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 December 2020, the 23rd day of April 2021 and the 29th day of March 2022, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Allen William Harold Davies.

The said Court finds that Allen William Harold Davies aged 85 years, late of 10 Palm Court, Blakeview, South Australia died at Royal Adelaide Hospital, Port Road, Adelaide, South Australia on the 26th day of June 2019 as a result of aspiration pneumonia due to dysphagia in a man with multiple spinal fractures and dementia. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for inquest

1.1. Allen William Harold Davies was 85 years of age when he died on 26 June 2019 at the Royal Adelaide Hospital (RAH). At the time of his death Mr Davies was subject to a Level 1 Inpatient Treatment Order (ITO) that had been imposed under the Mental Health Act 2009. The ITO had commenced on 20 June 2019.[1] An ITO involves the detention of the patient in an approved treatment centre. Mr Davies was detained in such a centre. His death was therefore a death in custody in respect of which an inquest was mandatory. These are the findings of that inquest.

1.2. A post-mortem examination of Mr Davies' remains was not necessary. A pathology review dated 8 August 2019 was performed by Dr Iain McIntyre of Forensic Science South Australia (FSSA). The review was conducted on the basis of the clinical course

[1] Exhibit C11a

prior to death as revealed in the case records from the RAH and the Lyell McEwin Hospital (LMH). In his report Dr McIntyre has succinctly and accurately summarised Mr Davies' clinical course as follows:

> 'On 12/06/2019 he was taken to the LMH following an unconscious collapse after dinner. He also had another fall whilst in the LMH on 14/06/2019. A CT scan on 14/06/2019 showed an undisplaced, comminuted fracture of the right occipital condyle.with no acute intracranial haemorrhage. There was also a hyperextension injury at C6/C7 causing widening of the disc space. There were also bilateral C6 laminar fractures extending into the foramina transversaria; a C6 spinous process fracture and a likely epidural haematoma. A C5 spinous process tip fracture was also evident. He was then transferred to the RAH for neurosurgical care. On admission he was found not only to have unstable cervical spine fractures but subsequently developed oropharyngeal dysphagia and consequent aspiration pneumonia with delirium. His agitation required his being placed under an inpatient treatment order. A geriatrician advised that the patient's condition was strongly suggestive of an underlying neurodegenerative dementing disorder which was likely to be the cause of his dysphagia. Following a discussion with his family, care was withdrawn and he died peacefully.' [2]

1.3. In his report Dr McIntyre describes the cause of Mr Davies' death as '*aspiration pneumonia due to dysphagia in a man with multiple spinal fractures and dementia*'. I accept that opinion and find that to be the cause of Mr Davies' death.

1.4. I make it plain that there is no stigma to be attached to the fact that Mr Davies was subject to an ITO at the time of his death. I find that it had been lawfully and appropriately imposed with Mr Davies' care and protection as its sole purpose.

2. <u>Background</u>

2.1. Mr Davies was born in Port Pirie. He moved to Adelaide in 1959. He married in 1961. He and his wife had two sons.

2.2. Mr Davies worked for Clarksons on a full-time basis for the entirety of his working life. He initially worked in the glass department before becoming a representative in respect of automotive paint. He also worked part-time in the evenings at a bar in Tonsley. Mr Davies retired at the age of 65 to enjoy spending time with his two sons, seven grandchildren and seven great-grandchildren.

[2] Exhibit C2a

3. Mr Davies' medical history

3.1. The most significant aspect of Mr Davies' medical history was a fall in December 2018 at the Munno Para Shopping Centre in which he sustained a skull fracture and a traumatic brain injury. Following this injury Mr Davies required a frame to help him mobilise. According to his wife, from this point forward his health generally began to deteriorate.[3]

4. Mr Davies' decline in health

4.1. On 25 March 2019 Mr Davies' driver's licence was cancelled by his general practitioner as he was deemed no longer fit to drive. Mr Davies suffered numerous falls in the year preceding his death which his general practitioner noted was due to the deconditioning of his body, deteriorating eyesight and his blood pressure dropping when he stood up.

4.2. Mr Davies was referred by his general practitioner to the falls assessment clinic which was part of the Northern Community Geriatric Service. Interactions with these services commenced on 20 June 2018 at which time he was identified as being at moderate risk of falls.

4.3. On 25 May 2019 Mr Davies was last seen by his general practitioner for numerous skin cancers on his scalp. His general practitioner referred him to a specialist for review and removal.

4.4. On 12 June 2019 Mr Davies attended with his son and his granddaughter at the Willaston Hotel where they had dinner and played the poker machines. Mr Davies became unsteady in his chair and collapsed. Mr Davies was taken to the LMH via the South Australian Ambulance Service.

