



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 27th day of April and the 15th day of August 2022, by the Coroner's Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of John Larchin.

The said Court finds that John Larchin aged 87 years, late of 40 Ballater Avenue, Campbelltown, South Australia died at the Royal Adelaide Hospital, Port Road, Adelaide, South Australia on the 20th day of July 2019 as a result of infective exacerbation of chronic obstructive lung disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for inquest

- 1.1. John Larchin was born on 25 June 1932 and died on 20 July 2019 at the Royal Adelaide Hospital (RAH). He was 87 years old.
- 1.2. Mr Larchin's death occurred whilst he was subject to a Level 1 Inpatient Treatment Order (ITO) under the Mental Health Act 2009. His death is therefore a death in custody as defined in section 3 of the Coroners Act 2003 and a mandatory inquest pursuant to section 21(1)(a) was required to be held. I note, however, that section 21 of the Coroners Act has since been amended and, as of 7 June 2021, Mr Larchin's death would likely have been certified by a medical practitioner to have been a death due to natural causes, upon which it would not have required a mandatory inquest.

- 1.3. Mr Larchin was first placed on a Level 1 ITO on 15 July 2019.¹ That order was revoked by consultant psychiatrist Dr Roman Onilov the following day.² A second Level 1 ITO was made by Dr Marnilar Nang at about 1:23am on 18 July 2019.³ That ITO was confirmed the same day by Dr Onilov.⁴
- 1.4. Mr Larchin was declared life extinct at about 2:30am on 20 July 2019 by Dr Li.⁵ At that stage the ITO was still in place.

2. Cause of death

- 2.1. A pathology review was undertaken by Dr Iain McIntyre of Forensic Science South Australia in consultation with senior forensic pathologist Professor Byard. In Dr McIntyre's report he proffered an opinion that the cause of Mr Larchin's death was infective exacerbation of chronic obstructive lung disease (COPD).⁶
- 2.2. It is of note that Mr Larchin did not report any breathing difficulties to his family or his general practitioner prior to the fall which led to his admission to hospital.⁷ However, the investigations conducted by the RAH, in particular the X-rays of his chest, strongly support the hypothesis that Mr Larchin was suffering from undiagnosed lung disease.⁸
- 2.3. I find the cause of Mr Larchin's death to be infective exacerbation of chronic obstructive lung disease.

3. Background

- 3.1. Mr Larchin was born in Merbein, Victoria. He was the youngest of five siblings. He grew up in Queensland, south of Brisbane.
- 3.2. Mr Larchin was widowed in 2003. He and his wife had one child together. Mr Larchin was also the stepfather to five children.
- 3.3. Prior to his retirement, Mr Larchin worked as an electrician and maintenance officer for the ABC.

¹ Exhibit C8, Annexure A

² Exhibit C5

³ Exhibit C4

⁴ Exhibit C5, page 6

⁵ Exhibit C8, Annexure B

⁶ Exhibit C1a - Chronic inflammatory lung disease that causes obstructed airflow from the lungs

⁷ Exhibit C2, Graham Pengilly; Exhibit C7, Dr Peter Moore

⁸ As conveyed to Mr Pengilly, Exhibit C2

- 3.4. When his wife passed away Mr Larchin continued to live independently. He was active and maintained a large garden and house.⁹ He continued to drive and cook meals for himself, and he had the support of his family.

4. Medical history

- 4.1. Mr Larchin had never been diagnosed with lung disease. His medical history is set out in the affidavit of his general practitioner, Dr Peter Moore.¹⁰ Dr Moore commenced treating Mr Larchin at Medical HQ in Glynde in December, 2014. Mr Larchin had been attending that practice for 58 years.
- 4.2. Dr Moore described Mr Larchin as healthy and active for a man of his age. He understood that Mr Larchin lived independently, his wife having passed away in 2003, and that he had the support of his children who saw him often.
- 4.3. Mr Larchin's medical history included an episode of atrial fibrillation in 2000, chronic kidney disease stage 2, osteopenia¹¹, impaired glucose tolerance, and diverticular disease.¹² Further, in 2010, he had an aneurysm of his aorta which required major reinforcing surgery. He also suffered from high blood pressure.
- 4.4. Mr Larchin was previously a smoker who consumed 10 cigarettes per day. He stopped smoking in 1995.

5. Circumstances leading to death

- 5.1. On 15 July 2019 Mr Larchin telephoned his son in law Graham Pengilly at about 10:34pm and told him he had had a fall.¹³
- 5.2. Mr Pengilly called the South Australian Ambulance Service whilst he and his wife June Pengilly drove to Mr Larchin's address. June had a key to her father's house, and it was their intention to unlock the door to allow the ambulance officers to enter.
- 5.3. When they arrived, Mr Larchin was lying on the floor in the kitchen. He was on the telephone, speaking to the 000 call-taker. Mr Larchin reported that he had fallen over

⁹ Exhibit C2

¹⁰ Exhibit C7

¹¹ Weakening of the bones

¹² Inflammation of the bowel

¹³ Exhibit C2

an electric blanket power cord at about 8:30pm. However, Mr Pengilly suspects that the fall occurred earlier than this, as Mr Larchin said that the sun was still out.

