



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 19th day of June 2024, by the Coroner's Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of Brian John Whelan.

The said Court finds that Brian John Whelan aged 84 years, late of the Holly Residential Care Facility, 16-24 Penneys Hill Road, Hackham, South Australia died at the Flinders Medical Centre, Flinders Drive, Bedford Park, South Australia on the 17th day of February 2021 as a result of head and pelvic injuries with contributing ischaemic and valvular heart disease (operated). The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

- 1.1. Brian John Whelan was born on 13 April 1936 and died on 17 February 2021 at the Flinders Medical Centre (FMC). He was 84 years of age.
- 1.2. An external examination and CT scan was undertaken by Dr Stephen Wills, senior consultant forensic pathologist, at Forensic Science South Australia. The cause of death was given as '*head and pelvic injuries with contributing ischaemic and valvular heart disease (operated)*'.¹ I find this to have been the cause of Mr Whelan's death.

2. Reason for Inquest

- 2.1. This is a mandatory inquest pursuant to Section 21 of the Coroners Act 2003 as Mr Whelan was under a guardianship order with special powers pursuant to section

¹ Exhibit C2a

32(1)(b) of the Guardianship and Administration Act 1993 at the time of his death, and his cause of death was not certified as natural.

3. Background

- 3.1. Mr Whelan was born in South Australia. He had two younger sisters.² He completed primary school and commenced at Adelaide High School for a short period before he transferred to Nailsworth Technical High until he was 14 years old. Mr Whelan was out of school early and into odd jobs in his early teens.
- 3.2. When Mr Whelan was about 16 years old, he was involved in a fatality whilst loading or unloading goods at Port Adelaide. His sister believes this incident commenced a decline in Mr Whelan's mental state.
- 3.3. Mr Whelan was married twice and had three children. He moved for a time to Darwin before returning to Adelaide in his 60s and moving into a caravan on a block owned by his parents. Eventually he took up accommodation in public housing and lived in various locations over the years.
- 3.4. By the time he was in his late 70s his family had some concerns about his mental state, and he was assessed by doctors at the Repatriation General Hospital (the Repat).

4. Medical history

- 4.1. Mr Whelan had an extensive medical history and presented regularly to hospitals in the years leading up to his death.
- 4.2. His diagnoses included prostate cancer, gastric ulcer, chronic ischaemic heart disease, atrial fibrillation, hypertension, gout, lumbar spine fracture, ASD, femur fracture, type 2 diabetes, vascular and mixed dementia, peripheral vascular disease, bilateral leg oedema, depression, delusional disorder, multiple crush fractures, pansystolic murmur, cirrhosis of the liver, hypercholesterolaemia, venous ulcers, atrial fibrillation, coronary artery bypass graft, congestive heart failure, myocardial infarction, cellulitis, delirium, alcohol abuse and peripheral vascular disease.

² Exhibit C1a

5. Guardianship order

- 5.1. On 21 September 2017 an application for a guardianship order with special powers in accordance with the Guardianship and Administration Act 1993 was submitted by a social worker at the Repat.
- 5.2. On 20 October 2017 after a full SACAT hearing, the Public Advocate was appointed as Mr Whelan's guardian. A special powers order authorising such force as may be reasonably necessary for the purpose of ensuring proper treatment and care was also issued.
- 5.3. Over the ensuing years the orders were regularly reviewed, and Mr Whelan was represented during hearings by the Public Advocate.

6. Circumstances of Mr Whelan's death

- 6.1. Mr Whelan moved into Holly Aged Care in Hackham in August 2018, transferring from St Basil's Aged Care.
- 6.2. At approximately 9:30pm on 16 February 2021, Nicholas Clausen, a registered nurse at Holly Aged Care, located Mr Whelan away from his bed and in the hallway, having had a suspected fall which was unwitnessed.³
- 6.3. Mr Clausen conducted neurological observations. Mr Clausen was aware of Mr Whelan's advance care plan, but due to the suspected head injury and the fact that Mr Whelan was taking anticoagulation medication at the time, he decided to call an ambulance.
- 6.4. SA Ambulance (SAAS) records indicated that at approximately 9:47pm on 16 February 2021 SAAS communications received a telephone call from Mr Clausen in relation to Mr Whelan.
- 6.5. At approximately 10:32pm an event comment was added to the tasking by a SAAS communications operator which said '*ETA: 90-120mins*'.⁴

³ Exhibit C3

⁴ Exhibit C8

- 6.6. At approximately 11:19pm an event comment was added by a SAAS communications operator which said '*Unable to establish contact at the scene ... 4 times phone number rang out, check number on website is cirrnet (current) number*'.
- 6.7. At approximately 1:53am on 17 February 2021 an event comment was added by a SAAS communications which stated '*ETA 45-60mins*'.
- 6.8. At approximately 3:19am an event comment was added by a SAAS communications operator which stated, '*Will be at least 1hr*'.
- 6.9. At approximately 4:20am SAAS eventually arrived at Holly Aged Care to assess Mr Whelan.
- 6.10. The SAAS patient clinical record submitted by the attending crew contained handwritten notes asserting that there were over eight unsuccessful attempts by SAAS to make contact with the scene between the time the call came in and SAAS's eventual arrival.
- 6.11. The Court received an affidavit from Ms Kerry Muller from Holly Aged Care.⁵ She stated the reason the phone was not being answered was that the main phone lines had not been switched by front office staff from their location to the residential floor where the nursing staff would hear it ring and could answer it. After receiving information that the ambulance had been unable to contact the nursing home, Holly Aged Care now has in place an automated process for this to occur at the end of the day.
- 6.12. Mr Whelan left Holly Aged Care via SAAS at about 5:28am on 17 February 2021.
- 6.13. Although I am of the view that the time it took for SAAS to reach Mr Whelan was excessive, I observe that in the interim Mr Whelan was being cared for by medically trained registered nurses. Furthermore, Mr Whelan had signed an advance care plan which clearly outlined his wishes, which were not for life prolonging treatment, to remain in his residence during end of life and to have no attempts at resuscitation. Thus, I find the length of time that passed between SAAS being contacted and their arrival had no bearing on the outcome for Mr Whelan.

⁵ Exhibit C4

- 6.14. At approximately 6:18am on 17 February 2021 Mr Whelan was transferred from SAAS into the care of staff at the Flinders Medical Centre.
- 6.15. A CT scan of Mr Whelan's head identified likely traumatic intracranial haemorrhage and a fracture of his pelvis. In conversation with the Public Advocate a decision was made for palliation, and Mr Whelan passed away later that day.

7. Conclusion

- 7.1. I agree with the conclusions of the SAPOL investigating officer, Senior Constable First Class Matthew Styles, that the guardianship order with special powers was lawful and appropriate.⁶
- 7.2. Subject to my observations about the since rectified after-hours telephone switching failure, in my opinion Mr Whelan's care and treatment at both Holly Aged Care and the Flinders Medical Centre was appropriate.
- 7.3. I make no recommendations.

Key Words: Death in Custody; Section 32 Powers

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

Seal the 19th day of June, 2024.

State Coroner

Inquest Number 07/2024 (0365/2021)

⁶ Exhibit C8