CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATH OF WAYNE MALCOLM CLARK

[2026] SACC 36

Inquest Findings of his Honour State Coroner Whittle

21 August 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a man with advanced dementia who suffered a fall in a secure residential facility and was given end-of-life care.

Held:

1. Wayne Malcolm Clark, aged 84 years of Glengowrie, died at Glengowrie on 23 August 2023 as a result of bronchopneumonia complicating C2 odontoid fracture (palliated) due to fall on a background of Alzheimer's and vascular dementia.

2. Circumstances of death as set out in these findings.

No recommendations made.

Counsel Assisting: MR D EVANS
Hearing Date/s: 18/08/2026
Inquest No: 28/2026 **File No/s: 2200/2023**

INQUEST INTO THE DEATH OF WAYNE MALCOLM CLARK [2026] SACC 36

Introduction

1 The Court heard a mandatory inquest into the death of an 84-year-old man while he was held in a secure residential care facility. The inquest explored whether there were care issues in the aftermath of a fall and during the palliative process. Given that there were no ambiguities arising in the investigational materials, oral evidence was not necessary, and the inquest proceeded on the papers.

Mr Clark

2 Wayne Malcolm Clark was born in Naracoorte on 11 June 1939. Both of his parents were teachers, which meant that the family moved around a lot. After Mr Clark left school, he commenced employment with the State Bank. He then moved to work with BHP at Rapid Bay and then Whyalla while studying accounting. Mr Clark married and had three children, but his marriage broke down.

3 He moved back to Adelaide and opened a business doing tax while also doing accounting work in various businesses. Mr Clark enjoyed golfing, jazz music, gardening and travelling.

4 Mr Clark commenced a relationship with Sharyn, who would become his wife in about 2003, and he became part of her family.

5 In 2015 Mr Clark was diagnosed with Alzheimer's disease and vascular dementia. He was supported through this by his wife. He suffered a number of transient ischaemic attacks and falls. His verbal communication reduced and he began to rely on a walker to move around.

6 By the end of 2022, Mr Clark's condition had deteriorated; he was struggling with incontinence and dysphagia, and it became clear he was not going to be able to remain at home. Reluctantly, his family agreed that he needed professional care and he was taken into Eldercare Allambi at Glengowrie in February 2023.

7 Soon after arriving Mr Clark began to frequently search the facility for his wife and he had to be moved to a secure unit for his own safety. A legal requirement for residents being housed in secure areas is for an order to be made by the South Australian Civil and Administrative Tribunal (SACAT) under the *Guardianship and Administration Act 1993* permitting that to occur.[1] The processes were followed and SACAT made a guardianship order which permitted Mr Clark to be securely housed (detained) from 29 March 2023.[2] At the time of his death Mr Clark was lawfully detained.

8 As a dedicated advocate for Mr Clark, Mrs Clark identified that he was not being toileted at night and she caused that to change, although she still considered that it should have happened more often than it was.

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1 *The Public Advocate v C, B* (2019) 133 SASR 353 at [54] and [56]
2 Exhibit C8

Fall

9 At about 1:30 am on 15 August 2023, an enrolled nurse found Mr Clark on the floor in his room after his room sensor triggered an alert for movement.[3] He was wrapped in his blankets beside the bed. This nurse called for a registered nurse, Pragya Chapagai, to do a head-to-toe assessment in accordance with protocol.[4] Mr Clark had a haematoma and laceration on his forehead.[5] They used a sling lifter to place him back in bed. His laceration was treated and observations were taken, which were within baseline.[6] Nurse Chapagai checked and found that Mr Clark had given an advance care directive that he was not to be transferred to hospital. At that time of night there were no doctors available to attend. Nurse Chapagai phoned Mrs Clark to see whether she wanted a hospital transfer notwithstanding the advance care directive. Mrs Clark indicated that she did want him taken to hospital, so Nurse Chapagai called for an ambulance.

10 Mrs Clark attended and sat with Mr Clark waiting for the ambulance. She raised that she thought he was in pain and paracetamol was approved and given.[7] Throughout the night several ambulances were dispatched but then called away on more urgent taskings. At about 5 am, the ambulance service called to confirm that they were delayed, but still coming. At about 6 am, Mrs Clark reported that Mr Clark appeared to be in pain again. Nurse Chapagai called and reported this to the ambulance service,[8] as she could not prescribe any medications herself. The ambulance service tried to arrange a virtual care service assessment to get more information, but Mrs Clark requested that paramedics physically attend. Paramedics arrived at 8:43 am.[9] They assessed that there was limited utility in taking Mr Clark to hospital for a CT scan given the advanced state of his dementia. Upon Mrs Clark's insistence, they engaged a doctor over the virtual care service. During this process, it was determined that palliative care was indicated.

