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 10th day of June and the 23rd day of November 2021, by the Coroner's Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of Raymond Saxon Beahl.

The said Court finds that Raymond Saxon Beahl aged 81 years, late of Oakden Makk House, 200 Fosters Road, Oakden, South Australia died at the Modbury Hospital, Smart Road, Modbury, South Australia on the 12th day of January 2017 as a result of metastatic rectal adenocarcinoma with infected necrotic sacral ulcer. The said Court finds that the circumstances of his death were as follows:

1. Introduction and Reason for Inquest

1.1. Raymond Saxon Beahl was born on 16 November 1935 and died on 12 January 2017 at the Modbury Hospital. He was 81 years old.

1.2. This is a mandatory inquest pursuant to section 21(1)(a) of the Coroners Act 2003 (the Act) as at the time of his death Mr Beahl was subject to a Level 3 Inpatient Treatment Order (ITO) and a Guardianship Order which granted his guardian powers of detention. Each of these orders renders Mr Beahl's death a 'death in custody' as defined in section 3 of the Act.[1]

[1] From 7 June 2021, following the amendment of section 21 of the Coroners Act 2003, Mr Beahl's death could have been certified by a medical practitioner to have been a death due to natural causes, in which case it would not have required a mandatory inquest. (See section 21(1)(b)(v), Coroners Act 2003)

1.3. Mr Beahl was first placed on a Level 1 ITO[2] on 15 September 2016 and was on Level 1 or Level 2[3] ITOs on and off, until a Level 3 ITO[4] was made by the on 29 December 2016.

1.4. The history of ITOs and Guardianship Orders thereafter is detailed in a statement of Melana Virgo, then Registrar of the South Australian Civil and Administrative Tribunal (SACAT). [5]

1.5. Elizabeth Irvin, Mr Beahl's partner in the last two years of his life, applied for a Guardianship Order on 20 September 2016, in case the ITO imposed on 15 September 2016 lapsed. There was an urgent SACAT hearing on 30 September 2016 as the ITO was expiring and Mr Beahl had attempted to abscond. Ms Irvin was appointed as limited guardian relating to accommodation and health care with special powers in relation to residence and detention until 21 October 2016. A further order was made on 19 October 2016, in effect extending the order made on 30 September 2016. On 9 November 2016 SACAT made a further order appointing Ms Irvin as limited guardian in relation to accommodation and healthcare, with special powers in relation to residence, detention, treatment and care. The special powers of detention were due for review on or before 8 May 2017.

1.6. On 12 December 2016 Drs Luiza Gheorghiu and Cheryle Lee submitted to SACAT an application for a Level 3 ITO. Mr Beahl's Level 2 ITO was due to expire on 5 January 2017. At a SACAT hearing on 29 December 2016 a Level 3 ITO was made, to expire on 29 December 2017. This was the ITO in force at the time of Mr Beahl's death.

2. Cause of death

2.1. Dr Matthew Williams, a Palliative Care Registrar at Modbury Hospital reported Mr Beahl's death to the State Coroner, giving an opinion as to the cause of death as 'metastatic rectal adenocarcinoma with infected necrotic sacral ulcer'. This I find to have been the cause of death.

[2] A Level 1 ITO may be made by a medical practitioner or authorised mental health professional
[3] A Level 2 ITO may be made by a psychiatrist or authorised medical practitioner
[4] Level 3 ITO may be made by the South Australian Civil and Administrative Tribunal
[5] Exhibit C10

3. Investigation

3.1. Following Mr Beahl's death, Detective Brevet Sergeant Melissa Maskall of SA Police was assigned to investigate the circumstances of his death on behalf of the State Coroner. Her comprehensive report[6] and the accompanying brief of evidence, in particular as to Mr Beahl's time in the Oakden Older Persons Mental Health Service (Oakden) has been the principal source of evidence and information for this inquest, which has proceeded by affidavit only.

