IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 1537

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008 (Vic)

I, AUDREY JAMIESON, Coroner having investigated the death of JOHN BARRIE HUGHES

without holding an inquest pursuant to section 52(3A) of the *Coroners Act 2008* (Vic):

find that the identity of the deceased was JOHN BARRIE HUGHES

born 13 October 1944

and the death occurred on 4 April 2017

at 283 Cotham Road, Kew, Victoria 3101

from:

1 (a) BRONCHOPNEUMONIA IN THE SETTING OF CHRONIC ASPIRATION IN A MAN WITH MIXED ALZEIMER'S AND ALCOHOL RELATED DEMENTIA

2 ISCHAEMIC HEART DISEASE, PROSTATE ADENOCARCINOMA

Pursuant to section 67(1) of the *Coroners Act 2008* (Vic), I make findings with respect to **the following circumstances**:

1. John Barrie Hughes was 72 years of age and residing in psychogeriatric facility in Kew at the time of his death. Mr Hughes was born in Australia, he lived in London and Europe before he returned to Australia where his son, Alexander Hughes, was born to

his second wife. He had a history of alcohol dependence and, in his later years, began to exhibit confusion, mood-swings and aggression. In 2012 these behaviours were identified as symptoms of degenerative dementia. His condition deteriorated and, consequently, he was admitted to hospital. On 3 November 2016, Mr Hughes was admitted to Normanby House, which is under the auspices of St George's Healthcare, in Kew.

2. At approximately 6.50am on 4 April 2017, Registered Nurse Supha Lam checked on Mr Hughes in his bed at Normanby House. He was not breathing and Nurse Lam was unable to find a pulse. A code blue medical emergency was activated but all checks indicated no signs of life and Mr Hughes was pronounced deceased. Victoria Police attended at 9.40am.

3. Mr Hughes' death was considered 'Reportable' as he was 'in care' pursuant to section 4(2)(d) of the *Coroners Act 2008* (Vic) ('*the Act*'); he was admitted to St Vincent's Hospital[1] as a 'compulsory patient' in accordance with section 1 of the *Mental Health Act 2014* (Vic).

INVESTIGATIONS

Forensic pathology investigation

4. Dr Melanie Archer, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy upon the body of Mr Hughes, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. Dr Archer reported that Mr Hughes suffered from significant naturally occurring diseases, including: bilateral bronchopneumonia, prostate adenocarcinoma and severe coronary atherosclerosis with myocardial fibrosis. Dr Archer observed that Mr Hughes had severe ischaemic heart disease with critical stenosis of two coronary arteries, predisposing him to harmful, lethal arrhythmia, especially during times of increased metabolic stress. Dr Archer identified Mr Hughes' cause of death as bronchopneumonia in the setting of chronic aspiration in a man with mixed Alzheimer's and alcohol related dementia. Dr Archer reported that ischaemic heart disease and prostate adenocarcinoma were contributing factors to Mr Hughes' death.

[1] St George's Healthcare is a part of St Vincent's Hospital.

5. Post-mortem specimens collected from Mr Hughes' body were tested for the protein procalcitonin (PCT) and C-Reactive Protein (CRP); these are two of the markers used to identify the presence of inflammation and sepsis. Dr Archer commented that the PCT levels were within normal limits and the elevated level of CRP were in keeping with bacterial sepsis secondary to bronchopneumonia.

Police investigation

6. Upon attending Normanby House after Mr Hughes' death, police found his body in his bed, bearing no sign of physical trauma nor medical intervention. Nursing staff had prepared Mr Hughes's body for viewing, pending the arrival of his son; his hands were crossed over his chest and a towel was rolled up behind his neck.

7. Leading Senior Constable (LSC) Paul Angove was the nominated coroner's investigator.[2] At my direction, LSC Angove conducted an investigation of the circumstances surrounding Mr Hughes' death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Alexander Hughes, General Practitioner Dr Peter Gamboni, and Psychiatry Registrar at Normanby House, Dr Michelle Baek.

8. In the course of the investigation, police learned that Mr Hughes' health began to noticeably deteriorate in 2012. He had been separated from his second wife for 15 years and was living with a woman named Beverly in Bendigo, Victoria. Beverly contacted Alexander Hughes and told him that his father had been behaving strangely. Upon staying with them for a number of days, Alexander Hughes observed that his father was increasingly paranoid and was under the false impression that he had a number of health problems. Alexander Hughes stated that his father had an episode of strange behaviour a few weeks later, whereby Mr Hughes grabbed a knife in the kitchen and appeared to threaten self-harm. Consequently, Mr Hughes was taken to the Marjorie Phillips unit, a mental health facility, at Bendigo Hospital.

9. Alexander Hughes reported that his father did not engage well with Bendigo Hospital's services that were intended to assist him to return to quasi-independent living. This

[2] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

resulted in Mr Hughes' return to the Marjorie Phillips unit. Alexander Hughes stated that his father subsequently lived in an in-patient care facility called Namarra in Caulfield. He then lived in a similar facility in Kew called Auburn House. However, Mr Hughes' outbursts of aggression toward staff meant that the residences' facilities and resources could not meet his needs.

10. On 3 November 2016, Mr Hughes was referred for admission to Normanby House. Upon admission, he was placed on an Assessment Order due to the risks posed by his aggressive behaviour and recent agitation in his previous residence; it was likely that restrictive measures would be implemented in healthcare management. On 4 November 2016, he struck a nurse and refused treatment, displaying no insight into his behaviours nor his illness. Consequently, the ward psychiatrist placed Mr Hughes on a Temporary Treatment Order and concluded that his presentation was symptomatic of exacerbation of the behavioural and psychological symptoms of dementia.

