CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 3rd day of March and the 8th day of May 2020, by the Coroner's Court of the said State, constituted of Anthony Ernest Schapel, Deputy State Coroner, into the death of Bryan Robert Hall.

The said Court finds that Bryan Robert Hall aged 71 years, late of Perry Park Aged Care, 26 River Road, Port Noarlunga, South Australia died at the Repatriation General Hospital, 216 Daws Road, Daw Park, South Australia on the 15th day of January 2017 as a result of general inanition on a background of end-stage mixed pattern dementia and acute renal failure. The said Court finds that the circumstances of his death were as follows:

1. <u>Introduction, cause of death and reason for inquest</u>

1.1. Mr Bryan Robert Hall died at the Repatriation General Hospital (RGH) on 15 January 2017. He was 71 years of age at the time of his death.

1.2. It was not necessary for a post mortem examination to be carried out in respect of Mr Hall's remains. Rather, a review of Mr Hall's clinical circumstances and of his medical history was conducted by medical professionals at Forensic Science South Australia. Their report[1] states the cause of Mr Hall's death was general inanition due to end-stage mixed pattern dementia and acute renal failure. I accept that evidence and find that to have been the cause of Mr Hall's death.

1.3. At the time of his death Mr Hall was subject to a Level 2 Inpatient Treatment Order (ITO) which had been imposed under the Mental Health Act 2009. His death was

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[1] Exhibit C2a

therefore a death in custody for which an inquest was mandatory pursuant to the provisions of the Coroners Act 2003. These are the findings of that inquest.

2. <u>Medical history and background</u>

2.1. Mr Hall was born in the United Kingdom. He met his wife, Mrs Pauline Hall, in 1964. They were married in 1967 and had three daughters together. They lived at Morphett Vale.

2.2. In 1998 Mr Hall and his wife moved to Melbourne for his work at Radio Frequency Systems where he was a supervisor in respect of operations connected with digital radio towers. In 2007 Mr Hall was made redundant by his employer company. At around that time he was diagnosed with depression. In Mrs Hall's statement[2] she notes that in hindsight, in her opinion Mr Hall was experiencing symptoms of dementia that had affected his ability to work and which may have contributed to his redundancy. In 2012 Mr Hall was diagnosed with dementia.

2.3. Mr Hall had a medical history that included Alzheimer's dementia, vascular dementia, transitional cell carcinoma, bladder cancer, hypertension, depression, carotid artery stenosis, intracranial arteriovenous malformation, chronic renal disease, seizures, and chronic lung disease.

2.4. In about 2013 Mr Hall and his wife established an enduring power of attorney and advanced care directive. Mrs Hall was named as a substitute decision-maker for Mr Hall[3].

2.5. Mr Hall experienced three seizure-type episodes while living in Melbourne. The first occurred when he was having his car serviced. The second took place approximately three to six months later at home. The third occurred at a respite facility where Mr Hall was being cared for while his wife was at work.

2.6. In 2014 Mr Hall and his wife returned to Adelaide. Mrs Hall states that prior to the diagnosis of dementia Mr Hall was always very fit and hardworking. He was never aggressive and was very loving and genuine. I accept that assessment of Mr Hall.

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[2] Exhibit C1

[3] Exhibit C17

3. The circumstances of Mr Hall's death

3.1. Between 11 September 2014 and 13 July 2016 Mr Hall was treated for his dementia and other ailments by Dr Ian Pope at the Reynella Medical Centre.

3.2. On 21 October 2014 Mr Hall was admitted to the Noarlunga Hospital following a suspected neurological seizure at a shopping centre. The hospital notes indicate that Mr Hall had experienced six similar episodes within the previous twelve months[4].

3.3. On 13 July 2016 Dr Pope discussed with Mr Hall and his wife the option of moving Mr Hall into Perry Park Hostel, a residential care facility. Consideration was given to this due to his difficulty in managing his medication and to his behavioural symptoms[5]. Mr Hall was accepted into Perry Park Hostel on 19 August 2016.

3.4. On 27 September 2016 Mr Hall was transferred to Noarlunga Hospital by the South Australian Ambulance Service due to blood in his urine. However, he was discharged later that day. He had undergone bladder cancer removal at St Andrews Hospital.

3.5. On 7 October 2016 a palliative care plan was executed by Mrs Hall. This was designed to cater for the contingency of Mr Hall's further deterioration. In this event the focus of his care would be on comfort such that no artificial measures would be taken to replace and support bodily functions[6].

3.6. On 29 November 2016 Mr Hall was transferred from the Perry Park Hostel to the Noarlunga Hospital following a suspected urinary tract infection and for aggression that no doubt was the product of his illness and which was not in keeping with his usual character and demeanour. Unfortunately the Noarlunga Hospital was not able to manage and provide appropriate care for Mr Hall. A request was made that he be transferred to the RGH. The discharge summary from Noarlunga Hospital describes Mr Hall as exhibiting aggressive behaviour due to dementia and Proteus urinary colonisation[7].

3.7. On 15 December 2016 Mr Hall was transferred to the Geriatric Evaluation and Management Unit - Ward 5 at the RGH. He would remain there until his death on 15 January 2017. Mr Hall's clinical course from his admission to his death is described

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[4] Exhibit C15, page 9
[5] Exhibit C7
[6] Exhibit C15, page 37
[7] Exhibit C15

in the statement of Dr Amalia Spiliopoulou, a geriatrician consultant physician working at the RGH[8]. The admission summary from the RGH describes the strategies used to manage Mr Hall's behaviour and cognition, as well as those to address possible falls and risks, circumstances which Dr Spiliopoulou states are common in patients with dementia. During much of his stay at the RGH Mr Hall would want to wander around the ward in an agitated and disoriented state. He became increasingly aggressive and had physical altercations with people[9]. One incident culminated in Mr Hall being pushed to the ground. Although staff did not witness this fall, it was considered likely that there was no head strike[10].