4.5. On 14 June 2019 while an inpatient on the Ward 1B at the LMH, Mr Davies had a fall on the ward. Prior to the fall, he had been observed by registered nurse Alexandra Kontos to be '*alert and orientated and holding conversations with nursing staff. He was mobilising independently*'.[4] Ms Kontos understood that Mr Davies had presented following a collapse when out for dinner with members of his family which had caused a period of unconsciousness. Following the fall, Mr Davies was found lying face-down

[3] Exhibit C7
[4] Exhibit C6, affidavit of Ms Kontos

on the floor in his room unconscious. His fall was heard at the nurses' station and nurses including Ms Kontos, immediately attended at his room. Mr Davies regained consciousness but he did sustain a significant laceration to the right side of his head which required sutures. He later reported to his wife that he had been trying to get to the toilet.

4.6. At the time of this admission LMH staff were aware that Mr Davies had engaged with the falls clinic. His falls clinic assessment from 20 June 2018 is contained within the LMH casenotes.[5]

4.7. Mr Davies' son Darren provided an affidavit to the Court. He states that during this admission he informed the staff at the LMH that his father had a history of wandering and falling and that they should have the side up on his bed.[6]

4.8. A CT scan following this fall showed that Mr Davies had a non-displaced comminuted fracture of the right occipital condyle with no acute intercranial haemorrhage. As well, he had vertebral injuries and fractures. He was transferred to the RAH for further care.

4.9. At the RAH Mr Davies was diagnosed with unstable cervical spinal fractures at C6 and C7 with an epidural haematoma. His injuries required a neck brace. He was confused but conscious when he was admitted to the ward.

4.10. The affidavit of the nurse unit manager at the RAH was tendered to the Court.[7] For the majority of the time that Mr Davies was at the RAH he required one-on-one nursing care.

4.11. On 16 June 2019 Mr Davies was diagnosed with multifactorial delirium.

4.12. On 17 June 2019 speech pathology diagnosed Mr Davies with severe pharyngeal dysphagia. This meant that he could no longer swallow and therefore could no longer take food orally. A CT scan was performed on that same day which showed a small bleed on Mr Davies' brain. It was not confirmed whether this bleed was due to his previous fall.

[5] Exhibit C15
[6] Exhibits C1a and C1b
[7] Exhibit C4

4.13. Throughout Mr Davies' admission to the RAH there were code blacks which involved security attending to assist nursing staff to restrain Mr Davies and to minimise the risk of harm to himself and others. On 20 June 2019 a level 1 ITO was initiated by Dr Kirsten Marchand[8] due to Mr Davies' agitation, confusion and combative behaviour. Multiple nursing and security staff had been required to physically restrain Mr Davies' physical behaviours and to prevent him from removing his C-spine collar and from attempting to climb out of bed. Unfortunately, Mr Davies was not responsive to verbal intervention. There was considered to be a risk of further injury to himself. Given the lack of response and the continued risk to himself and others, Dr Marchand considered that there was no less restrictive means of managing Mr Davies other than by way of the imposition of the ITO. The ITO was subsequently confirmed by a psychiatrist, Dr Lawlor. In my view, the imposition of the ITO and its confirmation were appropriate. A level 1 ITO remains in place for seven days unless revoked. It was not revoked in Mr Davies' case.

4.14. Mr Davies was administered with 1 mg of haloperidol via intramuscular injection. A geriatrician advised that Mr Davies' condition was strongly suggestive of an underlying neurodegenerative dementing disorder which was likely to be the cause of his dysphagia (difficulty in swallowing).

4.15. On 21 June 2019 in consultation with his family, the focus of Mr Davies' care was directed to comfort care, which included input from the palliative care team from 25 June 2019.

4.16. Registered Nurse Jesse Ekberg provided an affidavit to the Court[9]. Ms Ekberg was assigned to the care of Mr Davies as part of a one-on-one care plan. She commenced her shift at 9pm on 25 June 2019. Ms Ekberg received a briefing on the care of Mr Davies from the nurse on the previous shift. This included advice that Mr Davies had been reviewed by the palliative care team and that following a family meeting, the focus was on end-of-life care for Mr Davies.

4.17. Ms Ekberg was aware that a level 1 ITO was in place and of the palliative care team notation that despite the end-of-life care focus, the order could run its course.

[8] Exhibit C5
[9] Exhibit C3

4.18. Ms Ekberg provided comfort care and medications and observed Mr Davies throughout her shift. At 5:30am on 26 June 2019 Mr Davies' breathing was noted to be slowed. At approximately 6:30am Mr Davies' breathing was observed to deteriorate further. Ms Ekberg remained with Mr Davies until he ceased respirations and died at 6:56am on 26 June 2019.