4. Background and medical history

4.1. Mr Beahl was born in Broken Hill, New South Wales and was known as Ray. He left school in his teenage years and commenced work with the Broken Hill North mining company. He taught first aid, was the site safety officer and conducted tours of the site. He worked at the mine for about 35 years and left in his fifties, then undertaking security work until he retired in 1986.

4.2. With his first wife Mr Beahl had two children, Tim Beahl and Karen Martin. He had four grandchildren.

4.3. Elizabeth Irvin was Mr Beahl's partner for the two years and nine months before his death. They met whilst dancing at the Jack Young Centre for Seniors. Ms Irvin, in her affidavit, is critical of the care that Mr Beahl received, particularly at Older Persons Mental Health Services Oakden.[7]

4.4. Mr Beahl had a medical history that included type 2 diabetes mellitus, obstructive sleep apnoea, hypertension, transurethral resection of the prostate, ischemic heart disease, vascular dementia, acute pain, heavy alcohol use and rectal adenocarcinoma.

4.5. In 2008 a rectal polyp was investigated at the Queen Elizabeth Hospital and then was for six-monthly review.

4.6. Mr Beahl was diagnosed with dementia in 2013.

4.7. A colonoscopy in 2013 showed no evidence of recurrent malignant polyps. Mr Beahl then had no further symptoms until he presented to the Lyell McEwin Hospital in April

[6] Exhibit C15
[7] Exhibit C3

2016. He then had several presentations to hospital with rectal pain, tenesmus and bleeding.

4.8. Mr Beahl was diagnosed with rectal cancer in August 2016 and was admitted to the Lyell McEwin Hospital for consideration of surgery on 14 September 2016. It was decided not to proceed with surgery, due to dementia and the difficulties that would be associated with having a colostomy. It was also expected that the surgery would not completely remove the cancer, as it was so low in his bowel.

4.9. By the time of this admission, Mr Beahl's behaviour had changed significantly and there were concerns about his alcohol intake prior to admission. He was distressed and was attempting to leave the ward. The first Level 1 ITO was imposed by a medical practitioner at the hospital on 15 September 2016. Mr Beahl mostly received one-to-one special nursing (specialling) during this admission and there were repeated code blacks called due to aggressive behaviour. Restraints were used. Shackling and sedation were also used to manage his aggression.

4.10. Repeated attempts to discharge Mr Beahl into nursing care were unsuccessful. On 4 October 2016 Mr Beahl was discharged from the Lyell McEwin Hospital to the Estia Burton Nursing Home where, from arrival, he was agitated and aggressive. He threatened staff with a bowling pin and police were called. He was taken to hospital, then returned to Estia Burton the same day. On 7 October 2016 Mr Beahl climbed a fence and was later found by a gardener. Mr Beahl was considered a threat to himself and staff at the facility and was struggling to cope. He was transferred to the Lyell McEwin Hospital for review and was again placed under a Level 1 ITO. This was later revoked on 11 October 2016 as Mr Beahl was already under the Guardianship Order with special powers of detention under section 32 of the Guardianship and Administration Act 1993.

4.11. On 24 October 2016 Mr Beahl was discharged to the Salisbury Private Nursing Home and then readmitted to hospital the following day.

4.12. It is clear from the notes that hospital staff struggled to cope with Mr Beahl’s behaviour. He was repeatedly restrained and sedated. He was increasingly incoherent, intermittently drowsy and agitated.

4.13. Following these failed attempts to discharge Mr Beahl to a nursing home, he was admitted to the psychiatry ward for older persons at the Lyell McEwin Hospital on 17 November 2016, where he was noted to be 'highly agitated, extremely resistive, drowsy, delirious and aggressive'.

5. Mr Beahl's admission to Oakden

5.1. On 19 December 2016, Mr Beahl was transferred to the Oakden Older Persons Mental Health Service (Oakden), where he remained until 6 January 2017. He was transferred due to his high degree of agitation, disrobing, throwing objects and absconding. It was considered that he could not be managed within the hospital setting. He was on a Level 2 ITO, and the Guardianship Order with special powers of detention was also in force.

