IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002776

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Simon McGregor
Deceased:	Frank Allen Hall-Bentick
Date of birth:	30 May 1953
Date of death:	24 May 2023
Cause of death:	1(a) Septic arthritis of the knee 2 Severe restrictive lung disease, sensory motor neuropathy, ischaemic heart disease, hypertension
Place of death:	Austin Hospital, 145 Studley Road, Heidelberg, Victoria, 3084
Keywords:	In care, natural causes

INTRODUCTION

1. On 24 May 2023, Frank Allen Hall-Bentick was 69 years old when he died at the Austin Hospital. At the time of his death, Frank lived at Yooralla Ventilator Accommodation Support Service (**VASS**) at 335 Clarendon Street, Thornbury, Victoria.

2. Frank grew up in Altona, Victoria, and was the second eldest of four children. When Frank was approximately six years old, he was diagnosed with Muscular Dystrophy. Frank attended mainstream schooling until Year 8 at Altona Primary and high school. He was then moved to Yooralla School where he lived and completed his studies.[1]

3. In 2022, Frank was admitted to the Austin Hospital for pneumonia and spent four months on a ventilator. After unsuccessful attempts to wean him off the ventilator, he was released from hospital into the care of Yooralla VASS.[2] Frank was dependent on his carers for daily tasks and required bilevel positive airway pressure (**BiPAP**) to support his breathing 24 hours a day. He had experienced respiratory deterioration over the last five to six years.[3]

4. Despite Frank's considerable health challenges, he spent most of his time advocating for people with disabilities and was awarded the Order of Australia in 2012 for his work. He was until his death the chair of Australia Disability and Indigenous Education Fund. Frank's sister Annette described him as the sharpest, smartest man she had ever known.[4]

THE CORONIAL INVESTIGATION

5. Frank's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The

[1] Coronial Brief, statement of Annette Rooke dated 8 September 2023.
[2] Ibid.
[3] Coronial Brief, statement of A/Prof Stephen Joseph Warrillow dated 17 July 2023.
[4] Coronial Brief, statement of Annette Rooke dated 8 September 2023.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Frank's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Frank Allen Hall-Bentick including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[5]

10. In considering the issues associated with this finding, I have been mindful of Frank's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

11. On 22 May 2023, Frank was transported to the Austin Hospital Emergency Department by ambulance, presenting with sepsis secondary to right knee septic arthritis.[6]

[5] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[6] Coronial Brief, statement of A/Prof Stephen Joseph Warrillow dated 17 July 2023.

12. Upon arrival to the Austin Hospital Emergency Department Frank presented as drowsy, hypotensive and was becoming confused. A knee aspirate was performed on Frank's right knee which confirmed septic arthritis.[7]

13. A multi-disciplinary meeting was held to discuss Frank's medical management between intensive care unit (ICU) staff, anaesthetics, orthopaedics and Frank. Frank was deemed not to be suitable for surgical management, due to his poor respiratory function putting him at risk of being inseparable from the ventilator and therefore at risk of a tracheostomy needing to be performed. Frank agreed with the decision, stating that he valued his ability to communicate independently.[8] Frank was also deemed not suitable for spinal anaesthetic due to severe spinal kyphoscoliosis. As a result, Frank elected to pursue medical management only, by way of intravenous antibiotics, analgesia, non-invasive ventilatory support, and vasopressor therapy in the intensive care unit.[9]

14. Over the next day, Frank became increasingly unwell despite these measures, and it was apparent to medical staff that he had worsening septic shock. Frank's family was contacted and clinical staff advised them of their concerns for a poor outcome.[10]

15. Having been transitioned to comfort care, Frank passed away with his sister Annette and a close friend present at 8:38am on 24 May 2023.[11]

Identity of the deceased, pursuant to section 67(1)(a) of the Act

16. On 24 May 2023, Frank Allen Hall-Bentick, born 30 May 1953, was visually identified by his sister, Annette Rooke.

17. Identity is not in dispute and requires no further investigation.

[7] Medical Deposition of Dr Annie Tan, ICU Registrar, dated 26 May 2023; Coronial Brief, statement of A/Prof Stephen Joseph Warrillow dated 17 July 2023.
[8] Medical Deposition of Dr Annie Tan, ICU Registrar, dated 26 May 2023.
[9] Medical Deposition of Dr Annie Tan, ICU Registrar, dated 26 May 2023; Coronial Brief, statement of A/Prof Stephen Joseph Warrillow dated 17 July 2023.
[10] Coronial Brief, statement of A/Prof Stephen Joseph Warrillow dated 17 July 2023.
[11] Ibid.

Medical cause of death, pursuant to section 67(1)(b) of the Act

18. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine conducted an external examination on 26 May 2023 and provided a written report of his findings dated 29 May 2023.

19. The post-mortem examination revealed findings consistent with Frank's medical history. The post-mortem computed tomography (**CT**) scan showed no intracranial haemorrhage, gas in the right knee joint, bilateral pleural fluid, peripheral oedema.

20. Dr de Boer provided an opinion that the medical cause of death was 1(a) septic arthritis of the knee, with (2) severe restrictive lung disease, sensory motor neuropathy, ischaemic heart disease, and hypertension operating as contributing factors.

21. I accept Dr de Boer's opinion.

FINDINGS AND CONCLUSION

22. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Frank Allen Hall-Bentick, born 30 May 1953;

    b) the death occurred on 24 May 2023 at Austin Hospital, 145 Studley Road, Heidelberg, Victoria, 3084, from septic arthritis of the knee; and

    c) the death occurred in the circumstances described above.

23. As Frank was residing in Specialist Disability Accommodation at the time of his passing, his death is considered to be 'in care' as defined by section 3 of the Act and *prima facie* subject to a mandatory inquest.[12] I am, however, satisfied by the available evidence that Frank's death was due to natural causes and, pursuant to section 52(3A) of the Act, have therefore determined not to hold an inquest.

I convey my sincere condolences to Frank's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

[12] Section 52(2).

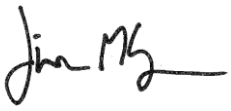
I direct that a copy of this finding be provided to the following:

Annette Rooke, Senior Next of Kin

Noemi Baquing, Austin Health

Constable Ayden McDonald, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 04 March 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.