



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 20th day of May and the 17th day of June 2020, by the Coroner's Court of the said State, constituted of Elizabeth Ann Sheppard, Deputy State Coroner, into the death of John Joseph Tiernan.

The said Court finds that John Joseph Tiernan aged 78 years, late of 9A Lyons Street, Brooklyn Park, South Australia died at the Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 11th day of May 2017 as a result of large left basal ganglia intracerebral haemorrhage with mass effect. The said Court finds that the circumstances of his death were as follows:

1. Introduction, cause of death and reason for inquest

- 1.1. John Joseph Tiernan was born on 6 December 1938 and died on 11 May 2017 at the Flinders Medical Centre. He was 78 years old.
- 1.2. Mr Tiernan's cause of death was determined by stroke registrar, Dr Angela Khou, as large left-basal ganglia, intracerebral haemorrhage with mass effect¹, and I so find. No pathology review or post mortem was conducted as Mr Tiernan's cause of death was clear from his clinical presentation and his death was expected. Mr Tiernan's body was identified by his son David Tiernan².
- 1.3. This is a mandatory inquest pursuant to section 21 of the Coroners Act 2003 as Mr Tiernan had been on an Inpatient Treatment Order (ITO) at the time of his death. A Level 1 ITO was imposed pursuant to section 21 of the Mental Health Act 2009. It was

¹ Exhibit C9

² Exhibit C1

put in place by Dr Alexandra Barrett at 2:55am on 5 May 2017 following Mr Tiernan's admission to the Flinders Medical Centre. The ITO was later reviewed and due to expire on 12 May 2017.

- 1.4. The ITO was made following medical assessment that Mr Tiernan was at risk of harming himself and others and was necessary to enable investigation of his presentation and adequate treatment. He had been acting violently towards himself and staff and was demonstrating signs of delirium. The ITO was reviewed and confirmed by Dr Bonita Lloyd on the same day.
- 1.5. Between 4:50am and 8:30am on 11 May 2017 Mr Tiernan suffered a stroke that left him comatose. The stroke ultimately resulted in his death. Earlier that day at approximately 4:10pm Mr Tiernan's ITO was reviewed by psychiatrist Dr Randall Long who formed the view that given Mr Tiernan's comatose state, the ITO was no longer justified and so he revoked the order.
- 1.6. Although the ITO was not in place at the time Mr Tiernan died, pursuant to section 3 of the Coroners Act 2003 a death in custody is defined 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 Tiernan's death, occurred whilst the ITO was in place and hence this is a mandatory inquest. I find that there are no concerns in relation to the lawfulness of Mr Tiernan's custody.

2. Background and medical history

- 2.1. Mr Tiernan was born in Birmingham in the United Kingdom and had previously worked as a self-employed painter and decorator. He had three children, Jackie, John and David. In 2010 Mr Tiernan and his wife immigrated to Australia to join Jackie and David who had immigrated earlier.
- 2.2. When he arrived in Australia, Mr Tiernan had a history of hypertension, impaired fasting glycaemia, mild chronic obstructive pulmonary disease and cervical spondylosis. He had been an ex-smoker.³ Mr Tiernan began attending the general practice at Oaklands Park. Dr Cruickshank was his treating doctor in 2013 and 2014.

³ Exhibit C5

- 2.3. On 5 September 2014 Mr Tiernan was referred to the Respiratory Clinic at the Flinders Medical Centre following a three month period of feeling unwell with a frequent cough. Over the preceding two weeks Mr Tiernan's coughing had produced blood. A number of investigations were undertaken resulting in a diagnosis of lung cancer. Arrangements were made for Mr Tiernan to commence chemotherapy and radiotherapy at the Flinders Cancer Clinic in November 2014⁴.
- 2.4. On 29 July 2015 Mr Tiernan suffered a cerebrovascular accident with accompanying seizures⁵. Two weeks earlier he attended Flinders Medical Centre with pneumonia followed by pulmonary embolism.⁶

