MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Robert Webster, Coroner, having investigated the death of Mr Bogdan Dora

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

a) The identity of the deceased is Bogdan Dora ('Mr Dora');

b) Mr Dora died in the circumstances set out further in this finding;

c) Mr Dora's cause of death was aspiration of gastric contents; and

d) Mr Dora died on 26 February 2019 at Lenah Valley, Tasmania.

1. In making these findings, I have had regard to the evidence gained in the investigation into Mr Dora's death which includes:

- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Affidavit of Dr Donald Ritchey, State Forensic Pathologist;
- Affidavit of Suzanne Dora;
- Affidavit of Casey Pagano, Tasmania Police (rank not stated);
- Affidavit of Alice Herbert, Tasmania Police (rank not stated) ;
- Medical records of Mr Dora obtained from the Royal Hobart Hospital (RHH);
- Medical records of Mr Dora obtained from the Roy Fagan Centre (RFC), and general practitioners.
- Miscellaneous documentation.

Mr Dora's legal status

2. Mr Dora's legal status at the time of the 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, made on 30 January 2019[1], are that Suzanne Dora be appointed as Mr Dora's guardian with powers and duties limited to decisions concerning where Mr Dora is to live permanently or temporarily.

3. Section 3 of the *Coroners Act 1995* defines a 'person held in care' as meaning:

> "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."[2]

4. Was Mr Dora, immediately before his death, a person held in care? The answer to this question is an important one because if it is in the affirmative, then I must hold an inquest.[3] In addition, in inquests concerning a person held in care, a coroner must, in addition to their usual findings under section 28(1), report on the care, supervision or treatment of the deceased person while they were a person held in care.[4]

5. Under s 140 of the *Mental Health Act* 2013, an approved hospital is one which is notified by the Minister in the Gazette. However, section 4(1) of the *Mental Health (Transitional and Consequential Provisions) Act* 2013 operates to recognise hospitals that were approved under the previous *Mental Health Act* 1996 as approved hospitals under the current *Mental Health Act 2013*. Under section 9 of the *Mental Health Act* 1996, the Minister approved the RFC as a hospital under that Act.[5]

6. The principles of statutory interpretation require words in legislation to be interpreted according to their ordinary meaning, within the context in which they appear. Extrinsic materials may be used to assist interpretation where the provision is ambiguous or obscure.[6] In this case, the ambiguity is sufficient to invoke the assistance of extrinsic materials.

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[1] The order says it remains in effect until 30 January 2022. Prior to that order an emergency guardianship order, appointing the Public Guardian, as Mr Bogdan's guardian was made on 21 December 2018.
[2] This is subparagraph (b) of the definition. Subparagraph (a) is inapplicable as it is limited to children.
[3] See s24(1)(b) of the *Coroners Act* 1995.
[4] *Coroners Act* 1995 s 28(5).
[5] Tasmania, Gazette, 3 October 2007, 1518
[6] *Acts Interpretation Act* 1931 s8B

7. The *Coroners Act* 1995 when first passed by Parliament contained the following definition of a 'person held in care':

> … a person detained or liable to be detained under the Mental Health Act 1963 in a hospital within the meaning of that Act.

8. This original definition made it clear that the detention or liability to detention must be under the (then current) *Mental Health Act.*

9. On 1 November 1999, the definition of a 'person held in care' was amended by the *Mental Health (Consequential Amendments) Act* 1996 to read:

> … a person detained or liable to be detained in an approved hospital within the meaning of the Mental Health Act 1996.

10. The second reading speech for that amending Act does not specifically mention the amendment to the *Coroners Act*. It referred only to amendments to a significant number of Acts due to the repeal of the *Mental Health Act 1963* and the enactment of the *Mental Health Act 1996*.[7]

11. The definition was further amended as a result of the *Mental Health Amendment (Secure Mental Health Unit) Act 2005* to read:

> ….a person detained or liable to be detained in an approved hospital within the meaning of the Mental Health Act 1996 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

12. This amendment was sought to extend jurisdiction to the then newly created secure mental health unit, without otherwise amending the first limb of the definition.[8]

13. On 17 February 2014, the definition was amended pursuant to the *Mental Health (Transitional and Consequential Provisions) Act 2013* to replace the reference to the *Mental Health Act 1996* to the current *Mental Health Act 2013*. This amendment led to the definition of a 'person held in care' being in its current form.

