



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 14th day of May and the 11th day of June 2020, by the Coroner's Court of the said State, constituted of Simon James Smart, Deputy State Coroner, into the death of Robert Duncan Strachan Smith.

The said Court finds that Robert Duncan Strachan Smith aged 85 years, late of 6 Humberstone Avenue, Hayborough, South Australia died at the Repatriation General Hospital, 216 Daws Road, Daw Park, South Australia on the 2nd day of October 2017 as a result of general inanition on a background of end stage dementia. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

- 1.1. Robert Duncan Strachan Smith was born on 22 July 1932 and died on 2 October 2017 at the Repatriation Hospital at Daw Park. He was 85 years old. Mr Smith was formally identified by his son, Lyndon Smith, at the Repatriation General Hospital, on 2 October 2017¹.
- 1.2. A pathology review was conducted by Dr Iain McIntyre from Forensic Science South Australia on 5 October 2017². Dr McIntyre found Mr Smith's cause of death to be general inanition on a background of end stage dementia, and I so find. Dr McIntyre noted a history including advanced mixed fronto-temporal and Lewy body dementia with behavioural and physical side effects, hypertension, gout, glaucoma and an internal jugular vein thrombosis in 2007.

¹ Exhibit C1

² Exhibit C2a, Pathology Review by Dr Iain N McIntyre dated 5 October 2017.

2. Reason for Inquest

- 2.1. On 3 September 2017 Mr Smith was placed on a Level 1 Inpatient Treatment Order (ITO) by Dr Jonathan Brailey pursuant to section 21 of the Mental Health Act 2009. The ITO was confirmed by psychiatrist Dr Christopher Veale on 4 September 2017. On 8 September 2017 Mr Smith was placed on a Level 2 ITO by Dr Deborah Blood pursuant to section 25 of the Mental Health Act 2009. That Level 2 ITO was in place at the time of Mr Smith's death on 2 October 2017. Accordingly, Mr Smith's death is regarded as a death in custody and as such this is a mandatory inquest pursuant to section 21(1)(a) of Coroners Act 2003.

3. Background

- 3.1. Mr Smith's second wife died in 2013 which left Mr Smith living alone in Victor Harbor. Dr Timothy Sullivan was Mr Smith's general practitioner in Victor Harbor from April 2011³.
- 3.2. Mr Smith's son Lyndon started to regularly travel from Adelaide to Victor Harbor to check on his father, and often stayed the weekend to keep him company. Lyndon Smith first noticed what he thought might be the onset of dementia in his father in about 2013. In about 2014 or 2015 Mr Smith started to talk to his son about people he saw within his house. Lyndon Smith had to explain the people were not real. Mr Smith installed a lock on his bedroom door so he could sleep in peace with the imaginary people outside. Lyndon Smith organised a hidden spare key for Mr Smith, but Mr Smith forgot where it was. This caused Lyndon Smith concern for his father's memory⁴. Mr Smith was referred to a psychiatrist because of his visual hallucinations on 5 February 2015⁵. Cleaning and gardening help was arranged for Mr Smith which also provided him with some company.
- 3.3. During 2017 Lyndon Smith assessed Mr Smith's dementia as worsening and so he reduced his workload to spend four days per fortnight with Mr Smith. Eventually Mr Smith was found wandering down his street, upset and talking to his deceased wife. Two weeks respite care was arranged at Estia, Victor Harbor, but Mr Smith was admitted to hospital after ten days.

