FINDINGS of Coroner Andrew McKee following the holding of an inquest under the *Coroners Act* 1995 into the death of:

TERENCE MICHAEL KETTLE

Table of Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Andrew McKee, Coroner, having investigated the death of Terence Michael Kettle with an inquest held at Hobart in Tasmania, make the following findings.

Hearing Dates

8 December 2020

Appearances

Counsel Assisting the Coroner: Senior Constable A Barnes

Introduction

1. Mr Terence Michael Kettle, aged 69 years, died on 20 November 2018 from asphyxia after choking on some food whilst a resident at the Roy Fagan Centre (RFC), situated at Kalang Avenue, Lenah Valley.

2. At the time of his death Mr Kettle was the subject of an order made by the Guardianship and Administration Board in favour of the Public Guardian.

3. The order was expressed in the following terms and remained in effect until 6 December 2018:

"*The board orders*

1. That the Public Guardian be appointed as the represented person's guardian.
2. That the powers and duties of the guardian are limited to decisions concerning:

(i) where the represented person is to live either permanently or temporarily; and
(ii) consent to any health care that is in the best interests of the represented person and to refuse or withdraw consent to any such health care; and
(iii) providing consent to the provision of support services to the represented person; and
(iv) pursuant to section 28 of the Act, if the guardian has reasonable grounds to believe that the represented person is likely to suffer damage to his physical, emotional or mental health or wellbeing unless immediate action is taken, the guardian and the Commissioner

of Police (or his delegate) may take the following measures or actions to ensure that the represented person complies with any decision of the guardian in the exercise of the powers and duties conferred by paragraph 2(i) of this order;

(a) facilitate transport of the represented person to the place of residence determined by the guardian; and

(b) keep the represented person at the place of residence determined by the guardian from time to time; and

(c) return the represented person to that place of residence should he leave it; and

(d) to use such reasonable force as is necessary to effect the guardian's purpose, including chemical restraint.

3. That the order remains in effect to 6 December 2018."

4. I deemed that a public inquest was required to be held in respect of Mr Kettle's death as he was a person 'held in care' under the *Coroners Act* 1995 (the Act).

5. In making the findings below, I have had regard to the documentary evidence gained in the investigation into Mr Kettle's death and note the following documents were tendered at the inquest:

- Report of Death, Constable C Le Grange;
- Life extinct affidavit, Dr Paul Bremmer;
- Affidavit of identification, Constable C Le Grange;
- Post-mortem affidavit, Dr Donald Ritchey;
- Toxicology report, Neil McLachlan-Troup;
- Royal Hobart Hospital Death Report, Dr Paul Bremmer;
- Ambulance Tasmania report;
- Affidavit of Paul Howard, senior next of kin;
- Affidavit of Saneliso Ncube;
- Affidavit of Jack Karagiannakis;
- Affidavit of Constable C Le Grange;
- Affidavit of Constable L Hicks;
- Police incident list (ESCAD);
- General practitioner records, Dr Anthony Popiel;
- Royal Hobart Hospital records;
- Police notebook notes, Constable C Le Grange;

- Guardianship Order, Colin Mckenzie; and
- Dr Anthony Bell's report.

Was Mr Kettle a Person "Held in Care" under the Act?

6. If a person is, immediately before their death, a person 'held in care', then under the Act, a coroner is required to hold a public inquest.[1] The coroner is also required to report on the care, supervision or treatment of that person while they were held in care.[2] Relevantly, a 'person in care' under the Act is *"a person detained or liable to be detained in an approved hospital within the meaning of the Mental Health Act 2013"*.[3] RFC is a specialised hospital operated by the Tasmanian Health Service (THS) to assess and treat older persons with psychiatric illness and / or cognitive impairment. The RFC is an approved hospital under the *Mental Health Act* 2013.