14. It is apparent, therefore, there was no express intention in the legislature to make broader the class of persons detained or liable to be detained by omitting on amendment the first appearing reference to the *Mental Health Act 1963*. Omitting the

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[7] Tasmania, *Parliamentary Debates,* House of Assembly, 3 October 1996, TJ Cleary (Minister for Transport on behalf of the Minister for Community and Health Services)

[8] Tasmania, *Parliamentary Debates,* House of Assembly, 8 November 2005, DE Llewellyn (Minister for Health and Human Services)

name of the Act in the first limb was likely to have been simply for the purpose of streamlining the phrase as a whole, rather than changing the class of persons who are said to be "held in care". Therefore, the sequence of amendments are reflective only of the changing of other legislation, providing an indication that the phrase 'a person detained or liable to be detained' should be interpreted as it originally was, being applicable only to those detained or liable to be detained specifically under the *Mental Health Act*.

15. Reinforcing this view, legislative provisions are to be interpreted as a whole and in context, rather than word by word.[9] The assumption that words will be read in context often leads to the omission of words. As noted, it appears that the drafter of the amendment has chosen not to repeat the phrase 'within the meaning of the *Mental Health Act*' after both phrases 'a person detained or liable to be detained' and 'in an approved hospital'. By using the phrase only at the end of both parts within the definition, a sensible contextual approach involves its applicability to the entirety of each clause.

16. The definition of a person held in care relies on the deceased person being within 'approved hospitals' and 'secure mental health units'. These are places that are specifically defined under the *Mental Health Act*.[10] They are only defined as such in other Acts by reference to the *Mental Health Act*.

17. Similarly, the phrase 'another place while in the custody of the controlling authority' is also linked to the *Mental Health Act*. The definition of 'controlling authority' in the *Coroners Act* refers to its definition in the *Mental Health Act*. The frequent use of terms specific to the *Mental Health Act* creates the context in which the entirety of the definition of 'person held in care' should be interpreted.

18. For the above reasons, I am satisfied that a person who is detained or liable to be detained within an approved hospital (as gazetted under the *Mental Health Act)* must be so detained or liable to be detained under the *Mental Health Act* and not otherwise.

19. Involuntary assessment and treatment orders[11] permitting detention of a person under the *Mental Health Act* 2013 may only be made in respect of a person who has a mental illness.[12]

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[9] *Ghali v Chief Commissioner of State Revenue* (2013) 85 NSWLR 378 at [21]
[10] *Mental Health Act* 2013 ss 3 and 140
[11] See Part 3 of Chapter 2 of the Mental Health Act 2013
[12] *Mental Health Act* 2013 ss 25 and 40

20. 'Mental illness' is defined in s 4 of the *Mental Health Act* as follows:

> **"**(1) For the purposes of this Act –
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> (a) a person is taken to have a mental illness if he or she experiences, temporarily, repeatedly or continually –
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> (i) a serious impairment of thought (which may include delusions); or
>
> (ii) a serious impairment of mood, volition, perception or cognition; and
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> (b) nothing prevents the serious or permanent physiological, biochemical or psychological effects of alcohol use or drug-taking from being regarded as an indication that a person has a mental illness.
>
> (2) However, under this Act, a person is not to be taken to have a mental illness by reason only of the person's –
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> (a)…
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> (k) intoxication (however induced); or
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> (l) intellectual or physical disability; or
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> (m) acquired brain injury; or
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> (n) dementia; or
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> (o) temporary unconsciousness."

21. In this case the medical records disclose Mr Dora had been diagnosed with dementia which is a recognised mental illness. The records however do not disclose he was subject to involuntary assessment and treatment orders. He was therefore not detained or liable to be detained under the *Mental Health Act*. Accordingly I do not consider Mr Dora was a person held in care within the meaning of the *Coroners Act 1995* even though he had a mental illness and the RFC is an approved hospital under the *Mental Health Act 2013*. In addition the terms of the Guardianship Order did not authorise Mr Dora's detention anywhere, and particularly not within an approved hospital or a secure mental health unit within the meaning of the *Mental Health Act 2013*.

19. Mr Dora was therefore not 'held in care' at the time of his death. It follows that, by reason of the operation of s24(1) of the *Coroners Act 1995*, there is no obligation on my part to hold an inquest in relation to Mr Dora's death. In addition even though I have a discretion to hold an inquest if I consider it desirable to do so[13] I do not

[13] Coroners Act 1995 s24(2).

consider there would be any benefit in holding an inquest in this case because the circumstances of Mr Dora's death are clear.

Background

20. Mr Dora was born on 8 August 1944 in Germany. He had a sister who predeceased him and no other siblings. He had a number of nieces, nephews and cousins who lived in South Australia and Tasmania. Mr Dora moved to Australia at age 5 due to World War II, living first in Victoria for a very short time before settling in Tasmania. He was married twice. He had a daughter from his first marriage who sadly predeceased him. At the time of his death, he was married to Suzanne Dora who he had been married to since 1985. He was living at the RFC at Lenah Valley in Tasmania. They did not have any children together.

21. Mr Dora lived an active lifestyle and loved sports. He played numerous sports, including tennis, football, squash, and golf until late in life. He played and coached soccer for many years. Before retiring in 1997, Mr Dora worked in numerous roles for Telstra. He was very handy and was constantly making objects such as furniture for the house.

