

# CORONERS COURT OF SOUTH AUSTRALIA

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## INQUEST INTO THE DEATH OF RONALD THOMAS CREEK

[2026] SACC 17

Inquest Findings of her Honour Deputy State Coroner Roper

19 June 2026

### CORONIAL INQUEST

Examination of the cause and circumstances of the death of a man who died following a fall while detained within the memory support unit of a residential aged care facility pursuant to section 32 of the *Guardianship and Administration Act 1993*.

Held:

1. Ronald Thomas Creek, aged 89 years of Christie Downs, died on 14 January 2023 as a result of traumatic intracranial haemorrhage and skull fractures following a fall, on a background of dementia and frailty.
2. Circumstances of death as set out in these findings.

No recommendations made.

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Counsel Assisting: MS R SCHELL

Hearing Date/s: 27/02/2026

Inquest No: 06/2026

File No/s: 0127/2023



**INQUEST INTO THE DEATH OF  
RONALD THOMAS CREEK  
[2026] SACC 17**

- 1 Ronald Thomas Creek was 89 years old at the time of his death on 14 January 2023. He had been a resident of the St Basil's Aegean Village (St Basil's) since 18 August 2022, where he lived alongside his wife.
- 2 On 9 January 2023 Mr Creek was found on the floor in the corridor with a laceration to his forehead. It was thought that he had hit his head on the doorframe. An ambulance was called and he was transferred to the Flinders Medical Centre.
- 3 A CT scan of his brain was performed which showed significant head injuries, including bleeding around and within the brain on both sides, with swelling causing a 4 mm shift of the brain to the left. There were also fractures to the right frontal skull, eye socket and sinus areas, as well as a forehead laceration. Following assessment of the severity of his injuries and poor prognosis, a decision was made in consultation with his substitute decision-makers to provide him with comfort care only. He was provided with subcutaneous pain relief and returned to St Basil's for end-of-life care.
- 4 He passed away peacefully on 14 January 2023.
- 5 At the time of his death, Mr Creek was a protected person under a guardianship order made pursuant to s 32(1)(b) of the *Guardianship and Administration Act 1993*. Accordingly, his death is a death in custody and requires a mandatory inquest pursuant to s 21 of the *Coroners Act 2003*, unless the death is certified to be from natural causes. The contribution of the fall to Mr Creek's death precluded such a certification.
- 6 As there was no factual ambiguity in the evidence that required clarification by oral evidence, the Court determined to conduct the inquest on the papers.

**Personal and medical background**

- 7 Mr Creek was a relatively recent arrival at St Basil's at the time of his death. Notwithstanding, he made a strong positive impression and was very well-liked and respected. He was described as a lovely gentleman.
- 8 Mr Creek would commonly wander the halls of his secure wing with his four-wheeled-walker, without direction or destination. His wife was able to visit him in the secure wing, and staff facilitated their time together. As recently as the day he died, he was observed to be walking about with his walker and playfully told one of the staff members to 'get out of the way', indicating that he was on the move.
- 9 Following his passing, Mr Creek was sadly missed by St Basil's staff.
- 10 Prior to his arrival at St Basil's, Mr Creek had been living at home independently with his wife. In April 2022, however, Mr Creek was diagnosed with a serious bladder infection with associated delirium. This led to a diagnosis of dementia, which had been suspected by those close to him for some time.
- 11 Mr Creek was initially taken to the Mount Barker District Soldiers' Memorial Hospital for treatment, however due to dementia-associated aggression towards the nurses, he was transferred to Flinders Medical Centre on 25 April 2022.

- 12 His symptoms progressively worsened, and he was transferred to a secure ward within the Noarlunga Hospital on 11 May 2022. Mr Creek's mobility also declined, resulting in falls. He wore head protection, including while sleeping, and hip protectors. He was noted to be confused and required assistance with all aspects of care. Due to concerns about his safety, an application was made to the South Australian Civil and Administrative Tribunal seeking special powers to authorise the detention of Mr Creek at his place of residence, and other orders to compel medical treatment. The orders sought were granted on 12 July 2022.
- 13 Eventually Mr Creek was transferred to the Repatriation General Hospital into the Specialist Advanced Dementia Unit, arriving on 5 July 2022. His medications were modified extensively during this admission. Consequently, there were no further difficulties with aggressive behaviour. A staff member of St Basil's visited him during this admission and indicated that St Basil's would be happy to accept him as a resident. Arrangements were made so that his wife Jean could also live there.
- 14 When Mr Creek moved into St Basil's alongside his wife on 18 August 2022, the Memory Support Unit of the Flinders Medical Centre continued to be involved in Mr Creek's care in an advisory capacity.
- 15 In addition to dementia, Mr Creek's medical history included incontinence, anxiety, atrial fibrillation, bronchitis, hearing impairment, depression, dizziness, dyslipidaemia, haematuria, hypercholesterolemia, hypertension, osteoarthritis, low blood platelets, gastro-oesophageal reflux disease and low magnesium.

