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

PHILIP PATRICK CLARK

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Philip Patrick Clark with an inquest held at Hobart in Tasmania make the following findings.

Hearing Date

12 March 2021

Representation

Counsel Assisting the Coroner: J Ansell

Introduction

1. Philip Patrick Clark died in the Roy Fagan Centre on 19 October 2019. He was 79 years of age at the time of his death and unable to make lifestyle financial decisions. At the time of his death an Emergency Guardianship and Administration Order was in place.

2. On the basis of the evidence at the inquest I make the following formal findings pursuant to section 28 (1) of the *Coroners Act* 1995:

    a) The identity of the deceased is Philip Patrick Clark;
    b) Mr Clark died in the circumstances set out further in this finding;
    c) The cause of Mr Clark's death was advanced dementia, atherosclerotic and hypertensive cerebral vascular disease and alcoholism; and
    d) Mr Clark died on 19 October 2019 at the Roy Fagan Centre, Kalang Avenue, Lenah Valley in Tasmania.

3. Mr Clark was born in Hobart, Tasmania on 3 August 1945. He was married at one stage, the father of four children but lived an apparently peripatetic life characterised by alcohol abuse.

4. By early 2017 Mr Clark was living in emergency accommodation at Flint House in Newtown. He was admitted to the Royal Hobart Hospital after suffering a fall at Flint House, allegedly due to an assault. He suffered a hairline hip fracture and his medical records indicate he was suffering delirium.

5. Following his discharge from hospital, he received rehabilitation care as an inpatient during which time he was diagnosed with an underlying cognitive impairment. This led to him being transferred from a nursing facility to the Roy Fagan Centre in October 2017. He stayed at the RFC until his death.

Circumstances of Death

6. It is evidence from the material tendered at the inquest, and in particular his medical records, that whilst at the RFC his health slowly declined. In the two months prior to his death, Mr Clark lost a substantial degree of mobility. His appetite declined and on 18 October 2019, appropriately in my view, a palliative approach to his care was adopted. He died the following day in the early afternoon.

Investigation

7. The fact of Mr Clark's death was reported in accordance with the requirements of the *Coroners Act* 1995. His body was formally identified and then taken by mortuary ambulance to the Royal Hobart Hospital. On 23 October 2019, at the Royal Hobart Hospital, experienced forensic pathologist, Dr Donald Ritchey, performed an autopsy. Following the autopsy Dr Ritchey provided a report. He expressed the opinion, which I accept, that the cause of Mr Clark's death was advanced dementia complicating atherosclerotic and hypertensive cerebral vascular disease and alcoholism. He noted the presence of centriacinar emphysema (no doubt a result of smoking).

8. Relevantly, Dr Ritchey did not find any fatal head injury or any evidence of a fall contributing to his death. There was no evidence either to suggest that Mr Clark had been in any way ill treated. His death was the result of natural disease.

Conclusion

9. The evidence at the inquest satisfies me to the requisite legal degree that the care, treatment and supervision of Mr Clark while he was an inpatient at the Roy Fagan Centre was entirely appropriate.

10. In the circumstances, there is no need for me to make any further comment or recommendations.

Dated: 25 March 2021 at Hobart in the State of Tasmania.

Simon Cooper
CORONER