7. Given the terms of order 2, in particular order 2 (iv)(a) to (d), I am satisfied that as a matter of fact, Mr Kettle was detained or liable to be detained at the RFC. He was not free to leave the approved hospital or to make his own medical decisions by virtue of the Guardianship Order.

8. I note and agree with the comments made by Coroner McTaggart in her findings following the inquest into the death of Molly Jesse Smith, where she stated:[4]

> *"The public policy rationale for the requirement in section 28(5) of the Act to report on the care, supervision or treatment is to ensure that the death of every person who is coercively held in any state run institution is carefully, independently and transparently examined'.*[5]

She further stated:

> *"It is therefore a question of fact as to whether the aspects of control or compulsion are present such that a person can be found to be detained, notwithstanding the absence of a formal order legitimising that detention."*[6]

9. As I have found that Mr Kettle is a person held in care under the Act, I am required to report on his care, supervision and treatment at the RFC.

---

[1] Section 24 (b) of the Act.
[2] Section 28(5) of the Act.
[3] Section 3 of the Act.
[4] [2017] TASCD 444
[5] Ibid p13
[6] Ibid p14

10. In compliance with that statutory obligation, I requested Dr Anthony Bell, an experienced medical practitioner attached to the Coroners Office, to review the care, treatment and supervision received by Mr Kettle at the RFC.

11. Dr Bell prepared a comprehensive report which was tendered at the inquest. Dr Bell, in that report, expressed the following opinion:

> *"In a very difficult case the care and attention were of high quality. The patient had been assessed and treated for swallowing dysfunction.*
>
> *There are no care issues."*

Background

12. Mr Kettle was born on 11 October 1949 at Scottsdale in Tasmania. At the date of his death he was a single man, never having married. He did not have any children.

13. He was one of five children born to the marriage of Cecil and Flo Kettle. His parents separated and Mr Kettle lived with his mother and step-father.

14. Mr Kettle was born with polio which affected the left side of his body. Mr Kettle had a limited education due to an intellectual disability. He was illiterate.

15. Mr Kettle spent his childhood in Scottsdale, Bridport and King Island. Whilst living on King Island, Mr Kettle obtained employment on a dairy farm. After leaving King Island he obtained employment at a tin mine in Rossarden.

16. In 1972 Mr Kettle moved to Deloraine and obtained employment with the Tasmanian Government Railways. He worked in a crew of four men undertaking repairs and conducting maintenance on railway lines and bridges. Mr Kettle was forced to retire from his position with the Tasmanian Government Railways after he was diagnosed as suffering from diabetes.

17. After his retirement from the Tasmanian Government Railways, Mr Kettle received a disability pension. He resided alone in Longford. Mr Kettle moved from Longford to Wynyard to live with his mother. He lived with his mother until her death in 1997. He lived independently until he was assessed as requiring care and he then commenced to reside at Emmerton Park, an aged care facility located in Smithton.

Mr Kettle's Medical History

18. After his mother's death, Mr Kettle's health began to decline. On average he was hospitalised once per year. His brother, and senior next of kin, Mr Paul Howard, swore an affidavit as part of the coronial investigation. That document was tendered at the inquest as C8. In that affidavit Mr Howard noted that Mr Kettle did not look after his health, he had a poor diet and on occasions would drink alcohol in excessive quantities.

19. In 2002 Mr Kettle's left leg was amputated below the left knee. He recovered well from that procedure and had a prosthesis fitted. Mr Kettle had issues with ulcers on his right leg.

20. In 2015 he was diagnosed with prostate cancer.

21. In the 18 months prior to his death, Mr Howard noted a significant decline in Mr Kettle's health and cognitive function. He noted Mr Kettle had issues with his speech and memory.

22. In 2017 it became apparent that Mr Kettle was unable to continue to reside on his own. He was made the subject of an emergency order made by the Guardianship and Administration Board. He underwent an ACAT assessment and was offered a placement at Emmerton Park in Smithton. Mr Kettle accepted the placement at Emmerton Park.

