

CORONERS COURT OF SOUTH AUSTRALIA

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INQUEST INTO THE DEATH OF TREVOR ALLAN CHEESMAN

[2025] SACC 19

Inquest Findings of his Honour State Coroner Whittle

3 July 2025

CORONIAL INQUEST

Examination into the cause and circumstances of the death of a 70-year-old man who died in hospital whilst the subject of an Inpatient Treatment Order. Mr Cheesman had undergone complex craniofacial surgery, complications of which led to further medical issues and the onset of delirium, which necessitated the treatment order. The inquest examined the circumstances of the imposition of the treatment order, and the appropriateness and adequacy of his treatment and care whilst in hospital.

Held:

1. Trevor Allan Cheesman, aged 70 years of Sheidow Park, died at the Flinders Medical Centre on 31 July 2021 as a result of complications arising from craniofacial resection and orbital exenteration for right sinonasal adenocarcinoma.
2. Circumstances of death as set out in these findings.

No recommendations made.

Counsel Assisting: MR M KIRBY

Hearing Date/s: 24 October 2024

Inquest No: 42/2024

File No/s: 1642/2021

**INQUEST INTO THE DEATH OF
TREVOR ALLAN CHEESMAN
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Introduction

- 1 Mr Trevor Cheesman was born on 28 January 1951. He was 70 years old at the time of his death on 31 July 2021. He and his wife Gillian had been married for about 45 years. They had two children: Mark, Mrs Cheesman's son from a previous relationship, who was later adopted by Mr Cheesman, and Matthew.
- 2 During his life, Mr Cheesman worked in various jobs, including working for Penfolds Wines and the Department for Housing and Construction. At the age of about 45 years, he suffered a back injury and commenced on a disability pension.
- 3 In about January 2021, Mr Cheesman began having problems with his right eye. He was experiencing a lot of headaches, which he raised with his general practitioner, Dr Daljit Janjua.
- 4 On 19 March 2021, Mr Cheesman consulted an optometrist who referred him to the Flinders Medical Centre (FMC) the following day. Mr Cheesman was found to be suffering a right sinonasal adenocarcinoma, an aggressive cancer behind his nose, which was growing into the space behind his eye.¹
- 5 On 23 June 2021, Mr Cheesman underwent complex surgery at FMC to remove the tumour.
- 6 Further surgery was conducted on 28 June 2021 to address significant complications of the surgery, and Mr Cheesman was admitted to the Intensive Care Unit (ICU) for recovery.
- 7 On 21 July 2021, Mr Cheesman was moved from the ICU to a ward. During this period, he developed significant delirium which necessitated the imposition of an inpatient treatment order (ITO) pursuant to the *Mental Health Act 2009*.
- 8 Mr Cheesman died in hospital on 31 July 2021.

Cause of death

- 9 By reference to FMC records, Dr Jane Alderman of Forensic Science SA undertook a pathology review in consultation with senior specialist forensic pathologist, Dr John Gilbert. The cause of death suggested following that review was 'complications arising from craniofacial resection and orbital exenteration for right sinonasal adenocarcinoma',² which I find to have been the cause of Mr Cheesman's death.

¹ Exhibit C1, paragraph 7 (as described by Mrs Cheesman)

² Exhibit C2a

Reason for Inquest

- 10 As Mr Cheesman was a person subject to an ITO, his death is deemed to be a death in custody, as defined in section 3 of the *Coroners Act 2003*. Accordingly, an inquest into his death is mandatory pursuant to section 21(1)(a) of that Act.

