
FINDINGS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 (Tas) into the death in care of:

David Richard Dufty

Record of Investigation into Death (With Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Simon Cooper, Coroner, having investigated the death of David Richard Dufty

Hearing Dates

With an Inquest held at Hobart on 20 September 2018

Appearances

E Avery – Counsel Assisting the Coroner

Introduction

1. On 11 January 2017 David Richard Dufty, aged 58, died in the Intensive Care Unit (ICU) of the Royal Hobart Hospital (RHH). At the time of his death Mr Dufty was the subject of a treatment order made by the Mental Health Tribunal under the *Mental Health Act 2013*.
2. Mr Dufty's death is subject to the *Coroners Act 1995* (the "Act"). The Act provides that an inquest must be held where a death occurs in Tasmania and the deceased person was, immediately before their death, a person held in care.
3. Section 3 of the Act provides that a person is in care if that person was 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. As a consequence, an inquest in relation to Mr Dufty's death was mandatory. In most other jurisdictions in Australia, an inquest is also mandatory in such circumstances.

4. The ambit of any coronial investigation is defined by the *Act*. Relevantly, section 28 provides:

"(1) A coroner investigating a death must find, if possible –

- (a) the identity of the deceased; and
- (b) how death occurred; and
- (c) the cause of death; and
- (d) when and where death occurred; and
- (e) the particulars needed to register the death under the [Births, Deaths and Marriages Registration Act 1999](#).
- (f)

(2) A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.

(3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

(4) A coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence.

(5) If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that person was escaping or attempting to escape from prison, a secure mental health unit, a detention centre or police custody, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care."

5. Section 28(5) of the *Act* imposes an obligation to report on the care, supervision or treatment of Mr Dufty in this case. The rationale for such a requirement is the public policy reason to ensure that the death of every

person who is detained against their will in any state-run institution by reason of an order of a court, tribunal, or the executive is carefully, independently and transparently examined. In Waller's *Coronial Law and Practice in New South Wales* (third edition) at page 28 it is said that:

“Society, having effected the arrest and incarcerations of persons who have seriously breached its laws, owes a duty to those persons, of ensuring that their punishment is restricted to this loss of liberty and is not exacerbated by ill treatment or privation while awaiting trial or serving their sentences. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the government provides a positive incentive to custodians to treat their prisoners in a humane fashion and satisfies the community that deaths in such places are properly investigated.”

Mr Dufty's Background

6. Mr Dufty suffered chronic schizophrenia for many years. His mental health meant he had numerous admissions as an inpatient for treatment. Many of those admissions were involuntary, i.e. as the result of an order under the applicable mental health legislation, which compelled him to be hospitalised and to undertake a particular course of treatment against his will.
7. He also suffered type 2 diabetes that appears to have been reasonably well controlled by medication.
8. Mr Dufty's mother says that his schizophrenia was controlled by maintenance treatment of electro-convulsive therapy (ECT).

Circumstances of Death

9. On 9 December 2016, after a period of increasing psychosis, Mr Dufty was admitted to the RHH under the terms of a mental health order. On 5 January 2017 while still in the RHH, as he was about to undergo ECT, an anaesthetist reviewing him prior to the procedure noted Mr Dufty was suffering tachypnoea,

tachycardia and wheezy breathing sounds. As result, the ECT procedure was not proceeded with and various investigations including ultrasound and CT scan were carried out. The investigations revealed the fact that he was suffering from untreatable pancreatic cancer. A palliative approach to his care was adopted, a reasonable decision in the circumstances, and he died in the ICU six days later.

10. The fact of Mr Dufty's death was reported to the Coroner's Office and investigated under the terms of the *Act*. Nothing suspicious about his death was identified. His body was examined by experienced forensic pathologist Dr Donald MacGillivray Ritchey MD, MSc, FRCPA who also reviewed his medical records. He found no signs of violence or injury on Mr Dufty's body.
11. Dr Ritchey expressed the opinion that the cause of Mr Dufty's death was metastatic carcinoma of the pancreas. I accept Dr Ritchey's opinion.

Formal Findings

12. On the basis of the evidence at the inquest, I find, pursuant to Section 28(1) of the *Coroners Act* 1995, that:
 - a. The identity of the deceased is David Richard Dufty;
 - b. Mr Dufty died in the circumstances set out in this finding;
 - c. The cause of Mr Dufty's death was metastatic carcinoma of the pancreas; and
 - d. Mr Dufty died on 11 January 2017 at the Royal Hobart Hospital, Hobart, Tasmania.

Comments, recommendations and report on care, supervision or treatment

13. I am affirmatively satisfied on the basis of the evidence at the inquest that the care and supervision of Mr Dufty was of an acceptable standard and in no way caused or contributed to his death.

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

Dated 19 October 2018

Simon Cooper
Coroner