



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign King at Adelaide in the State of South Australia, on the 28th day of February and the 22nd day of May 2024, by the Coroner's Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of Robert John Hough.

The said Court finds that Robert John Hough aged 72 years, late of 13/15 Ballater Avenue, Campbelltown, South Australia died at Disability Living, 98-100 Military Road, Semaphore South, South Australia on the 19th day of July 2021 as a result of asphyxia due to upper airway obstruction due to choking on food. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

- 1.1. Robert John Hough, born on 23 June 1949, died on 19 July 2021 at the Disability Living care facility in Semaphore South. He was 72 years of age.
- 1.2. Dr Alexandra Yuill of Forensic Science South Australia undertook a pathology review which was discussed with Dr Karen Heath, forensic pathologist.¹ The suggested cause of death was 'asphyxia due to upper airway obstruction due to choking on food', and I so find.

2. Reason for inquest

- 2.1. At the time of his death Mr Hough was under a guardianship order with special powers pursuant to Section 32(1)(b) of the Guardianship and Administration Act 1993, and his

¹ Exhibit C2a

death was not of natural causes. His death was therefore subject to a mandatory inquest pursuant to Section 21 of the Coroners Act 2003.

3. Medical history

- 3.1. On 4 March 1999 Mr Hough was admitted to the Flinders Medical Centre with a closed head injury after suffering a fall from a height onto a concrete floor.
- 3.2. He suffered from a left temporal lobe contusion, cerebral oedema with midline shift to the right, and a fracture of the right petrous bone. He needed an emergency craniotomy and evacuation of an acute subdural.
- 3.3. On 29 April 1999, now living with an acquired brain injury, Mr Hough was transferred to the Julia Farr Centre, where he remained until June 1999.
- 3.4. On 16 March 2014, Mr Hough presented to the Flinders Medical Centre after suffering a fall thought to be related to a seizure. A scan did not reveal any problems and excluded any acute infection and confirmed drug compliance. He was monitored in the hospital before being allowed to return home.
- 3.5. In August 2014 Mr Hough was admitted to the Flinders Medical Centre suffering from psychosis and paranoia secondary to the 1999 brain injury. During this admission, on 15 August 2014, an interim guardianship order with special powers of detention was granted. A full order was confirmed on 26 August 2014. Mr Hough remained at hospital from the time of this admission in August 2014 until January 2015.
- 3.6. In March 2015 Mr Hough was admitted to the Flinders Medical Centre after refusing to allow carers into his home and medication non-compliance. He remained there until November 2015 when he was discharged to reside at Disability Living at 13/15 Ballater Avenue, Campbelltown.
- 3.7. Mr Hough's medical situation was complex as a result of the acquired brain injury, as well as being diagnosed with sick sinus syndrome, hearing problems, dysphasia and depression. As a result of his acquired brain injury, he was also prone to seizures and psychosis and reportedly had no insight into this. He was on a variety of medications over the years to attempt to alleviate his medical ailments.

- 3.8. On 11 April 2021 Mr Hough moved temporarily to the Disability Living care facility at 98-100 Military Road, Semaphore South, as his regular accommodation was undergoing renovation.

4. Circumstances of Mr Hough's death

- 4.1. On Monday 19 July 2021, at approximately 10am, Ms Tabatha Bohmer, team leader at the care facility,² heard what she thought sounded like someone gasping for air. She walked into the living area at the front of the property and saw Mr Hough seated at the table. He appeared to be choking on something. He was eating eggs and ham on toast, something he would usually eat. Ms Bohmer performed back blows on Mr Hough and a small amount of food came out of his mouth. He then collapsed unconscious.
- 4.2. Ms Bohmer called 000 and, with instructions provided by the operator, she commenced CPR on Mr Hough. CPR was taken over by paramedics who arrived shortly afterwards, but this was unsuccessful, and Mr Hough was declared deceased at 11:17am.

5. Conclusions and recommendation

- 5.1. The witness statements I have received into evidence outline the care and treatment given to Mr Hough while under the guardianship of the Public Advocate, and the SAPOL investigating officer, Detective Brevet Sergeant Sarah Odell, did not identify any deficiencies in the care given to Mr Hough.³
- 5.2. The evidence does not suggest that Mr Hough had any issues regarding consumption of food. Witness statements indicate that he tolerated all foods, had no issues with eating and had no special dietary requirements. Although there was one previous issue in May 2021 where Mr Hough coughed whilst eating, causing food to become stuck, it was reportedly dislodged immediately with no further issues. His breakfast on the day of his death was ham and eggs on toast, as eaten daily with no difficulties.

² Exhibit C3

³ Exhibit C10

- 5.3. I agree with the conclusions of Detective Odell that the circumstances surrounding Mr Hough's death are not suspicious and do not indicate the involvement of any third party.
- 5.4. In my opinion Mr Hough's care and treatment was appropriate.
- 5.5. I make no recommendations.

Key Words: Death in Custody; Section 32 Powers; Choking

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

Seal the 22nd day of May, 2024.

State Coroner