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

ALEC LAURENCE BESTER

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Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Andrew McKee, Coroner, having investigated the death of Alec Laurence Bester with an inquest held at Hobart in Tasmania make the following findings.

Hearing Date

17 March 2021

Representation

Counsel Assisting the Coroner: Senior Constable A Barnes

Introduction

Mr Bester died on 7 May 2019 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.

At the time of his death, Mr Bester 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.

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 Alec Laurence Bester (also known as Peter Bester)
- b) Mr Bester died in the circumstances set out in this finding;
- c) The cause of Mr Bester's death was aspiration pneumonia complicating advanced multifactorial dementia and
- d) Mr Bester died on 7 May 2019 at the Roy Fagan Centre, 54 Kalang Avenue Lenah Valley

Evidence

I am satisfied that this matter has been comprehensively investigated and the relevant issues have been fully explored. I have taken into account and considered the evidence tendered at the inquest namely:

- CI – Report of Death;

- C2 – Life Extinct Affidavit, Dr Thomas Boyle;
- C3 – Affidavit of Identification, Constable D Natoli;
- C4 – Affidavit of Identification, A Cordwell
- C5 – Post-mortem report by Forensic Pathologist; Dr D Ritchey;
- C6 – Medical Report – Dr H Lake;
- C7 – Medical Report – Royal Hobart Hospital, Tasmanian Health Services;
- C8 – Medical Report – Royal Hobart Hospital, Chest X-ray;
- C9 – Affidavit of Mr R Bester;
- C10 – Affidavit of Mr L Bester;
- C11 – Affidavit of Ms J Ackerley;
- C12 – Affidavit of Constable M Redburn;
- C13 – Affidavit of Constable D Natoli;
- C14 – Property Receipt;
- C15 – Police Record;
- C16 – Report from the medical advisor to the Coronial Division, Dr A Bell; and
- C17- Guardianship Board Order

Background

Mr Bester was born on 8 March 1941 at Parramatta in New South Wales. His family relocated to Tasmania from New South Wales. His parents separated when he was 10 years of age and he and his siblings were placed in State care.

Mr Bester obtained employment at the slaughterhouses based on the Hobart wharf.

Mr Bester had several occupations throughout his working life. He was a fireman, bus driver and delivery driver. He met and married Miss R Green. Their marriage produced one son. The marriage ended in divorce.

Mr Bester suffered from alcohol dependency. Both his brother and son provided significant support to Mr Bester in relation to his alcohol dependence.

Records maintained by Tasmania Police indicate a number of interactions between officers of Tasmania Police and Mr Bester due to his behaviour when affected by alcohol.

Medical records indicate he was unable to manage his basic self-care requirements and nutritional needs. He presented as socially isolated, particularly vulnerable and lacking insight into his situation.

In 2016 Mr Bester rental unit was destroyed by fire. He was removed from his respite accommodation.

In July of 2016 he was assessed by an Aged Care Assessment Team as requiring high level residential respite care.

Mr Bester was provided accommodation at Flint House. This tenancy was placed at risk due to Mr Bester behaviours. He was eventually evicted from Flint House.

On 4 August 2017 the Guardianship and Administration Board made an order appointing the Public Guardian as Mr Bester's guardian. The order remained in effect until 3 August 2020.

On 10 August Mr Bester was admitted to the Roy Fagan Centre under the care of Dr H Lake. Throughout his time at the Roy Fagan centre Mr Bester did not have any visitors.

Health

Mr Bester did not regularly attend upon a medical practitioner and as such little is known about his general health prior to 2013.

Reports would indicate that he had a history of gout, arthritis, ischaemic heart disease, dementia and alcohol dependency.

The evidence before me discloses that Mr Bester was admitted to the New Norfolk District Hospital in 2013 in relation to his living conditions caused by his alcoholism.

Mr Bester was case managed through Older Persons Mental Health Services. I am satisfied that significant efforts were made to promote Mr Bester's independence and to enable him to continue to live independently.

In August of 2017 a decision was made requiring Mr Bester to reside at the Roy Fagan Centre. He was required to be accommodated at the Roy Fagan Centre due to dementia (which was primarily alcohol related) and a range of psychosocial factors that precluded him from living in a less restrictive environment.

Throughout his admission at the Roy Fagan Centre various options were explored to enable Mr Bester to be discharged. There were no private residential facilities that could accommodate his care needs. Mr Bester was resistant to accepting support services which would enable him to live independently. Interstate options were explored but were unavailable.

Whilst at the Roy Fagan Centre Mr Bester displayed a number of inappropriate behaviours.

Dr Anthony Bell, an experienced medical practitioner attached to the Coroner's Office, has reviewed the care provided to Mr Bester. In a report dated 2 February 2021 Dr Bell opined that the care provided to Mr Bester was of a good standard. I accept Dr Bell's opinion.

Circumstances Leading to Mr Bester's Death

On 6 May 2019 Mr Bester had both his lunch and evening meal. He retired to his bedroom at around 6.00pm. At 8.30pm enrolled nurse, Ms J Ackerly, was advised by staff that Mr Bester had become unwell and had vomited after his evening meal.

His was assessed by registered nurse, Ms M Price. She noted Mr Bester was unwell but alert and orientated. Observations were continued. Mr Bester was monitored closely and on a regular basis.

He was located deceased at 4.11am. Mr Bester was identified and transferred to the mortuary.

Post Mortem Examination

A post mortem examination was conducted by forensic pathologist Dr D Ritchey.

Dr Ritchey provided the following opinion regarding Mr Bester's cause of death:

"The cause of death of this 78 year old man, Alec Laurence Bester, was aspiration pneumonia complicating advanced multifactorial dementia. Significant contributing factors were chronic alcoholism and emphysema.

Mr Bester was under a guardianship order at the Roy Fagan Centre where he was cared for because of poor functionality associated with advanced dementia in the setting of chronic alcohol use. He developed emesis in the hours prior to being found dead in his bed.

The autopsy revealed a normally developed and nourished elderly Caucasoid man with bilious liquid in the trachea and lower airways."

I accept Dr Ritchey's opinion as to Mr Bester's cause of death.

Comments and Recommendations

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

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

I extend my condolences to the family of Mr Bester.

Dated: 4 August 2021 at Hobart in the State of Tasmania.

Andrew McKee
Coroner

EXPLANATORY NOTATION

On 29 July 2021 Coroner Olivia McTaggart, as Delegate of the Chief Magistrate for the State of Tasmania, directed that the investigation by Coroner Andrew McKee into the death of Mr Alec Laurence Bester be re-opened and the findings be re-examined on the ground that they contained mistakes. The findings made by this document follow that re-opened investigation and replace those previous findings made on 12 May 2021.

Andrew McKee, Coroner