MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (with inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, have investigated the death of John Andrew Dortkamp.

With an inquest in Hobart Coroners Court on the 15 July 2015.

Jurisdiction:
John Andrew Dortkamp died whilst an inpatient at the Millbrook Rise Centre on 7 October 2014. At the time of his death, Mr Dortkamp was the subject of at treatment order made pursuant to section 37 of the *Mental Health Act* 2013. Section 24 of the *Coroners Act* 1995 provides that an inquest must be held if the deceased "was immediately before death a person held in care".

Section 3 of the Coroners act 1995 defines a "person held in care" to mean, *inter alia*, a person subject to an order of the type that applied to Mr Dortkamp at the time of his death.

Formal findings:

In every case the subject of a coronial investigation, section 28 of the *Coroners Act* requires a Coroner to make, if possible, various findings. In that regard, the evidence at the inquest persuades me that the following findings should be made:

a) The identity of the deceased is John Andrew Dortkamp;
b) John Andrew Dortkamp died in the circumstances set out below;
c) John Andrew Dortkamp died as a result of hypertrophy of the heart;
d) John Andrew Dortkamp died on or about 7 October 2014 at Millbrook Rise Centre - Clyde unit 3, Hobart Road, New Norfolk in Tasmania; and
e) John Andrew Dortkamp was born in Albury, New South Wales on 3 November 1953 and was aged 60 years; he was a single man and a pensioner at the date of his death.

Background:
John Andrew Dortkamp was born in Albury, New South Wales on 3 November 1953. His parents are both deceased and he is survived by a brother Paul and a sister Catherine. Contact with his family was infrequent during his life.

It is apparent on the material tendered at the inquest, that he was a long-term sufferer of schizophrenia. After having a variety of labouring-type jobs Mr Dortkamp was unemployed for a significant period of time. His mental illness meant he qualified for, and was in receipt of, a disability support pension for a number of years.

His brother Paul says he was in a relationship for a time however he was uncertain whether Mr Dortkamp ever married or had any children. There is no evidence that he did.

Mr Dortkamp moved to Hobart in the early 1990s from the north coast of New South Wales.

In January 2013 he was admitted to the Royal Hobart Hospital after it was found he was having difficulty managing his own self-care.

In March 2013, he was transferred to Mistral Place, a mental health facility. He absconded from that facility and was subsequently returned to the Royal Hobart Hospital. There it was determined that he should be transferred to the Millbrook Rise Centre at New Norfolk. This occurred in March 2013. Initially, Mr Dortkamp was cared for in a secure section of that facility but was eventually transferred to an open ward, where he lived until his death.

Mr Dortkamp was a heavy smoker for most of his life. He developed and suffered from severe emphysema. He was diagnosed with schizophrenia in 1982.

He was being treated for both conditions whilst at Millbrook Rise. Mr Dortkamp was prescribed medication for both conditions.

On 9 September 2014, the Tasmania Mental Health Tribunal made a treatment order pursuant to section 37 of the *Mental Health Act* 2013. That order was to remain in effect until 2:00pm on 8 March 2015. It was in force at the time of Mr Dortkamp's death.

Circumstances surrounding the death:

The evidence tendered at the inquest leads me to make the following findings of fact. At approximately 7:30pm on Monday 6 October 2014, Mr Dortkamp attended supper. After supper he had a cigarette or two and then went to bed at 8:30pm as was his normal practice.

He was checked by a registered nurse at 10:30pm the same evening and again at 12:30am on 7 October 2014. On both occasions he was seen to be asleep on his bed.

At 2:35am on Tuesday 7 October 2014, the same registered nurse again checked on Mr Dortkamp. She discovered he was not on his bed where he had been when she had checked at 10.30pm and 12:30am. She entered his room. She found Mr Dortkamp lying on his left side with his face turned down on the floor of the room's ensuite. He was non-responsive. The nurse immediately called for staff assistance and then for an ambulance.

CPR was commenced by nursing staff and continued until ambulance officers arrived roughly 10 minutes later. Attempts were continued until 3:20am to resuscitate Mr Dortkamp. Unfortunately those attempts were unsuccessful.

The response of staff at the Millbrook Rise Centre and Tasmanian Ambulance Service personnel was entirely appropriate in the circumstances.

After formal identification, Mr Dortkamp's body was transported by mortuary ambulance to the Royal Hobart Hospital. There an autopsy was carried out by Dr Christopher Hamilton Lawrence, the State Forensic Pathologist. Dr Lawrence found that the cause of Mr Dortkamp's death was hypertrophy of the heart. His heart was found to be significantly enlarged weighing 730g when a normal weight is 400g – 450g. I accept this opinion.

As part of the coronial investigation samples taken at autopsy were analysed at the laboratory of Forensic Science Service Tasmania. Nothing of any significance was detected as a result of that toxicological analysis.

Report on Mr Dortkamp's care:

Section 28 (5) of the *Coroners Act* 1995 provides:

> "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."

There is a very sound policy reason underpinning this legislative requirement. It is fundamentally important that the death of every person who is detained in any state-run institution by reason of an order of a court, tribunal or the executive is carefully and transparently examined.

The consideration of the care and treatment afforded to Mr Dortkamp involved reviewing his medical records and obtaining reports from his treating medical practitioners. A review of that care and treatment leads me to conclude that Mr Dortkamp's care and treatment was entirely appropriate. The investigation shows that Mr Dortkamp had been, in the period leading up to his death, successfully treated for a chest infection. He was also being medicated for schizophrenia and emphysema. I am satisfied that the Millbrook Rise Centre provided an appropriate level of supervised care, and appropriate treatment, for Mr Dortkamp.

Comments & recommendations:

As has already been noted, Mr Dortkamp was the subject of an order made by the Mental Health Tribunal at the time of his death. As part of the investigation under the *Coroners Act* 1995 a request was made of the Tribunal for material relating to the making of that order. Some difficulties were identified in this regard, largely arising from the Tribunal practice of not keeping the original application. I observe that the Tribunal has ceased this practice as a result of reviewing its procedures. I also acknowledge the high level of assistance provided by the Tribunal during this investigation.

The circumstances of Mr Dortkamp's death do not require me to make any further comments nor any recommendations.

I thank Senior Sergeant Michelle Plumpton for her assistance as counsel in this matter. I commend Constable Fred Nyhouse on a thorough investigation.

In concluding, I convey my sincere condolences to the family of Mr Dortkamp.

Dated: 17 July 2015 at Hobart in the state of Tasmania.

Simon Cooper
CORONER