23. The Guardianship Order referred to in paragraph 3 was made on 7 December 2017.

24. In April of 2018 Mr Kettle's right leg was amputated. After the procedure he returned to Emmerton Park.

25. Upon his return to Emmerton Park Mr Kettle became difficult to manage. He was abusive to staff and medical practitioners. He caused damage to the facility. These behaviours were as a result of his cognitive impairments.

26. Mr Kettle presented to the North West Regional Hospital on 29 September 2018. Mr Kettle presented with a history of deteriorating behaviours with aggression, refusal of medications and foods, and threatening staff.

27. Due to his various behaviours Mr Kettle was transferred to the Roy Fagan Centre on 10 October 2018. On 20 October 2018 Mr Kettle presented with worsening agitation, abdominal pain and vomiting.

28. On 24 October 2018 he was transferred to the Royal Hobart Hospital for assessment. He was diagnosed with a urinary tract infection. His hyperglycaemia was treated with increased insulin. He was also treated for a non-ST segment elevation acute myocardial infarction.

29. On 7 November 2018 Mr Kettle was transferred to the Jasmine Ward at the Roy Fagan Centre.

Circumstances Leading to Mr Kettle's Death

30. On 19 November 2018, Mr Kettle was being assisted by Mr J Karagiannakis, a ward aide, to consume a toasted cheese sandwich.

31. Whilst eating the sandwich Mr Kettle commenced to cough and choke. Mr Karagiannakis immediately rendered assistance to Mr Kettle by moving him forward and performing back blows. Mr Karagiannakis called out for help and activated the duress alarm.

32. Nurse Ncube entered the room and pressed her duress alarm. Mr Karagiannakis left the room to seek assistance from other units. He believed the duress alarm had not activated.

33. Nurse Ncube continued performing back blows. Nurse Ncube then commenced CPR. Another nurse arrived and Mr Kettle was moved to the floor and CPR was continued.

34. An emergency ambulance was called. CPR was continued by nursing staff until the arrival of paramedics eight minutes and 30 seconds later. Whilst being treated by paramedics, Nurse Ackerly made contact with Dr A Syed who instructed that CPR was to continue and Mr Kettle should be intubated.

35. Records from Ambulance Tasmania indicate that Mr Kettle was intubated and transported to the Royal Hobart Hospital.

36. Mr Kettle was admitted to the Intensive Care Unit. After discussions with family members, a palliative approach to care was adopted. Mr Kettle died on 20 November 2018.

Post-Mortem Examination

37. A post-mortem examination was conducted by forensic pathologist, Dr Donald Ritchey MD, MSc, (American Board Pathology (Anatomic, Clinical and Forensic Pathology), FRCPA.

38. Dr Ritchey expressed the opinion in his affidavit tendered to the Court, that Mr Kettle's cause of death was asphyxia due to choking on food.[7] I accept Dr Ritchey's opinion.

39. I am satisfied based on the entirety of the evidence before me that there are no suspicious circumstances surrounding Mr Kettle's death.

Summary of Formal Findings

40. I find, pursuant to section 28(1) of the *Coroners Act* 1995, that:

    (a) The identity of the deceased is Terence Michael Kettle;
    (b) Mr Kettle died in the circumstances set out above;
    (c) Mr Kettle died as a result of asphyxia due to choking on food;
    (d) Mr Kettle died on 20 November 2018 at the Royal Hobart Hospital, Hobart in Tasmania.

Comments and Recommendations

41. I comment that, for the reasons contained in this finding, the care, supervision and treatment of Mr Kettle at the RFC was of a very good standard and in no way contributed to Mr Kettle's death.

42. I wish to acknowledge Senior Constable A Barnes' efforts in preparing the file for inquest and for her helpful submissions.

43. In concluding, I convey my sincere condolences to Mr Kettle's family.

Dated: 17 December 2020 at Hobart in the State of Tasmania

Andrew McKee
Coroner

[7] Exhibit C4