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 16th day of July 2020, by the Coroner's Court of the said State, constituted of Paul Marvin Foley, Deputy State Coroner, into the death of Alistair Douglas Eric Shankland.

The said Court finds that Alistair Douglas Eric Shankland aged 78 years, late of 6 Rockley Road, Reynella, South Australia died at Noarlunga Health Service, Alexander Kelly Drive, Noarlunga Centre, South Australia on the 21st day of January 2019 as a result of subarachnoid haemorrhage (bilateral) and occipital fracture. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Alistair Douglas Eric Shankland was born on 17 June 1940 and died on 21 January 2019 at the Noarlunga Hospital. He was 78 years of age.

1.2. A 'Death Report to Coroner - Medical Practitioner's Deposition' was completed by Dr Justin Baker. In that document Dr Baker has provided a suggested cause of death of bilateral subarachnoid haemorrhage and occipital fracture resulting from Mr Shankland hitting himself in the face with a door and falling backwards.[1] No pathology review or post mortem was conducted and Mr Shankland's death was expected as a consequence of this injury.[2] I find that Mr Shankland died as a result of subarachnoid haemorrhage (bilateral) and occipital fracture.

[1] Death Report to Coroner Medical Practitioner's Deposition
[2] Exhibit C5

2. Reason for inquest

2.1. Mr Shankland's death was the subject of a mandatory inquest pursuant to section 21(1)(a) of the Coroners Act 2003 as the cause of his death arose whilst he had been detained under an Inpatient Treatment Order (ITO).

2.2. A Level 1 ITO was made pursuant to section 21 of the Mental Health Act 2009 on 26 December 2018 by Dr Druva Mitra and confirmed by Dr Richard Weeks on 27 December 2018. That treatment order was due to expire on 2 January 2019.

2.3. On 2 January 2019 a Level 2 ITO was made by psychiatrist Dr Adele Jackson and due to expire on 12 February 2019.

2.4. On 15 January 2019 Mr Shankland's ITO was revoked as '*a result of increased engagement with treatment*'.[3] The medical team had revoked the order expecting that Mr Shankland was unlikely to live much longer; however his condition improved and they were unable to manage him without a further order. A Level 1 ITO was therefore made on this day by Dr Dyah Dharmeswari and was due to expire on 22 January 2019.

2.5. On 20 January 2019 Mr Shankland was seen by psychiatrist Dr Newton in order to review the ITO given Mr Shankland's deterioration. Dr Newton formed the opinion that an ITO was no longer the least restrictive treatment option and it was revoked.

2.6. Mr Shankland died the following day and, whilst not under an ITO at the time of his death, he was subject to an ITO on the day he suffered the fall that was relative to the cause of his death. For that reason Mr Shankland's death required a mandatory inquest.

3. Background and medical history

3.1. Mr Shankland was born in the United Kingdom and immigrated to Australia at the age of 21. Mr Shankland was married to Denise Shankland in 1972 and they had two daughters, Kylie Cooley and Melissa Giddio.

3.2. Mr Shankland was an electrician and for the majority of his career he was employed by the Electricity Trust of South Australia.[4]

[3] Noarlunga Health Services notes 16/1/19 11:42am
[4] Exhibit C4

3.3. Mr Shankland's relevant medical history includes atrial fibrillation, hypertension, osteoarthritis, enlarged prostate and mixed vascular and Alzheimer's dementia following a stroke in October 2015.

3.4. Mr Shankland suffered a stroke and was admitted to the Flinders Medical Centre on 8 October 2015 before being transferred to the Geriatric Evaluation and Management Ward (GEM) on 5 November 2015. He was then diagnosed with vascular dementia. Hospital records indicate that after the stroke Mr Shankland's condition deteriorated. He suffered progressive behavioural change and impulsivity with acute delirium and aggressive behaviour.

3.5. Mrs Shankland describes her husband's condition deteriorating in the twelve months prior to his death. He was losing his memory and starting to wander. Police were called a couple of times as Mr Shankland would just walk off without anyone knowing.[5]

3.6. In August 2018 Mrs Shankland and her daughters travelled to Bali for a holiday. Mr Shankland was placed in respite care but he did not cope well and became verbally aggressive. On Christmas Day 2018 Mr Shankland was at his daughter's home when he wandered away and was later found in a nearby park. When approached by family members he became aggressive and was taken to the Flinders Medical Centre. It was at this time that he was placed on the first Level 1 ITO referred to earlier in these findings.