Relevant medical history

- 11 Mr Cheesman attended the same medical clinic over many years and Dr Janjua took over his care at that clinic in early 2018. Dr Janjua described Mr Cheesman's main medical conditions as prostatic hypertrophy, gastro-oesophageal reflux disease (GORD), chronic obstructive pulmonary disease (COPD) and androgen deficiency.
- 12 In May 2021 Mr Cheesman had an optometry appointment following what was described as sudden onset blurry vision in his right eye, which had commenced two to three weeks prior. The optometrist noticed reduced visual acuity in the right eye and also detected a right afferent pupil defect, which can be a sign of various medical emergencies,³ so arranged for Mr Cheesman to be seen the next day at the Flinders Eye Clinic. Following further investigations, an MRI revealed a sinonasal mass with extension into the orbit, with compression of the optic nerve. A biopsy taken from that mass confirmed adenocarcinoma of sinonasal origin. Mrs Cheesman recalls they were told the tumour was very aggressive.
- 13 Following a number of consultations, on 10 June 2021 Mr and Mrs Cheesman attended an appointment at the FMC Ear Nose and Throat clinic. The notes reflect that they were told of the options resulting from a multidisciplinary team meeting held two days earlier. It is recorded that the recommended curative treatment of craniofacial excision, orbital exenteration⁴ and free flap reconstruction, followed by radiotherapy was discussed, as well as the alternative of palliation.⁵ According to the notes of that meeting, Mr Cheesman expressed a desire to have the surgery, knowing it was high-risk and that postoperative radiotherapy would be required.
- 14 In a letter to Dr Janjua dated 15 June 2021, providing a summary of the 10 June 2021 appointment, neurosurgeon Dr Vrodos set out the risks which were discussed with Mr and Mrs Cheesman. The major risks from a neurosurgical perspective were injury to the right carotid artery which can lead to death or stroke, CSF⁶ leak and possible loss of vision to the (remaining) left eye. Dr Vrodos also advised that the risks of complicating hematoma, infection and perioperative issues were discussed.
- 15 The surgery was conducted on 23 June 2021 and is carefully summarised, together with its complications, in the pathology review. The following description of the surgery and postoperative complications is taken from the pathology review of Dr Alderman, and I accept it as an accurate summary.

³ Affidavit of Nahal Saboohian, Exhibit C4

⁴ Removal of an eye

⁵ Exhibit C5, Annexure C

⁶ Cerebrospinal fluid

'Right craniofacial resection and orbital exenteration with free flap reconstruction and fascial leg graft and fat reconstruction was planned to be undertaken by ENT, plastics and neurosurgeons.

The surgery was performed on 23 June 2021 with margins macroscopically clear but was complicated by significant bleeding from the orbital apex due to an avulsed ophthalmic artery and injury to the right internal carotid artery. Multiple blood transfusions were required. A CT angiogram postoperatively showed tapering of the right internal carotid artery, and an established right cerebral infarction which correlated with left hemiplegia. Mr Cheesman developed a CSF leak from the nose postoperatively.

A lumbar drain was inserted on 25 June 2021. On 26 June 2021 a tracheal aspirate grew *Escherichia coli* and was managed with IV antibiotics. A repeat CT angiogram on 27 June 2021 showed the right internal carotid injury was stable. It was thought that the right anterior and middle cerebral vessels would be supplied from the left anterior circulation. A new hypo-density in the right centrum semi-ovale was thought to reflect a watershed territory cerebral infarct. Pneumocephalus was also noted and Mr Cheesman was treated with concentrated oxygen therapy.

Endoscopic repair of the skull base defect was performed on 28 June 2021 along with a surgical tracheostomy. On 2 July 2021 the lumbar drain was successfully clamped and was removed on 3 July 2021. On 4 July 2021 progressive swelling under the flap below the right orbit was noted. A CT scan and aspiration of periorbital soft tissue under ultrasound guidance were performed on 5 July 2021. The purulent fluid was positive for CSF and another lumbar drain was inserted. This aspirate was repeated on 9 July 2021 and this time CSF was not detected. Electrolyte disturbances were managed in ICU along with a rash on Mr Cheesman's back which required treatment with topical steroids and oral antihistamines.

