MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Magistrate Simon Cooper, Coroner, having investigated the death of Shane Reginald Lockley

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Shane Reginald Lockley;
b) Mr Lockley died as a consequence of long term alcohol dependence, Wernicke-Korsakoff psychosis and dementia;
c) The cause of Mr Lockley's death was decompensated liver failure, advanced cirrhosis and chronic alcohol dependence;
d) Mr Lockley died on 1 July 2020 at the Royal Hobart Hospital, Hobart, Tasmania.

Introduction

In making the above findings I have had regard to the evidence gained in the investigation into Mr Lockley's death. The evidence includes:

- Police Report of Death for the Coroner;
- Tasmanian Health Service – Death Report to Coroner;
- Affidavits establishing identity and life extinct;
- Report – Dr Donald Ritchey, Forensic Pathologist;
- Royal Hobart Hospital – Records and Medical Reports;
- Medical Records – Claremont Medical Centre;
- Guardianship and Administration Ward Tasmania file;
- Affidavit – Ms Elizabeth Love, Mr Lockley's Guardian, sworn 2 September 2020;
- Affidavit - Mr John Dimech, support worker, sworn 19 March 2021;
- Affidavits - Constable Christo Le Grange, Investigating Officer, sworn 25; November 2020 and 15 March 2021; and
- Report – Dr AJ Bell, Medical Advisor to the Coroner's Office.

Despite several requests, Mr Lockley's sister, Ms Debra Parker, refused to provide an affidavit to assist the investigation in relation to her brother's death.

Other records indicate that he suffered from intellectual impairment from a young age and was functionally illiterate.

Mr Lockley had a lengthy and well-documented history of alcohol abuse and dependence. At the time of his death, he was the subject of an order made by the Guardianship and Administration Board, appointing a guardian because he could not look after himself.

He was living in supported accommodation at a residential aged care facility in Claremont. Mr Lockley's medical condition was such that he required regular treatment, which necessitated lengthy hospital admissions. His compliance with medication was variable and he was frequently aggressive towards staff. Nonetheless, he continued to be supported.

Mr Lockley's legal status

Mr Lockley's legal status at the time of his death was that he was the subject of a Guardianship Order made pursuant to the *Guardianship and Administration Act* 1995. The terms of that order were as follows:

1. *The Public Guardian continues as limited Guardian of Shane Reginald Lockley with power to:*
    i. *Make health care and/or medical decisions for Shane Reginald Lockley.*
    ii. *Determine which services Shane Reginald Lockley should access and provide consent to such as required.*
    iii. *Decide where Shane Reginald Lockley is to live with a permanently or temporarily.*
    iv. *Pursuant to section 28 of the Guardianship and Administration Act 1995, any police officer; [sic] ambulance officer and the Public Guardian are [sic] empowered to take the measures or actions specified below to ensure that Shane Reginald Lockley complies with any decision of the Guardian made under this order.*
    Specified measures or actions
        a. *The use of such reasonable force or physical restraint as is necessary to facilitate transport of Shane Reginald Lockley to Menarock Life "The Gardens" Aged Care Claremont or the Royal Hobart Hospital as determined by the Guardian from time to time; and to keep Shane Reginald Lockley there or return him there should he leave, contrary to the Guardian's decision.*

The *Coroners Act* 1995 (section 3) defines a 'person held in care' as meaning, relevantly:

> "*A person detained or liable to be detained in an approved hospital within the meaning of the Mental Health Act 2013 or in a secure mental health unit or another place while in the custody of the controlling authority of a secure mental health unit, within the meaning of that Act*".

I do not consider that Mr Lockley was a person held in care within the meaning of the *Coroners Act* 1995. He was not detained in an approved hospital or secure mental health unit at the time of his death.

He was not, as a matter of law, liable to be detained in such a place at the time of his death.

The terms of the Order of the Guardianship and Administration Board, whilst authorising the use of reasonable force of physical restraint (assuming that to have been lawful) did not authorise his detention anywhere, and particularly not in an approved hospital within the meaning of the *Mental Health Act* 2013 or in a secure mental health unit.

Mr Lockley therefore was not 'held in care' at the time of his death. It follows, by reason of the operation of section 24 of the *Coroners Act* 1995, that there is no obligation on my part to hold an inquest in relation to Mr Lockley's death. In addition, I do not consider there would be any benefit in holding an inquest in the circumstances. No additional witnesses are likely to come forward if an inquest is held and the circumstances of Mr Lockley's death are clear.

Circumstances of death

On Thursday 25 June 2020, Mr Lockley was admitted, at the request of his Guardian, to the Royal Hobart Hospital. His treatment team decided to proceed with ward based management in light of his poor health and prognosis. Mr Lockley's condition continued to deteriorate and it was decided to transition his treatment to palliative care.

Whilst in hospital he suffered a fall. I am satisfied the fall did not cause or contribute to his death.

Mr Lockley's condition continued to deteriorate and he died at about 7.20 am on Wednesday, 1 July 2020.

Investigation

Mr Lockley's body was formally identified and then examined by the Tasmanian State Forensic Pathologist, Dr Donald Ritchey. Dr Ritchey also reviewed Mr Lockley's extensive medical records. Dr Ritchey provided a report in which he expressed the opinion that the cause of Mr

Lockley's death was decompensated liver failure complicating advanced cirrhosis on a background of chronic alcohol dependence. He noted significant contributing factors were alcoholic dementia and Wernicke-Korsakoff psychosis. I accept Dr Ritchey's opinion.

In light of the fact that he was the subject of supervision, I requested the medical advisor to the Coronial division Dr Anthony J Bell to review his care and treatment. Dr Bell provided a report in which he expressed the opinion that there were no issues in relation to Mr Lockley's medical treatment. I accept Dr Bell's opinion.

Conclusion

I am satisfied that Mr Lockley was well supported and that there are no suspicious circumstances associated with his death. The care and treatment he received in the lead up to his death was of an appropriate standard.

Comments and Recommendations

The circumstances of Mr Lockley's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mr Lockley.

Dated 2021 at Hobart in the State of Tasmania.

Simon Cooper
Coroner