- 5.4. Mr Larchin stated that he then dragged himself along the ground down the hallway to obtain a notebook containing phone numbers. Once he obtained the notebook, he dragged himself to the kitchen and called Mr Pengilly.
- 5.5. Mr Larchin was admitted to the RAH on 15 July 2019 via ambulance. An x-ray showed a displaced left sub-capital neck of femur fracture.¹⁴ A left hip hemiarthroplasty was performed that day. The surgery appeared to be successful. However, Mr Larchin's recovery was complicated by delirium and hypoxia.
- 5.6. While in the Post Anaesthetic Care Unit following surgery, Mr Larchin displayed physical aggression and disorientation. At around 9:30pm Dr De Jonge was called to attend a code black in relation to Mr Larchin. Dr De Jonge states that Mr Larchin was agitated and aggressive towards staff, and that he thought that gangsters were trying to get him.¹⁵
- 5.7. Dr De Jonge believed that Mr Larchin was experiencing an episode of post-operative delirium and that he was, at that time, a danger to himself and others. Dr De Jonge made a Level 1 ITO, and Mr Larchin was treated with the antipsychotic medication haloperidol and restrained with soft shackles. This was effective and a few hours later the shackles were removed, and Mr Larchin was transferred to a ward.¹⁶
- 5.8. The following day Mr Larchin was reviewed by consultant psychiatrist Dr Roman Onilov. Mr Larchin was no longer combative and was friendly and cooperative. Dr Onilov revoked the ITO.
- 5.9. However, Mr Larchin's physical condition began to decline. Staff noted a decline in his oxygen saturation. The cause was not able to be identified. However, there was speculation that Mr Larchin suffered from lung disease, given his long history of smoking.
- 5.10. Between 12am and 1am on 18 July 2019, there was another code black in relation to Mr Larchin. On this occasion, Dr Nang attended to assist. Dr Nang was advised that

¹⁴ Exhibit C1a

¹⁵ Exhibit C3

¹⁶ Exhibit C3

the nurses were unable to get close enough to Mr Larchin to measure his oxygen or to provide him with oxygenation due to his aggression.

- 5.11. Attempts made to calm Mr Larchin were unsuccessful and, after 30 minutes, Dr Nang placed Mr Larchin on an ITO at about 1:23am. This was done to enable medical staff to administer required treatment to Mr Larchin, including the provision of oxygen and the monitoring of his oxygen saturation. Mr Larchin was again medicated with haloperidol.
- 5.12. Mr Larchin's physical condition continued to deteriorate, and he was transferred to the Intensive Care Unit.
- 5.13. Dr Onilov reviewed Mr Larchin in the ICU at 1:50am. He observed that Mr Larchin was agitated and uncooperative. Dr Onilov confirmed the ITO made by Dr Nang at 2:12pm on 18 July 2019.
- 5.14. Mr Larchin's hypoxia was ongoing, and his general health continued to decline. He was given non-invasive ventilation and opioids to manage his pain. On 18 July 2019 Mr Larchin's airway became obstructed and he was given 100% oxygen and naloxone to reverse the opioids. This improved his condition for a short time. However, on 19 July 2019 he again became hypoxic with rapid shallow breathing and a productive cough.
- 5.15. A chest X-ray showed background changes of emphysema. A small increase in opacity in the right lung base was observed. As it was thought that this may indicate infective change, antibiotics were administered intravenously. Mr Larchin pulled off his ventilator and refused oxygen therapy.
- 5.16. At about 11pm on 19 July 2019, staff advised Mr Larchin's family of his poor prognosis and as a result they attended the hospital. Mr Larchin was surrounded by family when he passed away at about 1:08am on 20 July 2019.

6. Conclusions

- 6.1. The death of Mr Larchin occurred while he was subject to an Inpatient Treatment Order.
- 6.2. I agree with the analysis and opinion of Detective Peter Wise of the SAPOL Eastern District Criminal Investigation Branch, who investigated this matter on behalf of the State Coroner, that the ITO's were necessary and appropriate to enable Mr Larchin to

receive the medical treatment he clearly required. I so find, and I also find that the ITO's were lawfully imposed.

- 6.3. The RAH complied with the requirements of the Mental Health Act 2009 by notifying the Office of the Chief Psychiatrist (OCP) of both ITO's. Detective Wise did, however, identify that there was no record of the South Australian Civil and Administrative Tribunal (SACAT) having been informed by the OCP of the second ITO. This notification was required by section 22(2) of the Mental Health Act as the second ITO was made less than seven days after the first.
- 6.4. This issue appears to have been resolved, as addressed in an affidavit of a member of the Chief Psychiatrist's staff, which advises of the introduction of a new electronic system, which automatically forwards copies of ITOs to SACAT as required.¹⁷
- 6.5. Whilst there may have been a failure by the OCP to comply with the notification provisions of the Mental Health Act, a process has been implemented to ensure there is no recurrence, and the failure did not negatively impact upon the treatment of Mr Larchin. The orders were validly and appropriately made.
- 6.6. 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 15th day of August, 2022

State Coroner