Mr Cheesman was transferred from ICU to the ward on 21 July 2021. In view of the extensive surgery, complications and pre-existing comorbidities his prognosis was guarded.⁷

- 16 Following his surgeries, Mr Cheesman was released from the ICU to a ward on 21 July 2021.

Inpatient Treatment Order

- 17 There were changes in Mr Cheesman's behaviour whilst in hospital. On 24 July 2021 a code black was called when he was extremely agitated, climbing over the bed rails and attempting to remove his tracheostomy and nasogastric tube. Nurses could not de-escalate the situation verbally and called Mrs Cheesman who spoke on the phone with her husband, also unsuccessfully.⁸
- 18 Medical practitioner Dr Lily Kent examined Mr Cheesman and concluded that he had a mental illness; and because of that mental illness, he required treatment for his own protection from harm and protection of others from harm; and he had impaired decision-making capacity relating to the appropriate treatment of his mental illness; and there was no less restrictive means of ensuring appropriate treatment of Mr Cheesman's illness. These conclusions satisfied the criteria for the imposition of a level 1 ITO,

⁷ Exhibit C2a, page 2

⁸ Exhibit C7, FMC Medical Records

pursuant to section 21 of the Mental Health Act, which was then imposed. The ITO was expressed to expire at 2pm on 30 July 2021.

- 19 Section 21(5) of the Mental Health Act required that Mr Cheesman be examined within 24 hours of the making of that order by a psychiatrist or authorised medical practitioner so that it may be confirmed or, if the grounds for the order no longer existed, revoked. If it is not practicable for the examination to occur within that time, it must occur as soon as practicable thereafter. The subsequent examination, which should have been undertaken by the weekend consultant psychiatrist on duty on either 24 or 25 July 2021, did not occur.
- 20 Dr Randall Long, Senior Consultant Psychiatrist and Head of Unit for Consultation Liaison Psychiatry Services at FMC and the Statewide Eating Disorder Services provided a statement,⁹ partly compiled from the hospital notes, in relation to Mr Cheesman's mental health and treatment during his admission, and the imposition of the ITO.
- 21 Dr Long examined Mr Cheesman at around midday on 26 July 2021. He diagnosed delirium, noted symptoms of fluctuating cognition, uncharacteristic agitation and aggression and distress, including concerns that he was gesticulating with his fingers mimicking a gun to his head and that he was significantly frustrated about his severe and ongoing surgical complications. Dr Long confirmed the level 1 ITO, noting in his 'statement of reasons' that Mr Cheesman exhibited actions, appearance, behaviour, beliefs, history, mood, speech and thoughts consistent with delirium. He found that Mr Cheesman had significant risk of harm to himself and others and that he had impaired decision-making capacity relating to the treatment of his delirium mental illness. He concluded there were no less restrictive means than an ITO available to provide effective treatment for this mental illness.
- 22 Dr Long confirmed the ITO and explained in the 'statement of reasons' that the delay in confirming the order was due to nobody notifying the Consultation Liaison Psychiatry team or the psychiatrist on call over the weekend between 24 and 26 July 2021.
- 23 In his affidavit Dr Long elaborated that there was not a reliable automated notification system for ITOs and he considered that this may have been due to the early rollout stage of the SA Health electronic medical record system, known as Sunrise. Dr Long stated, and I accept, that there is now a reliable automated system to notify duty psychiatrists of ITOs to ensure that reviews happen within the required timeframe.
- 24 Consultant psychiatrist Dr Bonita Lloyd reviewed Mr Cheesman on 30 July 2021 at about 11:45am, prior to the expiry of the level I ITO, and concluded that it was appropriate to make a further order for the treatment of Mr Cheesman as an inpatient (a level 2 ITO). Dr Lloyd's notes indicated that Mr Cheesman was suffering ongoing cognitive impairment consistent with delirium. The level 2 ITO was then appropriately documented, including as to Dr Lloyd's satisfaction that Mr Cheesman met the criteria in section 25(2) of the Mental Health Act for the imposition of that order.