3.8. Staff conducted hourly neurological observations as a precaution and found that Mr Hall was in the normal range.

3.9. Mr Hall had recurrent falls during his admission which Dr Spiliopoulou stated was directly related to previous strokes and to the progression of his dementia. Mr Hall would refuse to take his medications and would spit them out[11].

3.10. Mr Hall’s behaviour began to deteriorate over the Christmas period. At around 4am on 26 December 2016 Mr Hall was restrained due to verbal and physical aggression. He was shackled due to this persisting aggression. As a result he was placed under a Level 1 ITO by medical officer Rose Turner which was later confirmed by psychiatrist Dr Taryn Cowain[12].

3.11. During the afternoon of 26 December 2016 Mr Hall experienced an unwitnessed fall and was attended to immediately. He then had a second fall while staff were changing his pad. There was no known head strike or loss of consciousness.

3.12. Mr Hall continued to display aggressive behaviour. He had poor fluid and food intake, was uncooperative and refused observations and medication. On 30 December 2016 Mr Hall was placed on a Level 2 ITO due to this behaviour. The ITO would remain in place until his death.

3.13. On 7 January 2017 Mr Hall experienced another fall in the sun room when he misjudged the chair that he was intending to sit on. Another patient witnessed the fall and there

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[8] Exhibit C6
[9] Exhibit C16, page 67
[10] Exhibit C16, page 102
[11] Exhibit C16, page 117
[12] Exhibit C16, page 130

was a presumed head strike. A CT scan was taken but no intracranial bleeding was found[13].

3.14. On 8 January 2017 Mr Hall's neurological observations were checked hourly and were in the normal range. He was sleeping for long periods of time. At about 8:30am staff discussed resuscitation with Mrs Pauline Hall who reconfirmed her wishes not to prolong Mr Hall's suffering. She expressed the understandable desire that her husband should remain in comfort and die with dignity. Mrs Hall elected to stop providing him with intravenous hydration. From this point forward Mr Hall was treated palliatively.

3.15. In the days prior to Mr Hall's death he was very drowsy and slightly resistive. Another CT scan was taken which showed no intracranial bleeding, although his Glasgow Coma Scale had dropped. He was provided comfort care but refused to take anything by mouth and resisted mouth care.

3.16. On 15 January 2017 Mr Hall's daughter, Ms Natalie Hall, was present in Mr Hall's room when she noticed a change in his breathing and that he had quickly become cool to touch[14]. She alerted staff and Mr Hall was declared deceased by medical officer Anthony Chuang at 3:25am that morning.

4. **Conclusions**

4.1. The circumstances of Mr Hall's death were thoroughly investigated by police. Tendered to the Court was the comprehensive report[15] prepared by Senior Constable Jake Wild of the South Coast Criminal Investigation Branch. I find myself in agreement with Mr Wild's conclusions which I will come to in a moment.

4.2. As pointed out in the statement of the geriatrician, Dr Spiliopoulou[16], progressive decline in physical, cognitive, functional and emotional health is the natural course of progression for all neurodegenerative diseases, including dementia. The doctor asserts that it is very common for such sufferers to have falls even at early stages of the disease and towards the end stage of it and that at least fifty per cent of such persons are not able to mobilise and are practically bed bound or wheel chair bound. I accept that evidence. The decline in Mr Hall typified that seen in many cases that come before this Court. Although Mr Hall's behaviours were part of the reason why he was detained

[13] Exhibit C16, page 257
[14] Exhibit C3
[15] Exhibit C12a
[16] Exhibit C6, page 6

under the Mental Health Act 2009, it is clear that these behaviours were the product of his illness and should not in any way be stigmatised. I trust I made that clear to members of Mr Hall's family during the course of this inquest. It is obvious that prior to Mr Hall being afflicted with this illness he had been a productive member of the community and a much-loved family man.

4.3. At the inquest Mr Hall's daughter, Ms Natalie Hall, addressed the Court. I note from Ms Hall's statement[17] that from 9 January 2017 until the day of his death, she did not leave her father's side other than in relation to a few trips to her home address. In addressing the Court Ms Natalie Hall described the staff at the Repatriation General Hospital as amazing and absolutely phenomenal. This assessment is not inconsistent with the conclusions expressed by Mr Wild in his report. Mr Wild concluded, based on the evidence that his investigation gathered, and which was tendered to the Court, that the Inpatient Treatment Orders imposed upon Mr Hall were appropriate and that the level of care Mr Hall received was also appropriate insofar as staff attempted to provide the highest level of care with minimal interventions. I agree with those conclusions.

4.4. I find that Mr Hall's Inpatient Treatment Orders were lawfully and appropriately imposed in his own interests. I find that his care at the Repatriation General Hospital, the hospital in which Mr Hall was detained, was of a high standard. I also find that Mr Hall's circumstances of detention did not in any way contribute to his death.

5. <u>Recommendations</u>

5.1. I make no recommendations in this matter.

Key Words: Death in Custody; Natural Causes; Inpatient Treatment Order

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 8th day of May, 2020.

Deputy State Coroner

Inquest Number 7/2020 (0093/2017)

[17] Exhibit C3