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 14th day of July and the 22nd day of December 2022, by the Coroner's Court of the said State, constituted of Naomi Mary Kereru, Coroner, into the death of Wayne John Shore.

The said Court finds that Wayne John Shore aged 55 years, late of 29 Kakara Avenue, Ingle Farm, South Australia died at the Royal Adelaide Hospital, Port Road, Adelaide, South Australia on the 8th day of May 2020 as a result of right intracerebral haemorrhage and left middle cerebral artery cerebrovascular accident on a background of infective endocarditis, end stage renal failure, multiple myeloma and ischaemic and valvular heart disease. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Wayne John Shore was born on 29 May 1964 and died on 8 May 2020 at the Royal Adelaide Hospital (RAH). He was 55 years of age.

1.2. A pathology review was conducted by Dr Alexandra Yuill of Forensic Science South Australia (FSSA). Her suggested cause of death was '*right intracerebral haemorrhage and left middle cerebral artery cerebrovascular accident in a man with infective endocarditis, end stage renal failure, multiple myeloma and ischaemic and valvular*

heart disease'.[1] Dr Yuill discussed her findings with forensic pathologist, Dr Cheryl Charlwood, who agreed with her conclusions.

1.3. I find Mr Shore's cause of death to be right intracerebral haemorrhage and left middle cerebral artery cerebrovascular accident on a background of infective endocarditis, end stage renal failure, multiple myeloma and ischaemic and valvular heart disease.

2. Reason for Inquest

2.1. Mr Shore was the subject of a Level 1 Inpatient Treatment Order (ITO) under the Mental Health Act 2009. During the period of its imposition, Mr Shore suffered an extensive intracranial haemorrhage which ultimately contributed to his death.

2.2. In law this meant that Mr Shore's death was a death in custody within that meaning of the expression in the Coroners Act 2003:

> 'death in custody means the death of a person where there is reason to believe that **the death occurred, or the cause of death, or a possible cause of death, arose, or may have arisen, while the person was**…detained.' [2]

2.3. This inquest was a mandatory inquest pursuant to section 21(1)(a) of that Act.

2.4. The reason for the imposition of the ITO will be detailed below.

3. Background

3.1. Mr Shore was born in South Australia in 1964. He never married or had children. Mr Shore's parents separated when he was young, and his father moved to Western Australia.

3.2. Mr Shore moved to Western Australia for work when he was 17 years of age. It is not clear when he returned to live in South Australia, but when he did, he moved into his maternal grandmother's house at Jakara Avenue, Ingle Farm.

3.3. Following a workplace injury in 2005 Mr Shore stopped working and became the carer for his maternal grandparents. Following their deaths, Mr Shore became the carer for his maternal uncle, Rudy Siegler, who also resided at the same address.

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[1] Exhibit C1a

[2] Coroners Act 2003 (SA) section 3, my own emphasis.

3.4. Mr Shore remained at his maternal grandmother's house until his final admission to the RAH.

4. Mr Shore's medical history

4.1. Mr Shore had a complex medical history. In September 2014 he was admitted to the Intensive Care Unit (ICU) of the Lyell McEwin Hospital (LMH) suffering from septic shock due to a staphylococcus aureus septicaemia. As a result of contracting septicaemia, Mr Shore's heart valve became infected. Consequently, he underwent an aortic and mitral valve replacement in his heart at the RAH. The valve replacement surgery required Mr Shore to take anticoagulant therapy. Mr Shore also sustained damage to his kidney as a result of this infective illness.

4.2. In 2019 Mr Shore was diagnosed with multiple myeloma. In January 2020 Mr Shore's renal function deteriorated and he was commenced on haemodialysis three times per week. He also commenced a course of chemotherapy at the same time for the multiple myeloma.

4.3. To facilitate the haemodialysis, a central line was inserted into the internal jugular vein in Mr Shore's neck. That put him at risk of infection during the administration of haemodialysis.

5. Mr Shore's decline in health

5.1. Between January and April 2020 Mr Shore had multiple admissions to hospital and in April 2020 he was diagnosed with endocarditis of his artificial mitral valve.

5.2. On 1 May 2020 Mr Shore was admitted to hospital after suffering a left middle cerebral artery ischaemic stroke. An endovascular procedure was performed and the clot was removed from the middle cerebral artery. After this procedure Mr Shore displayed significant cognitive impairment, dysphasia and a lack of insight into his condition.

