



## FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign King at Adelaide in the State of South Australia, on the 15<sup>th</sup> day of March and the 19<sup>th</sup> day of June 2024, by the Coroner's Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of William Cyril Denver Coom.*

*The said Court finds that William Cyril Denver Coom aged 92 years, late of Kalyra Aged Care Facility, 2 Kalyra Road, Belair, South Australia died at Belair, South Australia on the 4<sup>th</sup> day of December 2021 as a result of an unascertained cause. The said Court finds that the circumstances of his death were as follows:*

### **1. Introduction and reason for inquest**

- 1.1. William Cyril Denver Coom was born on 11 April 1929 and died on 4 December 2021 at Kalyra Belair Aged Care Nursing Home. He was 92 years of age.
- 1.2. Mr Coom was under a guardianship order with special powers pursuant to Section 32(1)(b) of the Guardianship and Administration Act 1993 at the time of his death. His death is unable to be certified as being from natural causes due to a precise cause of death being unascertained. Due to this, his was a mandatory inquest pursuant to Section 21 of the Coroners Act 2003.

### **2. Background**

- 2.1. Little is known about Mr Coom's social background, although records indicate he had been married twice and he had children in the UK with whom he had no contact as at the time of his death.

### **3. Mr Coom's medical history**

- 3.1. Mr Coom is recorded as having advanced dementia (mixed), atrial fibrillation, peripheral vascular disease, hypertension and hypercholesterolaemia.
- 3.2. Mr Coom was admitted to the Noarlunga Health Service on 22 July 2021 with left leg cellulitis. This admission was complicated by a fall on 24 July 2021 resulting in a left acetabular fracture. Mr Coom was transferred to the Geriatric Evaluation and Management ward at the Flinders Medical Centre (FMC) on 27 July 2021.
- 3.3. Mr Coom was not considered safe to return home and his wife agreed to placement in an aged care facility. He was discharged from FMC to Kalyra on 6 September 2021. His anticoagulation with warfarin was ceased at the time of discharge due to the ongoing falls risk.

### **4. Guardianship order**

- 4.1. An application to the South Australian Civil and Administrative Tribunal (SACAT) dated 19 August 2021 stated that Mrs Ann Coom, the wife of Mr Coom, was, until that time, the carer for Mr Coom, but wished to withdraw from that role.
- 4.2. Following an urgent hearing on 2 September 2021, an interim urgent action guardianship order and special powers order was made. A full hearing was then held on 16 September 2021.
- 4.3. An administration order appointing the Public Trustee was made, as was a guardianship order appointing the Public Advocate as his limited guardian, and a special powers order including powers of detention.
- 4.4. Those orders were all current and valid as at the time of Mr Coom's death.

### **5. Circumstances of Mr Coom's death**

- 5.1. Mr Coom had an unwitnessed fall on 3 December 2021 at approximately 5:30pm with no evidence of head strike, but with minor soft tissue injuries to his elbow. He then slept until about 9:30pm when he walked down to the dining room and ate half his dinner before returning to bed.
- 5.2. At around 11:45pm he was observed to stumble and lean onto a folded wheelchair which was against the wall. A staff member gently lowered him to the ground. No head strike was observed.

- 5.3. He was helped back to bed by staff and noted to deteriorate rapidly with no verbal communication, worsening conscious state and shallow respirations.
- 5.4. He was given supplemental oxygen, but ultimately, he was declared life extinct at 12:20am on 4 December 2021.

## **6. Report of death to the State Coroner**

- 6.1. There were a number of procedural issues around the reporting of Mr Coom's death to the Coroners Court.
- 6.2. A Registered Nurse from the aged care facility contacted SAPOL shortly after Mr Coom's death and SAPOL notified the Coroners Court by forwarding a document capturing the information the RN had provided over the phone.
- 6.3. That document indicated that Mr Coom was not under any type of order, (which was incorrect). However, it is clear from an endorsement on the email made by a court staff member that information was clearly provided to the Coroners Court on 4 December 2021 that Mr Coom was under a SACAT order.
- 6.4. Dr Tudor Thomas, Mr Coom's general practitioner, stated that on 6 December 2021 someone from his administrative team received a call from the funeral home indicating that a coroner's referral was not needed, and a '*normal*' death certificate was required. He completed one. Unfortunately, that death certificate set in motion the Registrar of Births, Deaths and Marriages granting a cremation certificate.
- 6.5. On 7 December 2021 the formal report of death from the aged care facility was received by the Coroners Court. Documents indicate the manager of the nursing home thought this had occurred earlier. It is unclear why the paperwork was not received by the Court until that date.
- 6.6. Mr Coom's death was formally reported to me the following morning and a pathology review was ordered.
- 6.7. On 10 December 2021 the pathology review was received. That pathology review stated:

'We suggest CT/external examination in the first instance to exclude trauma. A post mortem examination may be necessary to determine a specific cause of death.'<sup>1</sup>

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<sup>1</sup> Exhibit C1a

- 6.8. Approval for a post mortem examination was given on 11 December 2021.
- 6.9. However, it was then discovered that Mr Coom had been cremated the day prior. Accordingly, the recommended CT and potential post mortem, to exclude trauma being a contributing factor to Mr Coom's death, could not occur. Thus, a precise cause of death is unable to be ascertained.
- 6.10. Former Coroners Court Manager, Michele Bayly-Jones, wrote to Dr Thomas in January 2022 pointing out the consequences of his action of essentially creating two death reports with incompatible outcomes. Dr Thomas was reminded in this letter of his obligations and the potential penalties around his actions.
- 6.11. Dr Thomas stated in his affidavit,<sup>2</sup> which I have received into evidence, that he is now fully aware of those obligations and the practices he should follow and reminds himself and others at his workplace of those obligations whenever a patient passes away.

## **7. Conclusion and recommendation**

- 7.1. I find the cause of Mr Coom's death to be unascertained.
- 7.2. I agree with the conclusions of the SAPOL investigating officer, Detective Brevet Sergeant Micheal Clarke, that the guardianship order with special powers was lawful and appropriate.
- 7.3. In my opinion Mr Coom's care was appropriate.
- 7.4. I make no recommendations.

*Key Words: Death in Custody; Section 32 Powers*

*In witness whereof the said Coroner has hereunto set and subscribed his hand and*

*Seal the 19<sup>th</sup> day of June, 2024.*

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*State Coroner*