3.7. On 31 December 2018 Mr Shankland was transferred to the Noarlunga Hospital. Mr Shankland's behaviour continued to be aggressive and numerous code blacks were called. On 12 January 2019 Mr Shankland was described as '*mostly unsettled and quite disruptive*'. He had been acting inappropriately, wandering and running in ward corridors looking for a way out, calling out loudly and refusing medications.[6]

3.8. At 11:42am on 13 January 2019 Mr Shankland was noted to be drooling and greyish in colour, his blood pressure was low and he became limp and unresponsive. Mr Shankland was assisted into bed by medical staff, but became very aggressive requiring four to five staff to hold him as he was kicking, hitting and spitting. This behaviour continued throughout the day. Later that afternoon a code black was called as Mr Shankland was verbally and physically aggressive, destroying property and

[5] Exhibit C4
[6] Noarlunga Hospital EPAS Records, 12 January 2019

picking fights. He refused oral medication. Clonazepam was given with the assistance of security guards and his behaviour settled enough for Mr Shankland to eat his evening meal.

3.9. A further code black was called later the same evening as Mr Shankland again became physically aggressive to staff and patients. He reached over the door to the nursing station and attempted to hit hospital staff. Security guards attended and Mr Shankland punched and pretended to shoot staff members. He was given intravenous Clonazepam and escorted back to his room.[7]

3.10. Shortly thereafter Mr Shankland was attempting to enter the bathroom when he forcefully opened the door into his face causing him to fall backwards and hit his head on the floor. The code black team was present at the time and Mr Shankland was checked by medical staff including Dr Allena Cheong. There was obvious swelling and bleeding of the nose. Mr Shankland was then taken for a CT scan of his head. The scans showed bilateral frontal lobe subarachnoid haemorrhage; blood in the right sylvian fissure and middle cranial fossa, small occipital bone at the location of the haematoma. Mr Shankland's wife opted for comfort care in the event of any further deterioration.

4. Mr Shankland's deterioration and death

4.1. After the fall on the evening of 13 January 2019 Mr Shankland was placed on one-on-one care for monitoring purposes. He continued to behave aggressively when awake and was resistive to care.

4.2. At about 9:40am on 21 January 2019 Mr Shankland was having trouble breathing. Nurse Lynn Vale[8] left Mr Shankland's room to obtain medication to assist him. While absent from his room she heard his call-bell sound. On arrival at Mr Shankland's room she observed his daughter present and Mr Shankland's chest moving, but without taking in any air. Mr Shankland died shortly after.

[7] Exhibit C3
[8] Exhibit C2

5. Coronial investigation

5.1. Detective Brevet Sergeant Tyson Mobbs from the Southern Criminal Investigation Branch of SAPOL was tasked with investigating Mr Shankland's death in custody[9]. Detective Mobbs determined that the Inpatient Treatment Orders that Mr Shankland had been subject to were lawful and appropriate. He also found that the care and treatment provided to Mr Shankland whilst detained was appropriate in the circumstances.

6. Conclusions and recommendations

6.1. Mr Shankland's family did not raise any concerns relating to his care. In her statement tendered to the Court, Mrs Shankland stated '*I have no issues with any of the health staff at Noarlunga Centre, they do a wonderful job and took excellent care of Alistair under trying circumstances*'.

6.2. I would point out that Mr Shankland's aggressive behaviour throughout his admission was in no way indicative of Mr Shankland's personality prior to the deterioration of his medical condition in 2015. It is an unfortunate fact that Alzheimer's can often lead to such behaviour in a person not previously known to exhibit these traits.

6.3. I find that Mr Shankland's detention under the Mental Health Act 2009 was lawful. I further find that the care and treatment provided to Mr Shankland whilst detained was of an appropriate standard. I have no recommendations to make.

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 16th day of July, 2020.

Deputy State Coroner

[9] Exhibit C7