5.2. Mr Beahl was admitted with a medical history of vascular dementia and he quite clearly had significant behavioural and psychological symptoms. Dr Rebecca Wheatley, a Senior Medical Practitioner with the Northern Adelaide Local Health Network (NALHN), working at Oakden, described him as 'extremely aphasic with difficulty expressing himself and understanding words'.[8] He was described as 'highly agitated' throughout his time at Oakden.

5.3. Mr Beahl's rectal cancer had spread to his liver and lungs. On admission to Oakden, he was under pain relief medication for the cancer, and was also medicated for his dementia and significant behavioural disturbance.[9]

5.4. Upon arrival at Oakden, Mr Beahl also had bilateral heel pressure sores and a sacral pressure ulcer, for which he was taking antibiotics. Jeanette Tiltman[10], one of the nurses with responsibility for Mr Beahl's care at Oakden, refers to him being agitated, aggressive, taking off dressings and restless. She states that he would wander and intrude on others and was a high falls risk.

5.5. On 19 December 2016, Elizabeth Irvin signed a restraint authorisation, to allow the use of pelvic restraint in chairs, but restraint of Mr Beahl in a princess chair was found to be unsuitable, so the authorisation was amended to allow restraint only in a basic chair.

[8] Exhibit C5
[9] Exhibit C5, pages 4-5
[10] Exhibit C9

It quickly became evident that Mr Beale could also extract himself from this type of restraint.

5.6. On 25 December 2016 Mr Beahl had a fall, witnessed by a cleaner, onto his left arm and shoulder, without hitting his head. He was assessed that day by a locum doctor and his blood pressure was low. The following day he got up from his chair and fell, landing on his bottom with no obvious injury.

5.7. On 30 December 2016, Mr Beahl had another fall, unwitnessed. It was documented in the notes that he was unsettled and attempted to climb out of his chair whilst wearing a pelvic restraint, falling and landing on the floor behind his chair with his legs entangled in that restraint. He was found to have a bruise to the forehead, after which there were attempts to have him wear a helmet, which he would take off almost immediately.

5.8. Ms Tiltman refers in her interview to difficulties with caring for Mr Beahl, on about 2 January 2017.[11] By that date his sacral ulcer was noted to have reached stage 3. It had extended through the layers of skin to the muscle. Mr Beahl was still agitated. He was restrained throughout the day on 2 January 2017. He was sedated and wearing incontinence aids over his dressings. It is noted that Mr Beahl was stripping off his clothes and had his dressings changed. He was not getting enough hydration and nutrition and was wriggling around in his chair. He was also having soft bowel movements which increased the risk of infection in the sacral ulcer. On that day he was given his maximum dosage of painkillers.

5.9. Dr Wheatley[12], in describing some of the difficulties in caring for Mr Beahl, states that he was highly agitated and constantly attempting to get out of any chair he was put in. When placed in a pelvic restraint Mr Beahl would push himself up and climb out of this restraint to stand on the chair.

5.10. Merrilyn Penery, a Registered Nurse who was the Clinical Practice Consultant at Oakden[13], refers to the increasing use of a canvas pelvic restraint for Mr Beahl during his time there. An example is on 24 December 2016, when the records indicate restraint of plainly extreme duration, from 7am until midnight. This was subject to the restraints being removed hourly for five to ten minutes for him to go to the toilet.

[11] Exhibit C9, pages 22 and 47
[12] Exhibit C5
[13] Exhibit C8

5.11. Ms Penery states that she believes Mr Beahl's sacral ulcer could have been better managed. She states that the Oakden wound nurse was on leave at the time and Mr Beahl was never referred to someone who could appropriately review and assist with his wound management.

