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

ROGER ALAN GIBSON
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Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Roger Alan Gibson 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. Mr Gibson died on 29 July 2020 at the Roy Fagan Centre, Kalang Avenue, Lenah Valley. His 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.

2. At the time of his death, Mr Gibson was the subject of an order made under the provisions of the Guardianship and Administration Act 1995. Accordingly, an inquest in relation to his death was mandatory. The investigation and inquest focused upon his care, treatment and supervision whilst he was subject to that order at the Roy Fagan Centre.

3. Having regard to the evidence at the inquest I make the following findings pursuant to Section 28 (1) of the Coroners Act 1995:

   a) The identity of the deceased is Roger Alan Gibson;
   b) Mr Gibson died in the circumstances set out in this finding;
   c) The cause of Mr Gibson’s death was aspiration pneumonia; and
   d) Mr Gibson died on 29 July 2020 at the Roy Fagan Centre, 54 Kalang Avenue, Lenah Valley.

Background

4. Mr Gibson at the time of his death was a 65 year old man.1

1 Exhibit C1
5. For 25 years up until his hospital admissions, Mr Gibson was living in Perth, northern Tasmania with his partner Ms Christine Challis. The couple did not have any children together, although Mr Gibson had three children of a previous relationship – two sons and a daughter. His son lived locally.\textsuperscript{2}

6. Evidently a hard-working man, Mr Gibson was employed as a truck driver for Boral for his working life. He was forced to retire in 2014 because of memory and cognition difficulties.\textsuperscript{3}

Health

7. The evidence at the inquest demonstrated that Mr Gibson had numerous health conditions prior to the diagnosis of Alzheimer’s disease. His conditions, physical in nature, included osteoarthritis, hyperlipidaemia, diabetes and prostate adenocarcinoma.\textsuperscript{4}

8. It is evident that Mr Gibson was a heavy smoker, smoking around 20 cigarettes a day. Two years prior to his death, to his considerable credit, Mr Gibson, encouraged by Ms Challis, managed to give up smoking altogether.\textsuperscript{5}

9. Mr Gibson first started displaying signs of short-term memory loss in about 2011. Short-term memory loss prompted, in part, his decision to retire from truck driving. It got no better and in 2016 he was diagnosed with neurodegenerative dementia.\textsuperscript{6} The following year, 2017, saw Mr Gibson diagnosed with Alzheimer’s disease, a symptom of which was expressive aphasia (partial loss of the ability to produce language).\textsuperscript{7}

10. Sadly, with the onset of the disease, Mr Gibson began to demonstrate aggressive behaviour. He would on occasion become violent even towards persons he loved. Due to this behaviour, Mr Gibson was placed in respite.\textsuperscript{8}

11. Initially, Mr Gibson was admitted into Japara Aged Care in Riverside. Mr Gibson’s aggressive behaviour continued. He lashed out at staff. Ms Challis, who evidently loved him dearly, was frightened to visit him.

\textsuperscript{2} Exhibit C8
\textsuperscript{3} Exhibit C8
\textsuperscript{4} Exhibit C9
\textsuperscript{5} Exhibit C7
\textsuperscript{6} Exhibit C6
\textsuperscript{7} Exhibit C6
\textsuperscript{8} Exhibit C7
12. On 6 January 2020, Mr Gibson was taken from Japara Aged Care to the Launceston General Hospital. Mr Gibson remained at the Launceston General Hospital until 16 March 2020, where he was transferred to the Roy Fagan Centre in Hobart.9

Circumstances of Death

13. On 16 March 2020, Mr Gibson was admitted to the Roy Fagan Centre. Records tendered at the inquest noted evidence of severe dementia and that Mr Gibson was a significant falls risk.

14. Relevantly, his records indicate the following timeline:

(a) On 19 March 2020, an Emergency Guardianship Order was made. Medication changes were made with risperidone weaned and olanzapine commenced by 26 March 2020.10

(b) On 8 April 2020, Mr Gibson was manageable with improved behaviour. He wandered outside. Olanzapine was increased and valproate decreased.11

(c) On 17 June 2020, Mr Gibson’s behaviour was worsening. He displayed multiple episodes of unprovoked aggression. There was a high risk of violence to staff and other patients. The dementia was worsening since his admission.12

(d) On 9 July 2020, Mr Gibson had a serious episode of aggression and violence, with considerable danger to other patients as well as staff. Mr Gibson was over aroused and as a consequence sedative drug doses were increased and a low dose of fentanyl commenced. He was required to have security. Over the following week, his health continued to deteriorate.13

(e) On 17 July 2020, Mr Gibson underwent a COVID 19 test due to continual coughing and flu like symptoms. The test was negative however he was subsequently diagnosed with pneumonia.14 The same day, a CT scan was performed. It showed no evidence of injury but evidence of reduced white matter consistent with the diagnosis of dementia.15

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9 Exhibit C7/Exhibit C6
10 Exhibit C6
11 Exhibit C6
12 Exhibit C6
13 Exhibit C6
14 Exhibit C1
15 Exhibit C5
15. Treatment for the pneumonia included Mr Gibson being sedated and taking minimal fluid. There was no real improvement and his death by now was imminent.

16. At 4.00am on Wednesday 29 July 2020, Mr Gibson was checked on by a number of staff. His breathing was laboured and was not improving. Staff made a decision to insert a tube and attempt to suction some of the fluid out. At 4.30am, Mr Gibson appeared comfortable and nursing staff left the room to write notes.16

17. At 5.50am Mr Gibson was checked and he had passed away.17

Comments and Recommendations

18. The evidence at the inquest outlined an appropriate standard of care for Mr Gibson. There is nothing further that could have been done for Mr Gibson. The care and treatment he received was entirely appropriate in the circumstances.

19. There is no need therefore for me to make any other comments or recommendations.

20. I extend my respectful condolences to the family of Mr Gibson.

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

Simon Cooper
Coroner

16 Exhibit C1
17 Exhibit C1