5. Conclusions

5.1. Two issues of substance were identified during the course of this inquest. The first was whether Mr Davies' death had been contributed to by the fall and in particular by the injuries sustained in the fall at the LMH on 14 June 2019. This is a difficult question that probably cannot be resolved with complete certainty. There was evidence that Mr Davies had developed an underlying neurodegenerative dementing disorder and that this was likely to be the cause of his dysphagia or difficulty in swallowing. Given that, I find that the principal cause of death was as stated in Dr McIntyre's pathology review, namely aspiration pneumonia due to dysphagia - the contribution of the multiple spinal fractures is uncertain. Dr McIntyre has indicated that the principal cause of death was aspirational pneumonia due to dysphagia. The principal cause of death is not said to be due to or a complication of the spinal injuries. The reason for Mr Davies' aspiration pneumonia was a not unexpected complication of his difficulty in swallowing. I do not understand there to have been a demonstrable necessary connection between that circumstance and the spinal fractures that Mr Davies had sustained. Nevertheless, the fact that Mr Davies died within a fortnight of the sustaining of those spinal injuries cannot be entirely ignored. In my view the fact that Mr Davies was still in hospital with serious spinal injuries is a circumstance of his death.

5.2. The second issue concerned the fact that Mr Davies was able to leave his bed and attempt to make his way to the toilet when his son had indicated to staff at the hospital that a bed rail should be in place. With this issue in mind, the affidavit of Ms Monique Bolding, the nurse unit manager of Ward 1B at the LMH, was obtained. Ms Bolding has a Bachelor of Nursing and a Masters in Nursing both from Flinders University. Ms Bolding's duties were to manage the nursing staff in Ward 1B.

5.3. In her affidavit, Ms Bolding has described the Fall and Fall Injury Prevention and Management policy directive of SA Health. This document appears to have been promulgated in 2012. It was current at the time of Mr Davies' fall on 14 June 2019.

Ms Bolding has also commented on the issue as to whether it had been appropriate that Mr Davies not have bed rails in place prior to his fall. Ms Bolding indicates that a Falls and Fall-Injury Risk Review was undertaken in respect of Mr Davies on the morning of 13 June 2019 and again during the night shift on the same day. She asserts that it was noted on multiple occasions by staff that Mr Davies was alert and orientated and was mobilising independently on 13 June 2019. He also had decision-making capacity. Therefore, when considering the bed rail decision option, Ms Bolding suggests that Mr Davies' presentation did not warrant the use of bed rails. She points out that it was strongly emphasised with nursing staff that bed rails should only be used when they are the least restrictive and least harmful option as they are a form of restraint. Ms Bolding stipulates that the bed rail should not be used in respect of alert and orientated patients who are mobilising independently unless they were requested by the patient where the patient is concerned that they will fall out of bed. She points out that the use of bed rails for a patient presenting as alert and was independently mobilising, as Mr Davies was, can increase the risk of falls and of more significant injury. This is due to the fact that alert and independently mobile patients can attempt to climb over the bed rail and fall from a greater height or attempt to squeeze through a gap in the bed rail and lose balance. These risk considerations are set out in the Risk Management documentation attached to her statement. Ms Bolding also points out that bed rails are most commonly used in the transfer of patients or for patients where capacity is uncertain and they are drowsy or impaired. Even in those circumstances, she suggests, bed rails should only be used as a '*last resort strategy*'.

5.4. Ms Bolding deals with the matter raised by Mr Davies' son regarding bed rails. She points out that because Mr Davies was assessed as having '*capacity*', I presume meaning capacity to decide things for himself, the decision as to whether to have a bed rail or not would ultimately have been Mr Davies' own decision in any event.

5.5. It is apparent that Mr Davies did not fall out of bed. Rather, he was moving to the toilet when he fell. Nevertheless, when one considers that his original presentation to the LMH was as a result of an unconscious collapse after dinner, there appears to have been at least a risk that he might experience another similar episode when mobilising. Clearly his own son was alive to those risks and, it appears, not without good reason. However, the fact remains that in the initial stages of his admission to the LMH that there is no suggestion that Mr Davies lacked the capacity to make decisions for himself.

It is not known whether or not Mr Davies was provided with any options in that regard. Ms Bolding's affidavit asserts that there is no record of any discussion having taken place between staff and Mr Davies about the risks bed rails may have presented. It is therefore impossible to know whether or not the use of bed rails was a matter that Mr Davies had considered for himself. I do find, however, and it is not disputed, that Mr Davies' son put staff at the LMH on notice that his father was at risk of falls and that a bed rail would mitigate that risk. However, in assessing this issue it needs to be borne in mind that it has not been established to the necessary degree of proof that the spinal injuries sustained as a result of the fall on the ward contributed substantially to Mr Davies' death.

5.6. I find that in all of the circumstances, Mr Davies being placed on the ITO was lawful and appropriate. Leaving aside the issue of the bed rails and the fall on the ward, about which I make no further comment, it appears that Mr Davies' clinical management at both hospitals was appropriate.

5.7. I make no recommendations in this matter.

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

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 29th day of March, 2022.

Deputy State Coroner