5.12. She notes that a pressure mattress was not placed on Mr Beahl's bed, but could not give a reason for that. She says that he should have had a pressure mattress and a nurse should have been specifically allocated to him. Ms Penery expressed the view that they could have done better in looking after Mr Beahl.

5.13. One-to-one special nursing care was not available at Oakden. This is an issue dealt with by the then Independent Commissioner Against Corruption, the Honourable Bruce Lander QC in his report dated 28 February 2018, 'Oakden: A Shameful Chapter in South Australia's History'[14].

5.14. Throughout Mr Beahl's time at Oakden, his sacral ulcer was a significant issue. Dr Wheatley described the challenge of trying to keep a dressing over the sacral wound, whilst Mr Beahl was so agitated. There were also significant issues with the dressings on the wounds on his heels, which Mr Beahl kept taking off.

5.15. Dr Wheatley makes some criticisms of nursing staff relating to Mr Beahl's management at Oakden. She refers to an incident on 4 January 2017 when she located a loose white piece of paper with '38.4' recorded on it. She was then told by Registered Nurse Andrew Burnside that it was Mr Beahl's temperature and the temperature was due to Mr Beahl's pain.[15] Dr Wheatley was concerned about this, as observations should have been noted on the patient's file instead of on a loose piece of paper, especially when they were significant, such as a high temperature.

5.16. Ms Penery was unaware of an explanation but agrees that Mr Beahl's rapid detection and response chart was not completed for that day and that that was a clear breach in policy and procedure. She also expressed concern that a nurse thought that a high temperature could be attributed to pain.

5.17. In his affidavit Mr Burnside[16] stated that he does not recall noting the temperature on a loose piece of paper but agreed that he said Mr Beahl's high temperature was due to

[14] Oakden: A Shameful Chapter in South Australia's History (icac.sa.gov.au)
[15] Exhibit C7
[16] Exhibit C7

pain. He expressed embarrassment about saying this, as he now knows that pain cannot cause an increase in a patient's temperature.

5.18. Dr Wheatley was concerned that the temperature was due to infection and initially considered potential sites for infection to be his chest, urine or his heel ulcers. She did not initially believe it was from the sacral ulcer, as she was shown documentation by Ms Tiltman stating that the wound was dressed, fine, healing well and not infected. To treat this febrile illness, which at the time was of unknown aetiology, she prescribed oral antibiotics, Augmentin Duo Forte.

5.19. On 6 January 2017 Dr Wheatley reviewed Mr Beahl and found that there was ‘an unresolving, unspecified infection with increased sedation due to pain relief medication’. Dr Wheatley then telephoned Dr David Holden, a palliative care consultant at the Modbury Hospital and advised him that Mr Beahl needed to be cared for in a hospice.

5.20. Dr Holden and Dr Wheatley reviewed Mr Beahl together, that day.[17] Mr Beahl was highly agitated, and Dr Holden describes Mr Beahl continually moving and trying to stand despite wearing a pelvic restraint. He was appearing to try to squat and there was no comprehensible verbalisation.

5.21. During the review, Dr Wheatley concluded that Mr Beahl's sacral ulcer was at stage 4. It was very deep with an ulcerated area around the sacrum and the skin of the central area was broken down with surrounding erythema and excoriation.

5.22. Dr Wheatley states that it had not been reported to her that the wound was as bad as it was. Upon this review it became very clear to Dr Wheatley that the temperature on 4 January 2017 was likely due to an infection, as a result of the sacral wound.

5.23. It was decided to transfer Mr Beahl to the Modbury Hospital Palliative Care Unit that day. Regard was given to Mr Beahl's advance care directive, which stated:

> 'If I am unable to recognise family and friends and can't communicate, I do not want health care to prolong my life. If I am dying, I want to be in comfortable environment. If I have a terminal illness, I do not want life sustaining treatment. Please just keep me comfortable and pain-free until I die.'

