MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of Peter Blackwell Harris

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Peter Blackwell Harris (Mr Harris);

b) Mr Harris died as a result of complications arising from a fall at the Royal Hobart Hospital (RHH);

c) Mr Harris's cause of death was pneumonia and a head injury the latter being caused by the fall; and

d) Mr Harris died on 9 May 2020 at Hobart, Tasmania.

Introduction

Prior to proceeding to prepare this decision I ruled on whether or not an inquest is required in this case. I determined an inquest is not required and my reasons for that determination are attached.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Harris' death. The evidence includes:

- The Police Report of Death for the Coroner;
- Death Report to Coroner from the Royal Hobart Hospital (RHH);
- Affidavits as to identity and life extinct;
- Affidavit of Dr Christopher Lawrence forensic pathologist;
- Affidavit of Mr Neil McLachlan-Troup, forensic scientist, of Forensic Science Service Tasmania;
- Affidavit of Mrs Lesley Harris;
- Statement of Mr Keith Churchill;
- Statement of Ms Lucy Brown;

- Statement of Mr Cecil Kenny;
- Statement of Mrs Frances Parker and Mr Michael Parker;
- Statement of Jim and Joan;
- Statement of Ms Justine Heino;
- Statement of Ms Bronwyn Millar;
- Affidavits of Ms Buna Khadka;
- Letters of Ms Katrina Hodge, nurse director, acute medical services, RHH and enclosures;
- Medical records of Mr Harris held by the RHH and obtained from the Tasmanian Health Service (THS);
- Report of the Coronial Medical Consultant Dr Anthony Bell MB BS MD FRACP FCICM; and
- Forensic evidence.

Background

Mr Harris was 75 years of age (date of birth 15 January 1945), married and retired at the date of his death. He was born in Launceston however his family moved to Hobart shortly thereafter. He was the third of 4 children born to his parents. He met his wife, Lesley, when he was about 24 years old and they married in 1977. Mr and Mrs Harris had 4 children one of whom was the stepdaughter of Mr Harris.

Mr Harris was a qualified architect and he worked in that profession until he was about 30 years of age. He then became a woodworker and worked in that occupation until he retired at the age of 65.

Mr Harris was very active both physically and socially. He walked to Kingston Beach every day which is a distance of about 6 km or more. He played table tennis very regularly, he enjoyed bushwalking and camping, he played the viola in an ensemble and he regularly babysat his grandchildren.

Health

In so far as Mr Harris' medical history is concerned he had been previously diagnosed with hypertension[1] and dyslipidaemia[2].

[1] High blood pressure.
[2] Dyslipidaemia is the imbalance of lipids such as cholesterol, low-density lipoprotein cholesterol, (LDL-C), triglycerides, and high-density lipoprotein (HDL). This condition can result from diet, tobacco exposure, or genetics and can lead to cardiovascular disease with severe complications.

On 31 December 2018 Mr Harris spent the day bushwalking on Mount Wellington. He felt breathless after running back to the car from a lunch spot where he had left a hiking stick. The history in the RHH records indicates when the walking party got back into Mr Harris' car in order to drive to the top of Mount Wellington he *"felt like [he] might pass out."* He woke with his walking companions around him. They reported Mr Harris drove on Pinnacle Road when he slumped at the wheel. The front passenger got Mr Harris' foot off the accelerator and put on the handbrake. It took approximately 4 minutes for Mr Harris' companions to open his door and extricate him. There was no respiratory effort or seizure activity and no radial pulse so they went to commence CPR when Mr Harris became responsive.

Mr Harris was admitted to hospital and underwent a coronary angiogram. He was discharged on 4 January 2019. The diagnosis was a Non-ST-Elevation Myocardial Infarction which is a type of heart attack and which is often referred to as a non-STEMI. It usually occurs when a heart's need for oxygen cannot be met. This condition gets its name because it does not have an easily identifiable electrical pattern (ST elevation) like the other main types of heart attack. Thereafter he underwent rehabilitation via the outpatients department but by about 18 February 2019 he informed the RHH he did not think he needed to attend any more. The cardiologist Dr Black reported he reviewed Mr Harris on 27 March 2019. In that report he says *"[i]t is generally quite unusual for syncope as a single symptom to be related to obstructive coronary disease, however in this case it does really seem that this was Peter's problem. He had a very tight stenosis proximally in a very large marginal branch of the circumflex which was stented."* Accordingly despite Mr Harris having a fit and healthy lifestyle he had ischaemic heart disease.

