
**FINDINGS of Coroner Andrew McKee following the holding
of an inquest under the *Coroners Act 1995* into the death of:**

DAVID JOHN PORTHOUSE

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Record of Investigation into Death (With Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Andrew McKee, Coroner, having investigated the death of David John Porthouse with an inquest held at Hobart in Tasmania make the following findings.

Hearing Date

17 March 2021

Representation

Counsel Assisting the Coroner: Senior Constable A Barnes

Introduction

Mr Porthouse died on 3 September 2020 at the Royal Hobart Hospital, Whittle Ward, in Hobart Tasmania. It was initially thought that he was a person who, immediately before his death, was a person held in care as defined by Section 3 of the *Coroners Act 1995* (“the Act”) and, as such, an inquest into his death was mandatory. Based on the evidence before me I am satisfied that Mr Porthouse was not immediately before his death ‘a person held in care’.

At the time of his death, Mr Porthouse was the subject of an order made under the provisions of the *Guardianship and Administration Act 1995*. That order was in the following terms:

- I. *The Public Guardian (Tas) is appointed as limited Guardian of David John Porthouse with the power to:*
 - i. *Decide where David John Porthouse is to live whether permanently or temporarily.*
 - ii. *Determine which services David John Porthouse should access and provide consent to such as required.*
 - iii. *Advocate on David John Porthouse’s behalf and make any decisions required in respect of any NDIS plan development, plan implementation and/or plan review.*
 - iv. *Make healthcare decisions for David John Porthouse.*
 - v. *Make medical treatment decisions for David John Porthouse.*
2. *Pursuant to section 28 of the Guardianship and Administration Act 1995, any police officer; ambulance*

officer; the Public Guardian; any employee or agent of Tasmanian Health Service (THS) or hospital or facility where David John Porthouse is staying as determined by the Guardian, are empowered to take the measures or actions specified below to ensure that David John Porthouse complies with any decision of the Guardian made under this Order.

Specified measures or actions

- a. the use of such reasonable force or physical and/or chemical restraint as is necessary to facilitate transport of David John Porthouse to any residential aged care facility or THS facility determined by the Guardian from time to time; and to keep David John Porthouse there or return him there should he leave, contrary to the Guardian's decision.*
 - b. the use of such reasonable force or physical and/or chemical restraint as is necessary to keep David John Porthouse at any residential aged care facility or THS facility or return him there should he leave, contrary to the Guardian's decision.*
 - c. Restraining David John Porthouse by physical and/or chemical means in order to provide medical treatment to which the Guardian gives consent.*
- 3. This Order remains in effect until 22 July 2021.*

It was initially thought that Mr Porthouse, who had been in hospital from February 2020 due to a fractured neck of femur, had remained as a patient despite requests to be discharged.

It is now apparent that he was discharged from hospital on the 12 August 2020 in accordance with his wishes. He presented again to the Royal Hobart Hospital on 28 August 2020. Mr Porthouse was not an inpatient at the Royal Hobart Hospital as a result of the Guardianship Order. I am therefore not satisfied he was a person in care immediately prior to his death.

The investigation and inquest into Mr Porthouse's death has focused on his treatment and supervision whilst he was at the Royal Hobart Hospital.

Having regard to the evidence at the Inquest I make the following findings pursuant to Section 28(1) of the *Coroners Act 1995*:

- a) The identity of the deceased is David John Porthouse;
- b) Mr Porthouse died in the circumstances set out in this finding;
- c) The cause of Mr Porthouse's death was uraemic encephalopathy; and
- d) Mr Porthouse died on 3 September 2020 at the Whittle Ward Royal Hobart Hospital, Hobart.

Evidence

I am satisfied that this matter has been comprehensively investigated and the relevant issues have been fully explored. I have taken into account and considered the evidence tendered at the inquest namely:

- C1 - Report of Death;
- C2 – Life Extinct Affidavit, Dr Anne Fraser;
- C3 – Affidavit of Identification, Constable S Harmond;
- C4 – Short Final Report by Forensic Pathologist, Dr A Reid;
- C5 – Death Report to Coroner by Dr A Fraser;
- C6 – Guardianship Board Order;
- C7 – Affidavit of Ms R Taylor;
- C8 – Affidavit of Ms L Paine;
- C9 – Medical Records - General Practitioner;
- C10 – Medical Report from the medical advisor to the Coronial Division, Dr A Bell;
- C11 - Medical Records – Tasmanian Health Services; and
- C12 – Property Receipt.