[17] Exhibit C6

5.24. Dr Holden[18] states that Mr Beahl's symptoms of pain and his pressure area required specialised palliative care input and he could no longer be managed in a non-specialised setting such as Oakden. Dr Holden considered that Mr Beahl had reached a terminal phase of a terminal illness and was dying. He expressed the view that the sacral ulcer:

> '… could have progressed in the setting of decreased nutrition, decreased healing and a decreased immune status.'

He said about care of the wound:

> 'I think the wound care itself would have been difficult in Mr Beahl and trying to keep the dressing in place and pressure off of the sacrum in someone with the behavioural and psychological symptoms of dementia, may have been problematic.' [19]

6. Mr Beahl's admission to Modbury Hospital

6.1. Mr Beahl was transferred to the Modbury Hospital on 6 January 2017 following the review by Dr Wheatley and Dr Holden. He was admitted by Dr Patrick O'Neill who noted the large necrotic sacral pressure ulcer with surrounding erythema and excoriation. The management plan was for Mr Beahl to be started on a continuous subcutaneous effusion of hydromorphone and midazolam. The focus was on palliating Mr Beahl to make him comfortable in what appeared to be the end stage of his life.

6.2. Dr Teena Silakong reviewed Mr Beahl on 9 January 2017.[20] During the previous weekend Mr Beahl had required significant pain medication and sedation due to his restlessness, agitation and apparent significant pain. From 10 January 2017 Mr Beahl was unconscious.

6.3. Registered Nurse Joe Fiedler observed shallow breathing at 7:55am on Thursday, 12 January 2017[21]. At about 8:55am he entered Mr Beahl's room and observed that he was no longer breathing and did not have a pulse. Mr Beahl's death was certified by Dr Georgia Peters at 9:45am.

7. Clinical overview of treatment at Oakden

7.1. At the request of the Coroners Court, Associate Professor Craig Whitehead, Regional Clinical Director for Rehabilitation, Aged and Palliative Care in the Southern Adelaide

[18] Exhibit C6
[19] Exhibit C6, pages 7-8
[20] Exhibit C4
[21] Exhibit C2

Local Health Network and a specialist geriatrician of 25 years standing, undertook a review of the available documents and provided a report.[22]

7.2. Professor Whitehead's opinion of the management of the sacral wound is that there was no real coherent management plan and no clear pressure-relieving plan. Professor Whitehead's opinion is that the cause of death was multifactorial; Mr Beahl had metastatic malignancy which was terminal. He had comorbid dementia and significant complication with the pressure area. Professor Whitehead refers to the very high doses of medications which would have probably contributed to a loss of appetite and oral intake, which in turn would have contributed to Mr Beahl's general deterioration.

7.3. Professor Whitehead considers that Mr Beahl's death would have to be classed as possibly preventable.[23] The reason for this is that although he was in the last phase of his life, he suffered because of the poor quality of his care. Professor Whitehead points to the very high doses of medication and the development of delirium, which would have contributed to the loss of oral intake and worsening of his pressure injuries. He refers to the fact that although the medications that Mr Beahl was prescribed were all within common clinical practice, he was on maximal doses.

7.4. Professor Whitehead states that the use of restraint in managing behavioural disturbances is not recommended, and has not been recommended for the prevention of falls for more than a decade.[24] In the report he expresses disappointment that nursing staff repeatedly initiated the use of the pelvic restraint to prevent falls. He states there is no evidence that these restraints prevent falls, and notes that Mr Beahl fell several times despite being restrained. Professor Whitehead goes on to state that almost all health and aged care has moved to a restraint-free environment, and that this was the general view in 2016. He notes that the use of restraints was not only at Oakden but was throughout Mr Beahl's hospital admissions and during his final two months commencing at the Lyell McEwin Hospital. He referred to multiple soft shackle applications after code blacks at the Lyell McEwin Hospital, which he considered understandable from the staff safety point of view and employed in accordance with restraint management policies. He observes though, that this does tend to worsen

[22] Exhibit C11
[23] Exhibit C11, page 4
[24] Exhibit C11, page 5

behaviour and exacerbate problems. He regards the later use of pelvic restraints as completely inappropriate.

