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 23rd day of April and the 18th day of June 2020, by the Coroner's Court of the said State, constituted of Ian Lansell White, Deputy State Coroner, into the death of Colin Pryor Tucker.

The said Court finds that Colin Pryor Tucker aged 96 years, late of 28 Kyeema, Cumberland Park, South Australia died at the Repatriation General Hospital, 216 Daws Road, Daw Park, South Australia on the 10th day of July 2017 as a result of general inanition on a background of advanced dementia, chronic congestive cardiac failure and pneumonia. The said Court finds that the circumstances of his death were as follows:

1. <u>Introduction, cause of death and reason for inquest</u>

1.1. Colin Pryor Tucker was born on 13 April 1921 and died on 10 July 2017 at the Repatriation General Hospital. He was 96 years old. A pathology review was performed by Dr Iain McIntyre from Forensic Science South Australia and discussed with Dr Stephen Wills[1], forensic pathologist. Dr McIntyre's report suggested the cause of death as general inanition in a man with advanced dementia, chronic congestive cardiac failure and pneumonia. As the cause of death could be determined from the case notes with some certainty, an autopsy was not recommended.

1.2. This is a mandatory inquest pursuant to section 21 of the Coroners Act 2003 as Mr Tucker had been on a Level 2 Inpatient Treatment Order[2] at the time of his death

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[1] Exhibit C1a
[2] ITO

that had been made pursuant to section 25 of the Mental Health Act 2009. That order had been made on 30 June 2017 and was due to expire on 11 August 2017. There are no issues in relation to the lawfulness of his custody.

2. Background and medical history

2.1. Colin Pryor Tucker was born in Cheltenham and grew up in Woodville. He was married on 5 April 1945 and he had four children, Vivien, Josephine, Ian and Bronwyn. Mr Tucker worked at the Lands Titles Office and then served in the army and air force. Mr Tucker went on to become the Assistant Commissioner of State Taxation and subsequently Commissioner of State Taxation. He was described by his daughter, Vivien, as a very dedicated public servant.

2.2. Mr Tucker was part of a remarkable generation of men and women who served in World War II and then returned to civil life where they continued to make valuable contributions to peace time society[3].

2.3. Mr Tucker had a medical history that includes ischaemic heart disease with by-pass surgery and stenting in 1995, chronic congestive cardiac failure, patent foramen ovale, diabetes type 2, hypertension, falls, left subdural haematoma due to a fall in the bathroom at home which was operated on in April 2015, delirium, cognitive impairment, bilateral total knee replacement in 2001, hernia repair and a probable left renal cell carcinoma. Mr Tucker's general practitioner, Dr Margaret Harrington, summarised his medical history for the inquest[4].

2.4. From 2015 Mr Tucker lived between his own home, nursing care and in hospital. His daughter, Vivien Winn, stated that from 2015 he had regular falls but deteriorated significantly around Christmas 2016. Ms Winn stated that the family were having significant difficulties caring for Mr Tucker. He was increasingly aggressive, delirious and incontinent.

[3] A history of Mr Tucker's achievements and personal life is given by his daughter, Vivien Winn, in her statement, Exhibit C3
[4] Exhibit C6

3. Mr Tucker's decline in health, detention and death

3.1. Mr Tucker's health had been declining with increasing cognitive impairment for several months. Dr McIntyre noted in the pathology review that Mr Tucker was admitted to the Flinders Medical Centre on 14 May 2017 suffering from urinary retention, acute renal failure, delirium and left basal pneumonia. A large prostate gland and a left kidney mass were revealed on imaging. Small vessel ischaemic change was noticed in the brain.

3.2. On 16 May 2017 Mr Tucker developed pneumonia and delirium. He was catheterised, given antibiotics and transferred to the Repatriation General Hospital. Consultant psychiatrist Dr Christopher Veale described Mr Tucker as being combative and agitated with nursing staff.

3.3. On 21 May 2017 a Code Black was called when Mr Tucker became aggressive and tried to leave the ward. He was placed under a Level 1 ITO after midnight on 21 May 2017 by Dr Anna Li. This order was reviewed by Dr Veale on 23 May 2017.

3.4. Dr Veale stated that when he examined Mr Tucker he did not present as aggressive or threatening. He had no memory of the events relating to the Code Black. Dr Veale revoked the ITO as he felt that Mr Tucker had improved and said to avoid the use of antipsychotic medication.

3.5. On 8 and 10 June 2017 Mr Tucker had unwitnessed falls. A subsequent fall on 14 June 2017 resulted in an echocardiogram on 20 June 2017 which showed an ejection fraction of 28%, aortic sclerosis, a diastolic dysfunction grade of 2 to 3, mitral and tricuspid regurgitation and mild pulmonary hypertension. Mr Tucker was noted as being extremely agitated but he settled on or about 20 June 2017. He remained delirious and agitated, requiring sedation.

3.6. On 24 June 2017 Mr Tucker became aggressive with staff and his daughter. Staff restrained and sedated him. Mr Tucker was placed under a Level 1 ITO by Dr Kyaw Soe Moe. This order was reviewed by psychiatrist Dr Deborah Blood at 9:40am on 25 June 2017. As the order was due to expire that day at 2pm, intern Dr Megan Ball reinstated the Level 1 ITO at that time.

3.7. Dr Veale assessed Mr Tucker on 26 June 2017 and confirmed the order. Mr Tucker was grossly confused, delirious and poorly rousable. On 30 June 2017 Mr Tucker remained delirious and very confused. He had been aggressive to nursing staff and had required further medication. Dr Veale placed him on a Level 2 ITO. This order was due to expire on 11 August 2017.

3.8. A family conference on 2 July 2017 resulted in Mr Tucker being made palliative. From 6 July 2017 Mr Tucker had no oral intake. He died on 10 July 2017.

3.9. I turn now to the circumstances of his death. Registered Nurse Shanaz Begum has given a statement relating to Mr Tucker's death[5]. In summary, she checked on Mr Tucker at about 9:15pm on 9 July 2017. His daughter Bronwyn was with him. Ms Begum checked on Mr Tucker every 15-20 minutes. At about 1am she observed Mr Tucker's eldest daughter, Vivien, and her husband were with Mr Tucker. He took several deep breaths and then his breathing stopped.

3.10. Dr Jared Anderson was notified and declared Mr Tucker deceased at 1:27am on 10 July 2017.

4. Coronial investigation and conclusions

4.1. I find the cause of Mr Tucker's death was general inanition in a man with advanced dementia, chronic congestive cardiac failure and pneumonia, as suggested in the pathology review.

4.2. Vivien Winn stated in relation to the Repatriation General Hospital that:

> 'Staff were so amazing, professional, and acted with great kindness towards dad and us at all times. We couldn't fault them. Dad would have been a very difficult patient to manage.' [6]

This statement was confirmed with Ms Vivien Winn who attended at the inquest with her sister Bronwyn Scopacasa.

4.3. Mr Tucker's death was subject to a coronial investigation conducted by Detective Brevet Sergeant Vija Johnson of the Sturt Criminal Investigation Branch. In the report

[5] Exhibit C2
[6] Exhibit C3

tendered to the inquest Detective Johnson concluded that Mr Tucker received appropriate care and treatment at the Repatriation General Hospital and his detention was lawful[7]. His death was not suspicious. I agree with those conclusions.

4.4. 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 18th day of June, 2020.

Deputy State Coroner

Inquest Number 19/2020 (1323/2017)

[7] Exhibit C9a