⁹ Exhibit C3

25 I am satisfied that the level 1 and level 2 ITOs were appropriately imposed, with the criteria for the imposition of those orders having been met. The failure to review the level 1 ITO within 24 hours did not affect its validity and, in this instance, given the reported rectification of the issue which led to that, requires no action by way of coronial recommendation.

Mrs Cheesman's concerns

26 In her statement, Mrs Cheesman expressed concerns about her husband's treatment. I have carefully considered these concerns.

27 Due to COVID-19 restrictions Mrs Cheesman was unable to see her husband from 18 to 24 July 2021 and it was during this time that Mr Cheesman was moved from the ICU to a ward. On 24 July 2021 Mrs Cheesman was able to get an exemption to be able to visit her husband and observed him getting very upset and trying to pull out tubes and cords. This was the day upon which the first ITO was imposed.

28 In later visits she noted that his distress and agitation continued, and she felt that the standard of his care decreased once he was moved from the ICU.

29 She noted that on 28 July 2021 she found Mr Cheesman in a chair in the presence of two male nurses, and that Mr Cheesman had soiled himself. There were other occasions when she saw that he had soiled himself and perceived that he was not being appropriately cleaned up.

30 Mrs Cheesman was concerned about Mr Cheesman being moved without her being told, and that he was placed in a room or rooms which were not of the standard of his previous accommodation.

31 It is unsurprising that loved ones would be concerned if a patient is not immediately cleaned after soiling themselves, as would be ideal in every case. Pressures of work in a busy hospital may mean that this is not always possible, and I observe that these concerns arose during and proximate to peak COVID shutdown, when it also may not have been possible to improve on telephone communications and accommodation issues which arose. It was outside the scope of the inquest to resolve these specific complaints and I have not attempted through the evidence to do so.

Further observations regarding cause of death

32 I have set out the important details in Dr Alderman's pathology review of Mr Cheesman's surgery and hospital treatment which highlighted that, in view of the extensive surgery, complications and his pre-existing comorbidities, Mr Cheesman's prognosis was guarded.

33 I have also considered the post-operative treatment and care of Mr Cheesman, including the use of antipsychotic and sedative medications prescribed to assist with his ongoing issues of delirium. There is no evidence of electrolyte derangement connected with the use of these medications, noting Mr Cheesman's normal renal and liver functions, as tested on 30 July 2021.

34 The prescription and administration of olanzapine, which was temporally connected to Cheesman's death, was in accordance with protocol and he was appropriately monitored after administration of that medication.

35 I have also considered the possibility of extension of stroke as being a factor in Mr Cheesman's death, but again there is insufficient evidence in the medical records to raise this beyond speculation.

Coronial investigation

36 As Mr Cheesman was a person in custody at the time of his death, an investigation into his death was conducted by Detective Brevet Sergeant Micheal Clarke on behalf of the State Coroner. A copy of Detective Clarke's investigation report was tendered to the inquest.¹⁰

37 Detective Clarke obtained and reviewed witness statements and records, as has also been done in the course of this inquest, and found no issues with the lawfulness of Mr Cheesman being placed under the ITOs. He noted Mrs Cheesman's concerns but identified nothing to suggest that medical staff had failed in their duty of care to Mr Cheesman, or that they contributed in any way to his death.

38 I agree with Detective Clarke's assessment of these issues.

Conclusions

39 I find Mr Cheesman was lawfully in custody at the time of his death.

40 Mr Cheesman underwent surgery which was delicate, complicated and high-risk, as an alternative to palliation for an otherwise terminal condition. The complications which occurred were within the range of known potential complications, which were explained to Mr and Mrs Cheesman beforehand.

41 I find there were no failings by the medical staff that led to Mr Cheesman's death.

Recommendations

42 I make no recommendations in this matter.

Keywords: Death in Custody; Inpatient Treatment Order; High-Risk Surgical Procedure

¹⁰ Exhibit C6