Circumstances Leading to Mr Harris' Death

Mr Harris was taken by ambulance to the RHH on 30 April 2020. It was difficult to obtain a history from Mr Harris as he was fixated on certain topics such as pipes at a rental property, his blood pressure and his daughter's mental health. Mrs Harris gave a history of 4 to 6 weeks of poor sleeping, anxiety and him being obsessive about topics[3]. His condition had peaked in the last 2 days. Approximately 4 weeks ago he was concerned that the Chinese were taking over the South China Sea, they were going to take all his money and they had hacked into his phone. He had no mental health history whatsoever. Mr Harris had no other obvious physical symptoms. He had a flu vaccination the previous Tuesday and thought the GP was a fake. He had been very anxious since but was suffering from no fevers or any

[3] Mrs Harris says in her statutory declaration that as at 20 April 2020 Mr Harris was "perfectly fine". Nothing turns on the difference in history between what appears in her statutory declaration and what appears in the hospital records.

vomiting. The GP had visited that afternoon and administered Seroquel for anxiety. After dinner Mrs Harris tried to give him some more of that medication as he was very agitated saying the plumber was going to rip them off. It was at that stage Mr Harris' daughter telephoned Ambulance Tasmania (AT).

The report from AT says Mr Harris initially refused treatment or an assessment and police were required to place Mr Harris in the ambulance. He was therefore taken into protective custody[4] by police at 23:30 hours on 30 April 2020 arriving at the RHH at about 00:00 hours on 1 May 2020. It was determined by a medical practitioner at 01:06 hours on 1 May 2020 Mr Harris needed to be assessed against the assessment criteria[5].

Mr Harris was examined and a number of tests were run. In the Emergency Department Mr Harris is recorded saying *"they think I am crazy"*. Clinical examination did not reveal any clues to his condition. The serum sodium was 124 mmol/L; the normal range being 135 – 145 mmol/L. The urine osmolality[6] was 227 mOsm/kg and the urine sodium 50 mmol/L. Acid base metabolism was normal and the serum potassium was normal. The white blood cell count was elevated. A chest x-ray showed no lesions. A CT of the brain showed no changes. An electrocardiogram was unchanged from previous tests. The doctor's impression was Mr Harris was suffering delirium and queried whether this was related to hyponatraemia[7]. If he had hyponatraemia it was queried whether it was acute or mild to moderate or whether it was non-edematous[8] or hypotonic[9]. There was also a query as to whether Mr Harris had a glucose cortical deficiency and if he had hypothyroidism. If he had neither condition then it was questioned as to whether he had Syndrome of Inappropriate Antidiuretic Hormone Secretion (SIADH)[10]. It was also considered whether Mr Harris might have neutrophilia[11] but there were no clinical findings to support that diagnosis. The plan was to admit him and to conduct some further tests.

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[4] See ss17 and 18 of the *Mental Health Act* 2013.
[5] See s19(2) of the *Mental Health Act* 2013.
[6] Urine osmolality is used to measure the number of dissolved particles per unit of water in the urine. Urine osmolality is useful in diagnosing renal disorders of urinary concentration and dilution and in assessing the status of a person's hydration.
[7] Hyponatremia means that the sodium level in the blood is below normal. A person's body needs sodium for fluid balance, blood pressure control, as well as for the nerves and muscles.
[8] Not swollen by excess fluid.
[9] Having a lesser osmotic pressure in a fluid compared to another fluid.
[10] Syndrome of inappropriate antidiuretic hormone secretion occurs when excessive levels of antidiuretic hormones (hormones that help the kidneys, and body, conserve the correct amount of water) are produced.
[11] Neutrophilia is defined as a higher neutrophil count in the blood than the normal reference range of an absolute neutrophil count. Neutrophilia can be seen in infections, inflammation, and/or neoplastic processes. It occurs when a person's body produces too many neutrophils which are a type of white blood cell that helps fight infection.