11. On 6 November 2016, Mr Hughes continued to show signs of aggression and impulsivity, requiring a period of seclusion. Dr Baek stated that this was despite the reduction and cessation of venlafaxine which medical staff thought may have been contributing to his aggression. Mr Hughes also required frequent intramuscular injections of olanzapine. Dr Baek reported that the increase of his doses of mirtazapine, quetiapine and oxazepam produced no discernible improvement.[3]

12. On 21 November 2016, a Mental Health Tribunal hearing was held and a 12 week Treatment Order was made. At this time, Mr Hughes' mood appeared improved, however, his aggressive behaviour and assaults upon medical staff continued. At length, a lull in these incidences incited a trial period of three days leave back to Auburn House.

13. On 30 January 2017, the Mental Health Tribunal approved an order for three weeks to facilitate the transfer. However, Dr Baek said that the transfer was unsuccessful owing to Mr Hughes' aggressive behaviour and he returned to Normanby House. On 17 February 2017, an application was made to the Mental Health Tribunal for a further 26 week Treatment Order, which was approved.

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[3] Mirtazapine and quetiapine are prescription anti-depressant medication. Oxazepam is a prescription medication of the benzodiazepine class and typically used to treat anxiety.

14. Dr Baek stated that, despite further adjustments to Mr Hughes' medication, he continued to assault staff members, generally requiring three staff members for any nursing intervention.

15. On 9 March 2017, Mr Hughes had a Code Blue[4] for an episode of hypotension which spontaneously recovered. The geriatric team reviewed Mr Hughes and formed the impression that a chest infection had caused the incident; he was commenced on a course of oral roxithromycin.[5] Dr Baek stated that Mr Hughes appeared to improve and that there was a *'downtrend in his inflammatory markers'*.

16. On 10 March 2017, medical staff at Normanby House and Alexander Hughes met to discuss Mr Hughes' goals of care. In keeping with Mr Hughes' pre-morbid wishes, it was determined that, in the event of severe clinical deterioration, he should not be for acute resuscitation, intubation, transfer to an acute unit, or any other invasive treatment. Dr Baek indicated that the goals were formulated in the context of his father's current poor quality of life and likelihood of further impairment following invasive treatment. Alexander Hughes was happy for his father to have non-invasive treatment (such as oral anti-biotics) and 'comfort care', if appropriate.

17. Between 13 March 2017 and 19 March 2017, Dr Baek reported that Mr Hughes appeared more stable and his regular anti-psychotics and benzodiazepines were reduced as it appeared that he was drowsier with an ongoing cough and poor oral intake. He was still resistant to care, agitated, and required restraint to avoid falls, therefore, under the *Mental Health Act 2014* (Vic), he remained an involuntary patient and was not considered for transfer to the geriatric unit. On 22 March 2017, he suffered an unwitnessed fall with no major injury.

18. On 3 April 2017, Mr Hughes suffered marked deterioration with increased oxygen saturation, increased respiratory rate and tachycardia. The resident geriatric doctor reviewed and commenced him on empirical oral clindamycin for presumed aspiration pneumonia. Dr Baek stated that the palliative care unit was also contacted as it was determined that, despite anti-biotics, it was likely that Mr Hughes would pass away in the next few days.

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[4] In Victorian healthcare, 'Code Blue' refers to a medical emergency or a cardiac arrest.
[5] Prescription medication which may be prescribed for the treatment of chest infections.

19. At approximately 6.00am on 4 April 2017, Registered Nurse Yury Prudkov checked on Mr Hughes in his bed at Normanby House. She observed that his temperature was 37.3 degrees, pulse was 102, blood pressure was 145/76, and oxygen saturation was at 80%. At 6.50pm, when Nurse Lam attended Mr Hughes, he was not breathing and had no pulse.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. Section 52 of *the Act* mandates the holding of an Inquest if the deceased was, immediately before death, a person placed in care, save for circumstances where the person is deemed to have died from natural circumstances, pursuant to section 52(3A).

FINDINGS

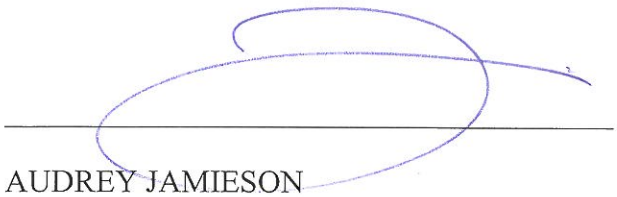
On the evidence before me, it appears that the healthcare and management provided to Mr Hughes was reasonable in the circumstances, and, I further find that there is no apparent causal relationship between his death and the fact that Mr Hughes was a person placed in care.

I accept and adopt the medical cause of death as ascribed by Dr Archer, and find that John Barrie Hughes died of natural causes; bronchopneumonia in the setting of chronic aspiration, in a man with mixed Alzheimer's and alcohol related dementia. I find that ischaemic heart disease and prostate adenocarcinoma were contributing factors to his death.

Pursuant to section 73(1B) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

I direct that a copy of this finding be provided to the following:
Alexander Hughes
Dr Michelle Baek
Dr Neil Coventry, Office of the Chief Psychiatrist
LSC Paul Angove

Signature:



AUDREY JAMIESON
CORONER
Date: **15 December 2017**