### **What was the cause of Mr Creek's death?**

- 16 On 8 January 2023, Mr Creek was conveyed to the Noarlunga Hospital following a complaint of chest pain. An x-ray was conducted, which revealed a nodular lesion on Mr Creek's right lung. Options were canvassed for his treatment and Mr Creek returned to St Basil's.
- 17 The following day, however, Mr Creek had an unwitnessed fall in the corridor of his residence. He was located by staff at approximately 5:45 pm, unconscious and unresponsive. He was found partially inside another resident's room with his legs in the corridor. Mr Creek's head was positioned against the doorframe separating the room from the corridor. He was wearing his 'head buddy'. This is a soft padded protective headwear product designed to cushion the head against impact from falls.
- 18 First aid was administered, including the provision of supplemental oxygen, and Mr Creek was conveyed to the Flinders Medical Centre by ambulance.
- 19 Upon assessment at the Flinders Medical Centre, Mr Creek was found to have swollen facial fractures and an intracranial haemorrhage. Following discussions with his substitute decision-makers, it was decided that Mr Creek would be transitioned to comfort care.
- 20 Mr Creek returned to St Basil's and passed away on 14 January 2023.
- 21 Dr Erin O'Connor, a medical practitioner experienced in providing opinions as to cause of death, conducted an examination of Mr Creek's longitudinal medical history.

- 22 In consultation with forensic pathologist Dr Tiemensma, Dr O'Connor opined that the cause of Mr Creek's death was traumatic intracranial haemorrhage and skull fractures following a fall, on a background of dementia and frailty, and I so find.

**Were adequate measures taken to mitigate Mr Creek's falls risk?**

- 23 Prior to his bladder infection in April 2022, Mr Creek was known to have sustained several falls. He was assessed as a high falls risk during his admission to the Flinders Medical Centre, which was attributed to physical deconditioning, cognitive changes, multiple medications and reduced spatial awareness. His risk of falls continued into his time at St Basil's.
- 24 Mr Creek had 13 falls during his time at St Basil's. Strategies were implemented to minimise Mr Creek's falls risk, including encouraging Mr Creek to use his walking frame, ensuring that he was well-rested, and keeping his walking areas clear of obstructions. St Basil's also implemented measures to minimise falls injuries including the use of sensor mats, adjusting of his bed height, providing higher chairs, and the use of hip protectors. These measures were implemented following an assessment by a physiotherapist at the time of his admission. Mr Creek also wore a 'head buddy' at all times.
- 25 The Court received into evidence an affidavit from Mr Creek's friend of 40 years and joint substitute decision-maker, Ms Wright. Ms Wright expressed the following view about the care received by Mr Creek at St Basil's:

I had no complaints about the nursing home, you couldn't stop him walking about, he walked around and he did everything he wanted to, but his bodily functions were leaving him.<sup>1</sup>

- 26 More generally, Ms Wright described the overall care provided by St Basil's to be 'lovely'. She did not believe that anything further could have been done to prevent Mr Creek from falling, and considered his final fall to be very sad, but a part of getting older. I agree.
- 27 St Basil's conducted an internal investigation into the circumstances of the fall, with a view to minimising the risk of another resident colliding with a doorframe. While the outcome of that investigation is presently unknown, I am satisfied that St Basil's has taken, and will continue to take, all appropriate steps to minimise the risk of a similar incident occurring in the future.

**Conclusions**

- 28 Mr Creek was lawfully detained at the time of his death.
- 29 I have no recommendations to make.

*Keywords: Death in Custody; Section 32 Powers; Fall*

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<sup>1</sup> Exhibit C3 at [17]