Medical history

22. Mr Dora was a smoker from a young age and he developed a nicotine dependency. He eventually gave up smoking in 2018 upon entering RFC. A hospital record from 2014 shows Mr Dora was then smoking 20 cigarettes per day. Another from 2018 suggested Mr Dora was smoking 30 cigarettes per day and he was a heavy smoker. While Mr Dora frequently consumed alcohol in his younger years, this decreased as he aged.

23. I have examined the medical records of the Royal Hobart Hospital and Mr Dora's general practitioner. These records show Mr Dora had an extensive medical history. In 2005, Mr Dora was diagnosed with cancer. As a result, in 2007, Mr Dora had a left deltoid malignant fibrosarcoma excised. Records show this surgery was successful in preventing a recurrence of the cancer. In 2007, he was diagnosed with chronic obstructive pulmonary disease and hypertension. In 2011, Mr Dora was diagnosed with osteoarthritis. Mr Dora underwent a left total knee replacement in 2014 and right total knee replacement in 2016. On 18 December 2014, he had a cell

neuroendocrine carcinoma of the right upper lung lobe excised at the Hobart Private Hospital.

24. Mr Dora first exhibited dementia symptoms, such as forgetfulness, four years prior to his death. By the end of 2018, Mr Dora's dementia had progressed to a stage where he could not recognise family members or remember his personal history. He also developed aggressive behaviours that his wife, Suzanne, struggled to manage. Mr Dora was diagnosed with advanced dementia on 18 December 2018.

25. Mr Dora was admitted to the RFC in Lenah Valley on 24 December 2018. He was admitted because he had taken to barricading himself in his home and refusing entry to others in addition to becoming aggressive towards his wife. Mrs Dora was burdened by her own medical issues and she could not remain as his at-home, sole carer. His family confiscated the keys to his car in late 2018 as Mr Dora was still attempting to drive despite his progressing dementia.

26. Upon admission to RFC, it was noted in the records Mr Dora showed signs of aggression, threats of violence, and self-neglect.

27. On 13 January 2019, Mr Dora was transferred to the Royal Hobart Hospital (RHH) for right lower quadrant pain with a CT scan identifying colitis as a cause, before he returned to RFC on 17 January 2019. On admission to the RHH, Mr Dora was assessed as a high falls risk as "the patient can be unsteady on his feet".

History of falls

28. The RFC in-patient progress notes disclose Mr Dora fell on 7 occasions while at the RFC. The details of the first 5 falls are as follows:

- On 26 December 2018 Mr Dora fell in his bedroom at about 17:40 hours. The fall was unwitnessed and the duress alarm was sounded. He was assessed by Dr Fasnacht and no injuries were sustained. Mr Dora was uncooperative with the post fall observations and the falls risk assessment tool (FRAT) was updated to high. His relatives were notified.

- On 18 January 2019, Mr Dora again fell in his bedroom at 02:00 hours which was unwitnessed. The FRAT status was recorded as 'high.' Post-fall observations were only partially completed as he was uncooperative. Mr Dora's family were

not alerted on this occasion, possibly due to the late hour and the fact that he suffered no obvious acute injury.

- On 20 February 2019, Mr Dora had an unwitnessed fall at 12:30 hours in his bedroom. The FRAT status was recorded as 'high.' RFC staff completed all four required post-fall observations, which suggests Mr Dora was compliant. No obvious injuries were detected however Mr Dora's family was advised of the incident.

- On 23 February 2019, Mr Dora had a witnessed fall at 16:30 hours in the outdoor area to the ward. RFC staff completed all four required post-fall observations, indicating Mr Dora was compliant. Mr Dora's family was advised of the incident. Mr Dora suffered a skin tear to his left elbow and a graze to his left shoulder. RFC cleaned the wound and administered first aid. Following this fall, a 'high falls risk' alert was issued for Mr Dora.

- On 24 February 2019, Mr Dora had a witnessed fall at 18:30 hours in his bedroom. The FRAT status was recorded as 'high.' RFC staff were able to complete all four required post-fall observations, once again indicating that Mr Dora was compliant. His family was advised of the incident. Mr Dora did not suffer any obvious injuries.

Circumstances leading to Mr Dora's death

29. On 26 February 2019, Mr Dora suffered two falls in the four hours prior to his death. The first occurred at 16:20 hours. The RFC 'fall alert' document does not indicate whether this fall was witnessed. Mr Dora was found lying conscious on the floor next to a chair in the lounge area. Records show he was uncooperative with the post-fall observations and as such these were not completed. His family was advised of the incident. The RFC records show the attending doctors did not find Mr Dora showing any signs of seizure activity. There was no evidence of a head strike and Mr Dora's pupils were equal and dilated. He did not suffer injuries as a result of this fall. It was concluded that the fall was related to the underlying dementia process.