7.5. Despite the poor quality of care, Professor Whitehead could not determine whether it accelerated Mr Beahl's death. Professor Whitehead states:

> 'There were so many concerns I had with his care it is difficult to know how much better off Mr Beahl would have been in an appropriate environment. Mr Beahl's behaviour could have been managed in a more appropriate environment. Unfortunately Mr Beahl never really had the opportunity to receive appropriate specialised care for his behaviour and palliative care needs.' [25]

Although Professor Whitehead is critical of the quality of care, he notes that even patients who receive optimal medical care can deteriorate and die with metastatic malignancy.

7.6. Professor Whitehead provided context to some of the difficulties that would have been faced by the professional clinicians looking after Mr Beahl, who was undoubtedly a very difficult patient to manage. Professor Whitehead states that Mr Beahl would have been in the tier 7 category of behaviour; tier 7 behaviours refer to severe physical aggression and violence that occur in less than 1% of all patients with dementia.[26]

7.7. Professor Whitehead notes that for patients like Mr Beahl, the appropriate care environment is very difficult to find in South Australia. He states that there are very few services that bring together medical nursing staff with a good medical knowledge and nursing knowledge, skills and behaviour management and skills in palliative care with oversight by a geriatrician and old age psychiatrist. Professor Whitehead states that such a facility does exist, referring to the Specialised Advanced Dementia Unit at the Repatriation General Hospital (The Repat Precinct) and formerly at Myles Ward at Noarlunga Hospital. Professor Whitehead states:

> 'Unfortunately Mr Beahl was really not able to access an adequate standard of care for his problem in any of the sites that he was being cared for.' [27]

One option available was palliative care, and Professor Whitehead explained that hospice units are not really appropriate for someone like Mr Beahl, with his significant behavioural disturbances. However, Mr Beahl could not be appropriately cared for in

[25] Exhibit C11, page 9
[26] Exhibit C11, page 4
[27] Exhibit C11, page 6

an aged care facility. He required one-to-one specialling and palliative care was not possible within that setting.

7.8. In his report Professor Whitehead queries whether there was a delay in identifying the colonic malignancy. A Coroners Court sessional medical adviser reviewed the file and advised that there was adequate assessment of the rectal polyps and that, although there was some delay with the final colonoscopy, Mr Beahl was not a good candidate for surgery and the delay would not have altered that outcome. I have decided to accept that opinion without seeking further formal clinical review.

8. The Oakden Review and the Oakden Report

8.1. On 20 December 2016, the Chief Executive Officer of the Northern Adelaide Local Health Network, Ms Jackie Hanson, contacted the Chief Psychiatrist raising concerns about the level of clinical care provided at the Oakden Older Persons Mental Health Service. Those concerns did not specifically relate to the care of Mr Beahl. Ms Hanson requested the Chief Psychiatrist undertake an external independent review of the Oakden facility as a matter of urgency with the intention of providing a report in April 2017. A review was undertaken by the then Chief Psychiatrist, Dr Aaron Groves, assisted by Professor Nicholas Procter, Dr Duncan McKellar and Ms Del Thomson. Aspects examined in the Oakden Review, under its terms of reference, included Model of Care, Staffing Model, Quality and Safety of Care, Culture and Restrictive Practices. The report of the Oakden Review, known as the Oakden Report[28], was delivered on 10 April 2017 and contained findings and recommendations under each of those headings.

9. The Oakden Report response[29]

9.1. The South Australian Government through SA Health established the Oakden Report Response Plan Oversight Committee to oversee and lead implementation of the six recommendations in the Oakden Report. The Oakden Report Response reported in June 2017 as to the work of six expert working groups established under the Oversight Committee. A review date of December 2017 was fixed for each group.