11 The virtual care doctor withheld apixaban[10] because of the laceration and prescribed common end-of-life medications; morphine, midazolam, metoclopramide and hyoscine, to be administered as needed.[11] He requested that a general practitioner review be conducted when Mr Clark's practitioner was next available, which he noted to be 17 August 2023.[12] Throughout that day Mr Clark's pain was managed with paracetamol, which was observed to have good effect. Following the fall, Mr Clark was assessed by a physiotherapist twice, a palliative care nurse, a Dementia Support Australia nurse and a speech pathologist. Mr Clark's general practitioner, Dr Sian Hodgkinson, coordinated this care over the phone. He was then reviewed by Dr Hodgkinson in person on 17 August 2023. She considered that there were signs of a brain injury. Mr Clark had erratic and noisy breathing, possible seizure activity and reduced consciousness. In discussion with family, she confirmed that the end-of-life process was underway and care of this nature continued.

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3 Exhibit C4 at [7]
4 Exhibit C10
5 Exhibit C4 at [10]
6 Exhibit C4 at [12]
7 Exhibit C4 at [15]
8 Exhibit C9, Event Chronology at 1
9 Exhibit C9
10 An anticoagulant or blood thinner
11 Exhibit C5
12 Exhibit C7b

12 Mr Clark died on 23 August 2023. He was 84 years old.

13 Mrs Clark said that there was a lack of attention given to Mr Clark during the days leading to Mr Clark's death.[13] She said that he was not medicated sufficiently after it was determined that he was to be given end-of-life care. Mrs Clark's view was reinforced by a friend with palliative care experience who raised concerns based on her impressions, but without specific details of his medication regime.[14] Mrs Clark considered that the staff at the facility did not care about her husband and that some of the palliative care provided was not in accordance with best practice. I directed an investigation into those issues.

Post-mortem examination

14 A post-mortem examination was conducted by senior consultant forensic pathologist, Dr John Gilbert.[15] Dr Gilbert found evidence of pulmonary oedema and congestion, extensive patchy pneumonic consolidation of the lower lobes of both lungs, focal occlusion of the anterior descending coronary artery without evidence of old or recent myocardial infarction, mild uncomplicated diverticular disease of the sigmoid colon, mild congestion of the liver, numerous thrombi in the prostatic venous plexus and right frontal scalp bruising, but without any evidence of underlying skull or facial fractures and no evidence of intracranial haemorrhage.

15 There was an oblique fracture through the base of the odontoid process of vertebra C2 with rearward displacement of the odontoid as well as vertebra C1. The spinal cord was however uninjured. There was a deposition of blood clot over the fracture surfaces which was in keeping with an antemortem origin.

16 Dr Gilbert concluded that Mr Clark had died as a result of bronchopneumonia complicating C2 odontoid fracture (palliated) due to a fall on a background of Alzheimer's and vascular dementia.[16]

17 I am satisfied that Dr Gilbert conducted all the necessary medical investigations and that his opinion properly reflects the evidence. I find that Mr Clark's cause of death was as Dr Gilbert described.

Assessment of the care provided

18 I was greatly assisted by a review and report from independent expert geriatrician, Associate Professor Timothy To.[17] Associate Professor To said that the falls risk management plan put in place was reasonable and he noted that it had a sustained period of effectiveness. I agree with Associate Professor To's assessment.

19 Regarding the decision to pursue end-of-life care, I am satisfied that this was appropriate, given the advanced state of Mr Clark's dementia and the indicators present at the time that he was approaching death.

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13 Exhibit C2 at [26]
14 Exhibit C3 at [9]
15 Exhibit C1
16 Exhibit C1 at 2
17 Exhibit C6

20 In relation to the care provided to Mr Clark following his fall, Associate Professor To explained that the assessment of this issue requires caution because there was no in-hospital assessment of Mr Clark, which means that his actual condition at that time is not known. The appropriateness of the interventions is therefore being measured against an unknown condition and unknown trajectory. He said, and I agree, that the decision for Mr Clark to remain at Allambi was reasonable, however it has the consequence of limiting the assessment that one can make of the actual impact of the care provided.