Background

Mr Porthouse was born on 20 July 1950 in Hobart, Tasmania, to William and Jessie Porthouse. He had two elder siblings.

He lived in Tasmania his entire life. He was educated at New Town High School.

He married Shirley McGuinness in 1982. Their marriage produced two children. They divorced in 1990.

After the divorce, Mr Porthouse had minimal contact with his daughters and they became estranged. His daughters contacted him in approximately 2012 and they re-established a relationship.

Both of Mr Porthouse's daughters swore affidavits as part of the Coronial Investigation. Ms L Paine described her father as a quiet, private person who enjoyed sport and music. Mr Porthouse was an avid gardener. He also enjoyed camping and going fishing on his boat Mr Porthouse regularly attended greyhound and horse racing events. Mr Porthouse held employment as a storekeeper and a DJ during his working life.

Health

As part of the investigation into Mr Porthouse's death his medical records from Tasmanian Health Service have been obtained, along with the records maintained by his general practitioner.

Mr Porthouse had a number of medical conditions. Those conditions can be summarised as:

- a) Diabetes mellitus type 2
- b) Chronic renal failure
- c) Hypertension
- d) Coronary artery disease
- e) Congestive heart failure
- f) Fractured left neck of femur.

Mr Porthouse's health deteriorated between 2014 and 2015. In 2016 family members noted a decline in his cognitive state.

In February of 2020 Mr Porthouse suffered a fall at his home which resulted in a fractured neck of femur. The fracture was surgically repaired. Whilst an inpatient and during his recovery Mr Porthouse displayed aggressive behaviour towards treating medical staff and family members. In June of 2020 he was diagnosed with stage-five kidney disease.

Given Mr Porthouse's mobility issues, it was recommended that he move into an assisted living facility. He indicated he would not adopt that course of action. Mr Porthouse made it clear he wished to return home. According to Ms Paine, Mr Porthouse would not discuss his medical treatment and he presented as unrealistic about the prospect of him returning to his home.

There were occasions when Mr Porthouse was not compliant in returning to the hospital when allowed to leave the hospital for agreed periods of time.

It was decided by family members that it would be appropriate to apply for a Guardianship Order. As mentioned earlier in this finding a guardianship order was made by the Guardianship and Administration Board on 23 July 2020.

Circumstances Leading to Mr Porthouse's Death

According to the report of death, Mr Porthouse presented to the Accident and Emergency Department on 28 August 2020 with severe diarrhoea. Mr Porthouse was in severe renal failure. Mr Porthouse's condition continued to deteriorate. In conjunction with his guardian, family and Mr Porthouse a decision was made to provide palliative care. Mr Porthouse died on 3 September 2020.

Dr A Bell, an experienced medical practitioner attached to the Coroner's Office, reviewed the care and treatment provided to Mr Porthouse at the Royal Hobart Hospital. Dr Bell expressed the opinion that a good standard of medical care and treatment were provided to Mr Porthouse. I accept his opinion.

Post Mortem Examination

A post mortem examination was conducted by forensic pathologist, Dr A Reid. Dr Reid provided the following opinion as to Mr Porthouse's cause of death:

"This 66 year old pensioner tripped, slipped, fell or otherwise collapsed due to an unwitnessed hypoglycaemic attack in the context of chronic brittle Type 2 diabetes and chronic kidney disease in February 2020. Initially the occult fractured left neck of femur was not identified on radiology. Subsequent radiology confirmed the occult fracture and a dynamic hip screw operation was performed. Following discharge from orthopaedic surgical care he remained an inpatient from March 2020 onwards due to other background chronic medical problems and in the context of prolonged hospital admission he became infected by drug resistant bacteria including methicillin resistant staphylococcus aureus; vancomycin resistant enterococcus; multi resistant gram negative bacilli and carbapenemase producing enterobacteria. The death was reportable as it may have been directly or indirectly related to his fracture however, the fracture was not due to accidental trauma but appears to have occurred in the context of collapse due to pre-existing diabetes."

I accept Dr Reid's opinion as to Mr Porthouse's cause of death.

Comments and Recommendations

The evidence at the inquest outlined an appropriate standard of care for Mr Porthouse. There is nothing further that could have been done for Mr Porthouse. The care and treatment he received was entirely appropriate in the circumstances.

There is no need for me to make any other comments or recommendations.

I extend my condolences to the family of Mr Porthouse.

Dated: 12 May 2021 at Hobart in the State of Tasmania.

Andrew McKee
Coroner