3. Mr Tiernan's detention and decline in health

- 3.1. On 4 May 2017 at about 11pm Mr Tiernan was admitted to the Flinders Medical Centre. He had presented after decreased mobility following a fall a few days earlier. The admitting doctor, Dr Alexandra Barrett, could not find any major injuries or illnesses associated with that fall.
- 3.2. Shortly after admission, Mr Tiernan exhibited increasing agitation and confusion which quickly progressed to acute hyperactive delirium which led to the ITO being made at 2:55am on 5 May 2017.⁷
- 3.3. Dr Long reviewed the ITO at 10:45am on 5 May 2017 and assessed Mr Tiernan's presentation as 'delirium on a background of cognitive decline in the setting of stage 4 lung cancer, a previous cerebrovascular accident affecting the right frontal lobe and obstructive lung disease'.⁸
- 3.4. By 7 May 2017 bloods were taken to exclude infection as a cause of his presentation. A CT of the brain was performed and which excluded any recent changes. Mr Tiernan had a MET⁹ call incident at 3pm due to a high respiration rate of 36 breaths per minute which resolved with repositioning and medication. Physiotherapy and speech pathology support was provided.

⁴ Exhibit C10

⁵ Exhibit C9

⁶ Exhibit C5

⁷ Exhibits C2 and C9

⁸ Exhibit C3

⁹ Medical Emergency Team

- 3.5. On 9 May 2017 an MRI of the brain was conducted which revealed extensive cancer deposits consistent with his stage 4 lung cancer diagnosis. In the opinion of consultant Dr Mangoni, Mr Tiernan's physical and cognitive generation was explained by the cancer rather than by the fall at home.¹⁰ I accept the opinion expressed by Dr Mangoni.
- 3.6. There was little that could be done in terms of active management for Mr Tiernan's brain cancer and so, in consultation with Mr Tiernan's family, hospital staff moved to a palliative care strategy. It was intended that Mr Tiernan remain in hospital for a number of days to see whether his situation would stabilise to enable plans to transfer him to home to spend his remaining time there or in a care facility.
- 3.7. At about 4:50am on 11 May 2017 Mr Tiernan was observed by nursing staff with nothing unusual to report. By 8:30am Mr Tiernan had suffered a stroke which left him comatose. Upon further analysis it was apparent that there had been a 'massive spike in blood pressure' which was thought to explain the major cerebrovascular bleed which was confirmed on CT scan.¹¹
- 3.8. The CT scan showed a large left basal ganglia haemorrhage with midline shift and subfalcine herniation.¹²
- 3.9. Mr Tiernan's care was transferred to the stroke team within the hospital to provide palliative care. Mr Tiernan was visited by his daughter Jackie and son David. During the day his son noticed the colouration of Mr Tiernan's face change and called nursing staff to check on his father. Mr Tiernan continued to deteriorate and died at 4:42pm on 11 May 2017.
- 3.10. No post-mortem or pathology review was required in these circumstances because the cause of Mr Tiernan's death was clearly identified and was expected.

4. Coronial investigation and conclusions

- 4.1. Detective Sergeant Vija Johnson from the Sturt Criminal Investigation Branch was tasked with investigating Mr Tiernan's death in custody. Detective Johnson was of the

¹⁰ Exhibit C4

¹¹ Exhibit C4

¹² Exhibits C9 and C11

opinion that the care and treatment provided to Mr Tiernan at the Flinders Medical Centre was appropriate in the circumstances.

- 4.2. I note that no concerns in relation to care were raised by Mr Tiernan's family.
- 4.3. I find that Mr Tiernan's detention was lawful and did not contribute to his death. I further find that the Flinders Medical Centre provided Mr Tiernan with an appropriate level of care.

5. Recommendations

- 5.1. 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 her hand and

Seal the 17th day of June, 2020.

Deputy State Coroner