21 Associate Professor To said:

> With respect to the broader management of this case, the documentation suggests a comprehensive clinical response with the partnership between the South Australian Ambulance Service, Virtual Care Service, the general practitioner Dr Hodgkinson, the Eldercare Palliative Care Nurse Practitioner team and the Eldercare residential aged care staff including nurses, speech pathology and physiotherapy. The Palliative Care Nurse Practitioner team is not ubiquitous in residential aged care, but here demonstrated support for and partnership with both Dr Hodgkinson and the Allambi staff. Additionally the utilization of an End-of-Life Pathway at Eldercare supports the staff to deliver and document reliable care at the end-of-life, prompting assessment and care. Acknowledging that residential aged care is not an acute hospital service, Mr Clark received regular care, reassessment and treatment modification as his condition deteriorated over days. From the documentation provided I feel that the care delivered to Mr Clark following the fall by the staff of Allambi appears appropriate, responsive and commendable. I also commend the commitment of Eldercare to end-of-life care as demonstrated in their nurse practitioners and End-of-Life Pathway.[18]

22 I therefore find that there is no criticism to be made of the scale of the care response provided to Mr Clark following his fall.

23 More particularly, in relation to the issue of the pain relief provided to Mr Clark in the days that followed his fall, Associate Professor To highlighted a particular approach that impacted the clinical decisions made. Professor To said:

> I note in the nursing care report from the 16/8/23 that Sharyn is reluctant about the use of morphine for pain relief for Mr Clark. The note by Dr Hodgkinson on 17/8/2023 at 1830 documents a discussion with Sharyn and their son about the indications and use of as required medications including morphine, midazolam, metoclopramide and hyoscine butylbromide (buscopan). Later that evening the nursing note indicates that staff felt that Mr Clark was in pain, however further pain relief was declined by both Sharyn and their son. After further discussion another dose of morphine was permitted by the family at 2230. Through the remainder of the admission if the family were not present, staff were required to contact family by phone to consent for further medication for symptoms regardless of time of day.[19]

24 Dr Hodgkinson said that the use of a continuous subcutaneous infusion (ie: medication pump) was commenced after the first 24 hours of receiving multiple doses of subcutaneous medications, which is standard practice in palliative care. Associate Professor To also said that it is normal practice to commence with as-needed doses of end-of-life medications and that it is common to have periods where symptoms are not completely controlled while the dosages are titrated. This will on occasion be distressing

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[18] Exhibit C6 at 5
[19] Exhibit C6 at 6

to family members but is part of normal care in the palliative process. Associate Professor To explained:

> It is usual practice to initiate symptom management at the end-of-life with as required dosing, with usage giving an indication of symptom burden but also guiding the commencement and escalation of continuous subcutaneous infusion if frequent doses have been required. The primary goal is for the person to be comfortable, without unnecessary sedation or other side effects. During the period on as required medications, and even with starting a continuous subcutaneous infusion, it is not uncommon to have periods of incompletely controlled symptoms as doses are titrated to effect. The variability between individuals, injuries and impact of comorbidities means that sufficient control of symptoms requires titration guided by regular clinical assessment, experience and teamwork between medical and nursing staff.[20]

25 Associate Professor To concluded:

> Overall, I think the initiation of as required medications, followed by continuous subcutaneous infusion with ongoing titration represents contemporaneous practice and manages the balance between proactive and responsible prescribing, symptom control and progressively changing condition.

After my review of the materials, I agree. The medication regime and its evolving manner of administration was appropriate and reasonable, even if continuous infusion could have been commenced slightly earlier.

26 In relation to whether the level of care provided contributed to Mr Clark's death, Professor To concluded:

> In this case the fall triggered a cascade of deterioration with pain from a fracture, reduced mobility and ultimately pneumonia leading to progressive decline and ultimately death. I believe that this end-of-life course is consistent with the natural history and progression of advanced dementia.[21]

27 I accept this opinion and find that Mr Clark progressed to the end of his life due to the advanced nature of his condition and there were no different approaches that might have prevented his death. I therefore find that there were no issues with the level of care provided to him.

Recommendations

28 Given my findings, I have no recommendations to make that might prevent or reduce the likelihood of further similar deaths.

Condolences

The process of supporting a loved one through end-of-life care is difficult to endure. I express my sincere condolences to Mrs Clark and her family for their loss.

Keywords: *Death in custody; Falls; Section 32 Powers*

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[20] Exhibit C6 at 7
[21] Exhibit C6 at 9