30. The second fall occurred at 17:40 hours in his bedroom. This fall was unwitnessed but the duress alarm was activated (presumably by Mr Dora). Mr Dora was uncooperative with the post-fall observations so these were not able to be completed. Dr Fasnacht attended to Mr Dora and noted he was exhibiting hypotensive, seizure-like activity,

and incontinence. Dr Fasnacht's notes record that Mr Dora suffered seizures and appeared to be approaching the terminal phase of dementia. Mr Dora's 'Medical Goals of Care plan' was updated to 'palliative' in light of the seizure activity and end-stage dementia diagnosis. The change of care plan does not include a time of update, but I infer Dr Fasnacht updated it following the second fall because it includes a reference to seizure activity.

31. At 20:15hours Mr Dora was located deceased in his bed by RFC staff members. He had no pulse and he was cold to the touch. Staff exited and locked the room and awaited the arrival of police.

Investigations

32. An examination of both the deceased and the scene by Tasmania Police officers found no suspicious circumstances. In particular, there were no signs of violence or disturbance.

33. The State Forensic Pathologist, Dr Ritchey, performed a post-mortem examination on 28 February 2019. Dr Ritchey found:

> *"… a normally developed, frail appearing elderly Caucasian man with advanced natural disease of the heart and its blood vessels. There was a severe calcified atherosclerosis of the aorta and its major branches and there was a thrombus within the proximal portions of the superior mesenteric artery (the main artery supplying blood to the gastrointestinal tract). There was copious food debris and gastric contents within the trachea. Histologic sections of [the] lung confirmed large volume aspiration of gastric contents."*

34. Dr Ritchey determined that Mr Dora died from aspiration of gastric contents, significantly contributed to by advanced dementia and emphysema. I accept Dr Ritchey's opinion. Aspiration occurs when food, drink, or foreign objects are breathed into the lungs. The 7 falls described above are therefore not a cause of death. Dr Ritchey found a common contusion on the lower lateral left-side of the chest, a contusion on the left shoulder and left elbow and small contusions on the lateral left knee. These appear to me to be consistent with the most recent falls. There were no scalp contusions, skull fractures or intracranial collections of blood and there were no soft tissue injuries of the neck or any recent or healing rib fractures.

35. Because of the circumstances surrounding Mr Dora's death I arranged for the medical advisor to the Coronial Division of the Magistrates Court, Dr Bell, to review the medical care he received. In his report Dr Bell notes Mr Dora's medical history. He notes a diagnosis of advanced dementia on 18 December 2018 the major features of which were restlessness and agitation. Admission to RFC on 24 December 2019 is noted. He also notes a history of forgetfulness. Recent deterioration led to disorientation and the development of violence towards Mrs Dora who was Mr Dora's main carer. Over the last few days before his admission Mr Dora had barricaded himself in the family home preventing his wife's entry. His memory was poor, familiar faces were not recognised, he refused to perform activities of daily living and a clinical examination was refused. An emergency guardianship order was made and medication treatment was commenced. Over the next 4 days his behaviour improved but he remained disorientated.

36. By 4 January 2019 he had settled but he continued to be intrusive and confused. He appeared happy and was redirectable. His appetite was mostly good. On 13 January 2019 Mr Dora was admitted to the RHH with suspected appendicitis. It was noted he had increased confusion, decreased appetite and he looked unwell. There was fever, tachycardia and complaints of right lower quadrant abdominal pain. Clinical examination was consistent with acute appendicitis. A CT scan of the abdomen showed a loculated thick walled fluid collection in the right lung base consistent with a prior or current empyema (a collection of pus in the plural cavity). The appendix was identified and did not appear inflamed. There was an eccentric thickening of the rectum and minor thickening of small bowel loops raising the possibility of inflammatory bowel disease. Mr Dora was treated with intravenous antibiotics. The respiratory physician Dr Hewer was consulted and he indicated the chest collection had been present on private radiology scans. Pain continued until 16 January 2019. A working diagnosis of caecal colitis was made. Mr Dora was transferred back to the RFC on 17 January 2019 and over the next 5 weeks he deteriorated with increasing dementia, the onset of falls and possible seizure activity. Dr Bell notes Dr Ritchey's opinion as to the cause of death.

37. Dr Bell concludes by saying the notes disclose no medical issues in this case. Dr Bell considers the management of Mr Dora's condition at RFC appears sound and of a good standard. I accept Dr Bell's opinion.

Comments and Recommendations

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

39. I extend my appreciation to investigating officer Constable Alice Herbert for her thorough investigation and report.

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

Dated: 11 August 2022 at Hobart in the State of Tasmania.

Robert Webster
Coroner