[28] Oakden Report Final (sahealth.sa.gov.au)
[29] Oakden Response Report (sahealth.sa.gov.au)

9.2. One objective was to transition residents and close all facilities at Oakden.

9.3. The Oakden facility was closed on 22 September 2017

10. ICAC Report - 'Oakden: A Shameful Chapter in South Australia's History'

10.1. On 28 February 2018, the then Independent Commissioner Against Corruption, the Honourable Bruce Lander QC released a report entitled 'Oakden: A Shameful Chapter in South Australia's History'[30].

10.2. The report followed an investigation carried out into potential serious or systemic maladministration in public administration, associated with the Oakden facility. The ICAC report, together with the Oakden Review provides detailed and relevant context to this examination of Mr Beahl's care at Oakden.

10.3. To summarise the context to which I refer, I simply recite the opening paragraphs of the Commissioner's Introduction to the Executive Summary[31],

> 'The consumers who resided at the Oakden Older Persons Mental Health Service (Oakden Facility) were some of the most frail and vulnerable persons in our community. They did not have a voice. They were obliged to live in a facility which could only be described as a disgrace, and in which they received very poor care. The process and procedures were such that they were forgotten and ignored. The State did not provide them with the level of care that they deserved.
>
> Every South Australian should be outraged at the way in which these consumers were treated.
>
> It represents a shameful chapter in this State's history.
>
> It should not have happened. It must never happen again.'

10.4. Oakden and the reports to which I have referred, as well as the whole of government and SA Health responses, have been the subject of considerable public scrutiny and debate.

11. Since Oakden - current facilities and oversight

11.1. I have received a helpful affidavit[32] from Dr Duncan McKellar, Clinical Adviser for Older Persons Mental Health in the Office of the Chief Psychiatrist,[33] detailing facilities

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[30] Oakden: A Shameful Chapter in South Australia's History (icac.sa.gov.au)
[31] Ibid, at page 14
[32] Exhibit C25
[33] and one of the authors of the Oakden Report

which might have been available at the time and which would be available to a patient such as Mr Beahl today.

11.2. Dr McKellar states that at the time of Mr Beahl's hospitalisation, Oakden was the only designated long stay service in South Australia for someone with Mr Beahl's behavioural and psychological symptoms of dementia (BPSD).

11.3. There were specialist dementia services within the Older Persons Mental Health Service that were located at various hospitals such as Ward Southeast at the Queen Elizabeth Hospital, Ward 1H at the Lyell McEwin Hospital and Ward 18V at the Flinders Medical Centre (previously Ward 18 in the Repatriation Health Precinct). These services continue to exist within these hospitals. However, these were and continue to be short stay services, usually to accommodate patients who have dementia with severe BPSD or another acute mental health issue.

11.4. Dr McKellar details the facilities that are currently available for somebody in Mr Beahl's position and the changes to the quality of care and the number of beds. He states that these facilities are vastly different to those available in 2016. In 2021, a patient in Mr Beale's position would be accommodated in either Northgate House (hosted by NALHN) or the Repat Neuro-Behavioural Unit (RNBU) at the Repatriation General Hospital (hosted by SALHN). These facilities are open to anyone within South Australia.

11.5. Dr McKellar details differences between the level and quality of care now provided at those facilities, when compared with the Oakden facility[34]. There are geriatricians embedded within both facilities to ensure patients are given appropriate geriatric care, as well as significant old-age psychiatry input. Both facilities have significantly more robust nursing profiles in that each patient receives 13 hours of individual nursing care per day, compared to the three or four hours each patient received at Oakden. There are embedded physiotherapists, occupational therapists and other allied health professionals in both facilities, with an emphasis on ensuring that residents remain active, are not restricted and are able to engage in meaningful activities that provide quality of life.