5.3. It was in that context that Mr Shore expressed to clinicians his desire for no further treatment. He specifically stated that he did not want to continue with haemodialysis or chemotherapy, and he then expressed the intention to end his life by driving his car

into a tree. Mr Shore also displayed signs of aggression and irrational behaviour requiring a number of code blacks to be called.

5.4. As a result of Mr Shore’s expressed suicidal ideation and desire to leave hospital, combined with the left middle cerebral artery cerebrovascular accident, a Level 1 ITO was put in place on 4 May 2020.

5.5. The following day, 5 May 2020, an application was brought before the South Australian Civil and Administrative Tribunal (SACAT) to place Mr Shore under a section 32 Guardianship Order following a number of aggressive or violent episodes. It was determined that Mr Shore at that stage was not rational. The Guardianship Order was granted and the Public Advocate was made Mr Shore's guardian for the following 21 days.

5.6. On 5 May 2020, Mr Shore came under the care of Dr Michelle Kiley, consultant neurologist. Dr Kiley obtained consent from the Public Advocate to continue with haemodialysis, anticoagulation therapy and antibiotics for Mr Shore’s infective endocarditis.

6. Circumstances of Mr Shore’s death

6.1. On the morning of 6 May 2020, whilst subject to the Level 1 ITO, Mr Shore suffered sudden onset headache, vomiting and a reduced conscious state. An urgent CT scan of his brain was performed which showed a right-sided intracerebral temporal lobe haemorrhage with intraventricular extension.

6.2. Mr Shore's anticoagulation was reversed immediately. At 1pm on the same day a medical emergency team (MET) call was made in relation to Mr Shore. He was found to be extremely drowsy, difficult to rouse, with roving eye movements and exhibiting Cheyne-Stokes respirations. This was considered by Dr Kiley to indicate further swelling of the right cerebral hemisphere, an extension of the mass effect, and further raised intercranial pressure.

6.3. During this time there was consultation with the Neurosurgery Department. Given that the effects of the anticoagulant would still be evident (notwithstanding the reversal), it was considered too dangerous to operate to remove the intracerebral haemorrhage,

which was thought to be due to a mycotic or an infected aneurysm in his brain, directly related to his endocarditis.

6.4. Dr Kiley consulted both with Dr Chen Peh, the renal physician looking after Mr Shore, and Dr Angelina Yong, the haematologist managing Mr Shore's multiple myeloma.

6.5. As a team, they concluded that with reference to the conditions of infective endocarditis, end-stage renal failure, and multiple myeloma, Mr Shore's life expectancy was in the order of months. Those conditions had been complicated by what Dr Kiley described as '*devastating strokes in both hemispheres*' and, as a result, any chance of meaningful neurological recovery was extremely poor. Furthermore, since the insertion in 2014 of the aortic and mitral artificial valves, Mr Shore's survival depended on being anticoagulated. The administration of this medication was now contraindicated in the presence of the intracerebral haemorrhage.

6.6. It was deemed that there were many factors likely to lead to Mr Shore's imminent death, hence it was unanimously decided to provide Mr Shore with palliative care, and the Guardianship Board was notified. Haemodialysis was discontinued and antibiotics were withdrawn.

6.7. The Level 1 ITO was no longer considered necessary and it was revoked on 7 May 2020.

6.8. Mr Shore died on the morning of 8 May 2020, the eighth day of his admission.

6.9. While Mr Shore was not the subject of an ITO at the time of his death, I find that he suffered from the medical event that ultimately brought about or contributed to his death at the time the ITO was in place; namely the right-sided intracerebral lobe haemorrhage.

7. <u>Conclusion</u>

7.1. I find that the care Mr Shore received during his last inpatient admission was appropriate and of a high standard.

7.2. I find that the ITO and the Guardianship Order were both valid and appropriate.

7.3. Consistent with the conclusions of the investigating officer, Brevet Sergeant Andrew Porter, there were no suspicious circumstances or indications of the involvement of any third party in the death of Mr Shore.

8. Recommendations

8.1. I make no recommendations.

Key Words: Death in Custody; Natural Causes; Inpatient Treatment Order; Section 32

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

Seal the 22nd day of December, 2022.

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Coroner

Inquest Number 13/2022 (0905/2020)