Mr Mansvelders' death, occurred whilst the ITO was in place.

3. Background and medical history

- 3.1. Mr Mansvelders was born in Holland emigrating to Australia in 1950. He was married twice and had a total of four children. He worked as a draftsman for Mitsubishi before taking a redundancy package in the 1990s to look after his second wife and children.⁹
- 3.2. He married his first wife, Anitra Conen in 1963. They had three children together, Mark, Lara and Renee. Mr Mansvelders and his wife Anitra separated in 1977. Anitra moved to Burra with their three children and Mr Mansvelders remained in Adelaide.¹⁰
- 3.3. Mr Mansvelders married his second wife Irene in 1985. They had a son, Danny. Irene Mansvelders suffered mental health issues and Mr Mansvelders became her primary carer. They had a difficult relationship and Mrs Mansvelders was seeking advice on separating from her husband at the time of the imposition of the ITO.
- 3.4. Mr Mansvelders was a patient of the Blackwood Clinic from at least 2003. His medical records reveal he had a significant history of cardiovascular disease. He suffered a heart attack in 2008 requiring insertion of a coronary stent followed by a triple coronary arterial bypass graft in 2014. He was obese, suffered hypertension, hypercholesterolemia and impaired fasting glycaemia.¹¹

⁷ Exhibit C11, Investigating Officers Report, pg 10; RAH Medical Notes for 10 June 2017

⁸ Exhibit C5, Statement of Roman Onilov, [11] and [15]

⁹ Exhibit C2, Statement of Danny Mansvelders, pg 2, Exhibit C1a, Statement of Renee Rechichi, pg 2

¹⁰ Exhibit C1a, Statement of Renee Rechichi, pg 2

¹¹ Exhibit C6, Statement of Tudor Thomas, [5]

4. Clinical circumstances leading to Mr Mansvelders' death

- 4.1. As previously stated, Mr Mansvelders was admitted to the FMC on 8 June 2017 prior to his transfer to the Repatriation General Hospital on 9 June 2017.
- 4.2. Mr Mansvelders was seen multiple times by staff at the hospital and a nursing note timed at 8:30pm on 10 June 2017 details Mr Mansvelders as being well. At about 8:55pm nursing staff found Mr Mansvelders slumped on the floor. He was noted to be densely hemiplegic on his left side, having right side gaze palsy and a decreased Glasgow coma scale score of 10 with copious secretions.¹²
- 4.3. At 10:15pm on Saturday 10 June 2017 MedSTAR paramedics were called to retrieve Mr Mansvelders to the Royal Adelaide Hospital (RAH) and it was believed he had suffered a stroke.¹³
- 4.4. MedSTAR paramedics arrived on scene at 11pm. Mr Mansvelders had been intubated, sedated and ventilated prior to their arrival. He was not fully conscious at this time. Mr Mansvelders was conveyed to the RAH where he was assessed by the Emergency Department team and the on-call Stroke Registrar.
- 4.5. Mr Mansvelders underwent a CT scan which revealed a large non-dominant middle cerebral artery (MCA) territory infarct with extensive core and brain tissue necrosis. It was agreed by medical staff that there was limited chance of improvement with intervention.
- 4.6. Mr Mansvelders was admitted to the Intensive Care Unit of the RAH on 11 June 2017 for monitoring and neuroprotective measures. He was seen daily by the specialist stroke team who noted fluctuating changes in neurology. Mr Mansvelders' past medical history correlated with the radiological findings conducted at the RAH which demonstrated an ischaemic stroke had occurred.¹⁴
- 4.7. Given his poor prognosis Mr Mansvelders was provided with the necessary medical treatment prior to a decision being made that Mr Mansvelders was for palliative care.¹⁵
- 4.8. At about 8:40am on Saturday 17 June 2017 Mr Mansvelders was in ward B7 of the hospital where he was seen by Dr Tania Salahi. It was noted at this time that

¹² Exhibit C11, Investigating Officers Report, pg 10; RGH Medical Notes for 10 June 2017

¹³ Exhibit C4, Statement of David Tingey, [3]

¹⁴ Exhibit C11, Investigating Officers Report, pg 10; RAH Medical Notes

¹⁵ Exhibit C11, Investigating Officers Report, pg 12; RAH Medical Notes

Mr Mansvelders breathing had become laboured and he was not responsive to voice. He appeared to be at the end stages of life, but not in discomfort. He was on a ‘niki’ pump which was administering Morphine, Midazolam and Hyoscine.¹⁶

- 4.9. When checked by nursing staff at 9:10am on Saturday, 17 June 2017 Mr Mansvelders’ respirations had ceased and he had passed away. He was formally certified life extinct by Dr Salahi at 6:05pm.¹⁷

5. Coronial investigation

- 5.1. Mr Mansvelders’ death in custody was investigated by Detective Brevet Sergeant Jim Page from the South Coast Criminal Investigation Branch of SAPOL. Detective Page conducted a thorough investigation into this matter as is evidenced by his report which was tendered to the Court.

- 5.2. Following his investigation Detective Page concluded that the care provided to Mr Mansvelders was appropriate in the circumstances and that the ITO was lawful. There were no suspicious circumstances surrounding the death of Mr Mansvelders.¹⁸

6. Conclusion and recommendations

- 6.1. Consistent with the views of Detective Page, I find that Mr Mansvelders’ detention was lawful and did not contribute in any way to his death. I further find that Mr Mansvelders received an appropriate level of care and treatment during his admissions to the Flinders Medical Centre, the Repatriation General Hospital and the Royal Adelaide Hospital.
- 6.2. 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 12th day of October, 2020.

Deputy State Coroner

¹⁶ Exhibit C3, Statement of Tania Salahi, pg 2

¹⁷ RAH Medical Notes for 17 June 2017

¹⁸ Exhibit C11, Investigating Officers Report, pg 11-12