[34] Exhibit C25, page 4

11.6. Electronic systems for the keeping of medical notes are employed within Northgate House and the RNBU.

11.7. At the time of signing of Dr McKellar's affidavit there were 28 places available between the RNBU and Northgate House with the facilities expected to expand to accommodate 34 places. The Oakden Report recommended that 24 places at this level of care was an appropriate number for the level of demand for these services.

11.8. For patients with Tier 5 and Tier 6 BPSD, specialist dementia care units delivered in partnership with residential aged care providers are in the early stages of development, with beds funded or to be funded by the Commonwealth and State Governments, providing care into which a patient whose BPSD improved from Tier 7 to Tier 5 or 6 could be moved.

11.9. Since 2017, mechanical restraints are no longer in use in the Older Persons Mental Health Service, including Northgate House and the RNBU.

11.10. Acknowledging the need for restraint in certain circumstances, the Chief Psychiatrist Restraint and Seclusion Standard[35] was released on 1 February 2021, with compliance expected by 1 July 2021. The Standard is entitled, 'A Standard to Reduce and Eliminate where possible the Use of Restraint and Seclusion applied under the *Mental Health Act* 2009' and aims to significantly reduce the need for and use of restraints and ensure there is appropriate oversight of decisions to use them when considered necessary. One aspect of the standard is to confine the use of physical and mechanical restraint to emergency situations where an individual's behaviour presents an imminent or immediate risk of physical harm to self or others.

12. Discussion and conclusions

12.1. Mr Beahl was suffering from end stage rectal cancer which was causing significant pain. He also suffered painful ulcers on his heels and sacrum, exacerbated due to sedation and restraint, leaving him susceptible to infection. This was complicated by his dementia and its associated severe behavioural and psychological symptoms which

[35] Restraint-and-Seclusion-Standard-28-May21

were identified as being Tier 7 BPSD (meaning dementia with the highest and most extreme behavioural and psychological symptoms).

12.2. Mr Beahl was in the final stage of his life. As his illness progressed his behaviour worsened and so did his medical condition. He was a very difficult patient to manage, with complex needs. There were significant shortcomings in his management and treatment. The evidence received in this inquest has not established that his death was preventable. However, his life may have been shortened by as a result of the shortcomings in his treatment, particularly to the extent that his sacral ulcer was exacerbated by restraint and was not satisfactorily treated. As a result, Mr Beahl at least endured great discomfort which he ought to have been spared.

12.3. In his final months, Mr Beahl required intensive, if not one-to-one nursing, neither of which was available at Oakden and which he did not receive until he was moved to a palliative setting.

12.4. Oakden was a specialist mental health facility for older persons. Criticisms made in this inquest of the facility and of Mr Beahl's treatment there have been well-founded. The failings of that service were extensively investigated in the Oakden Review and the ICAC investigation and publicly reported, along with the whole of Government and SA Health responses. The Oakden facility is no longer operational, with good reason.

12.5. Section 25(2) of the Coroners Act 2003 provides:

> (2) The Court may add to its findings any recommendation that, in the opinion of the Court—
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> (a) might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest; or
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> (b) relates to a matter arising from the inquest, including (but not limited to) matters concerning—
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> (i) the quality of care, treatment and supervision of the dead person prior to death; and
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> (ii) public health or safety; and
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> (iii) the administration of justice,
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> and is, in the circumstances, an appropriate matter on which to make a recommendation.

12.6. This inquest has been heard at a time when, as a result of the failings exposed at Oakden, action has been taken to comprehensively identify and address those failings, with the establishment of new facilities and the creation of new systems and procedures intended to ensure the provision of proper care for older patients suffering with poor mental health.

12.7. Having regard to the actions which have been taken, I make no recommendations.

Key Words: Death in Custody; Natural Causes; Inpatient Treatment Order; Section 32 Powers

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 23rd day of November, 2021.

State Coroner

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Full text links

ICAC Report
https://www.icac.sa.gov.au/__data/assets/pdf_file/0008/370727/ICAC_Report_Oakden.pdf

Oakden Report Final
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