³ Exhibit C8, Affidavit of Dr Timothy Sullivan dated 24 October 2017

⁴ Exhibit C1a, Affidavit of Lyndon Smith dated 18 April 2018, paragraphs 7 and 8

⁵ Supra n.3 at paragraph 10

4. Mr Smith's hospitalisation

- 4.1. Mr Smith was hospitalised at the South Coast District Hospital for respite care. Due to difficulties with his management, Mr Smith was transferred from the South Coast District Hospital to the Flinders Medical Centre on 19 July 2017. At the Flinders Medical Centre Mr Smith was assessed and sedated before being transferred to the Repatriation General Hospital on 9 August 2017⁶. It had been thought that other aged care options would be sought, but due to a repeat of aggression and a worsening condition, hospitalisation was the only option⁷.
- 4.2. Dr Amalia Spiliopoulou provided a summary of Mr Smith's time at the Repatriation General Hospital⁸. In particular she details his behaviours and resistance to medication and food. On 3 September 2017 Mr Smith was placed on a Level 1 ITO by Dr Jonathan Brailey⁹. That ITO was confirmed by Dr Christopher Veale on 4 September 2017¹⁰. On 8 September 2017 Mr Smith was placed on a Level 2 ITO¹¹ by Dr Deborah Blood¹².
- 4.3. On 9 September 2017 Mr Smith was moved from Ward 6 to Ward 5 at the Repatriation General Hospital. Ward 5 is for patients with behavioural concerns due to cognitive impairment. He was admitted due to behavioural and psychological symptoms of dementia. At that time Mr Smith was mobile. Nurse Barbara Zwarts commented that by 30 September 2017 Mr Smith was unwell, bed bound and dying¹³.

5. Circumstances of death

- 5.1. Mr Smith continued to deteriorate at the Repatriation General Hospital and he stopped eating and drinking leading to sustained and severe weight loss. Mr Smith became resistant to care and medication.
- 5.2. On 29 September 2017 a meeting was held between medical providers and Mr Smith's family. A decision was reached to provide palliative care. Mr Smith was made comfortable until he died on 2 October 2017 with his family present¹⁴.

⁶ Exhibit C6, Affidavit of Dr Amalia Spiliopoulou dated 3 April 2018

⁷ Supra n.4 at paragraph 18

⁸ Supra n.6

⁹ Exhibit C11a, Inpatient Treatment Order Level 1 Form

¹⁰ Exhibits C11b and C11c, Inpatient Treatment Order Confirmation Form

¹¹ Exhibits C11d and C11e, Inpatient Treatment Order Level 2 Form

¹² Exhibit C7, Affidavit of Dr Deborah Blood dated 4 April 2018

¹³ Exhibit C3, Affidavit of Barbara Zwarts dated 7 January 2018

¹⁴ Exhibit C5, Affidavit of Dr Saxena Rucchi dated 19 April 2018

6. Coronial investigation

- 6.1. Detective Sergeant Carl Whitaker¹⁵ attended the Repatriation General Hospital at 3pm on 2 October 2017 in relation to the death of Mr Smith. Detective Whitaker spoke with Lyndon Smith and observed the body of Mr Smith and made other observations at the Repatriation General Hospital in accordance with standard procedures.
- 6.2. Detective Brevet Sergeant Francisco Nazar investigated the death in custody of Mr Smith and prepared a comprehensive report for the State Coroner¹⁶. Detective Nazar's investigation revealed no issues of concern.
- 6.3. Mr Smith's family were initially shocked by the imposition of an ITO but once it was explained they understood the necessity. Mr Smith's children were consulted about his treatment in his last few weeks and were agreed on its best course. Mr Smith's family were generally happy and thankful for the treatment Mr Smith received at both the Repatriation General Hospital and the Flinders Medical Centre¹⁷.

7. Conclusions and recommendations

- 7.1. I find that Mr Smith's care and treatment at the Flinders Medical Centre and the Repatriation General Hospital was appropriate. I further find that the imposition of the ITO was appropriate.
- 7.2. I have no need to make recommendations in relation to the death of Mr Smith.

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 11th day of June, 2020.

Deputy State Coroner

¹⁵ Exhibit C9, Statement of Carl Whitaker dated 5 October 2017

¹⁶ Exhibit C11, Final report dated 18 April 2018

¹⁷ Supra n.3 at paragraph 22