Mr Harris was reviewed by the geriatric team at 15:30 hours. He was alert and orientated. A 3-D Cam[12] was negative for delirium. A mini cognitive test[13] was not suggestive of cognitive impairment. Mr Harris' conversation was repetitive and there was reference to a plumber and an imposter doctor. Mr Harris was fixated on the belief Mrs Harris was restricting his salt intake. The impression which was formed was that Mr Harris had psychotic features in a setting of hyponatraemia that is a low serum sodium level in the plasma. Further blood tests showed normal cortisol levels and normal thyroid function tests.

By 4 May 2020 Mr Harris's condition was unchanged. A history was obtained he had lost 23 kg in a short space of time. The endocrinology team assessed Mr Harris but did not make any diagnosis. At 20:10 hours a medical emergency team (MET) call was made as Mr Harris fell backwards from a standing position. He was assessed to have low blood pressure and a Glasgow Coma Score (GCS) of 8/15 and a radial pulse which could not be palpated. He slowly improved but he remained hyponatraemic. The measured fluid intake for the day was 370 ml with 900 ml of urine output. A CT scan of the brain showed extensive skull fractures with subarachnoid blood and a subdural haematoma adjacent to the frontal lobes. There was no acute injury to the cervical spine.

By the next morning Mr Harris' GCS had fallen and a further CT scan showed bifrontal subdural haematomas larger on the left, blood in the lateral ventricles with frontal and temporal contusions. Mr Harris was transferred to the intensive care unit. On 6 May 2020 palliative care was decided upon due to his poor prognosis. He was transferred to the Whittle Ward and commenced on a syringe driver for symptom control. He slowly declined and passed away on 9 May 2020.

Investigation

Dr Christopher Lawrence conducted a post-mortem examination on 11 May 2020. Dr Lawrence noted a history of ischaemic heart disease which presented with syncope which was treated with a stent. More recently it was noted Mr Harris developed behavioural disturbances and hyponatraemia. While being treated for this condition he had a fall striking his head and he developed a significant head injury from which he subsequently died. Dr Lawrence thought the cause of the hyponatraemia was probably SIADH and this may have contributed to the fall. It was also possible the fall may be a consequence of the ischaemic heart disease given the earlier episode of syncope. Because of the previous syncope and left bundle branch block Dr Lawrence thought it more likely the fall was caused by the hyponatraemia. The results of toxicology testing show the medications which were found in

[12] This is a 3 minute delirium test. This document has been provided by the RHH.
[13] This document has been provided by the RHH.

the blood sample did not contribute or cause Mr Harris' death. Dr Lawrence concludes by saying Mr Harris died as a result of pneumonia the onset of which occurred after he received palliative care after he suffered a head injury in a fall. I accept the opinion of Dr Lawrence. Pneumonia is a common illness. It is caused by many different germs. Pneumonia that starts in the hospital tends to be more serious than other lung infections because:

- People in hospital are often very sick and cannot fight off infection; and
- The types of germs present in a hospital setting are often more dangerous and more resistant to treatment than those outside in the community.

The coronial medical consultant, Dr Anthony Bell, was asked to review this file because of the concerns raised by Mr Harris' family about the treatment he received. Dr Bell says hyponatraemia is defined as a serum sodium concentration below 135 mmol/L, and it is usually caused by a failure to excrete water normally. In healthy individuals, the ingestion of water does not lead to hyponatraemia because the suppressed release of antidiuretic hormone (ADH), also called vasopressin, allows excess water to be excreted in a diluted urine.

Renal water excretion is impaired in most patients who develop hyponatraemia and this is usually due to an inability to suppress ADH secretion. An uncommon exception occurs in psychotic patients with primary polydipsia[14] who drink such large quantities of fluid (15 l/day) and despite appropriately suppressed ADH release, the excretory capacity of the kidney is overwhelmed.

The majority of patients with hypotonic hyponatraemia have an impaired ability to dilute their urine. In most patients with an inability to dilute their urine, the cause is an inability to suppress antidiuretic hormone (ADH) release, usually due to reduced effective arterial blood volume, resulting either from an oedematous state (heart failure or liver failure) or from true hypovolemia. The other cause is SIADH.

Dr Bell explains SIADH is a disorder of impaired water excretion caused by the inability to suppress the secretion of ADH. If water intake exceeds the reduced urine output, the ensuing water retention leads to the development of hyponatraemia. The diagnosis requires exclusion of hypothyroidism and normal cortisol levels.

Dr Bell says SIADH should be suspected in any patient with hyponatraemia, hyposmolality, and a urine osmolality above 100 mOsm/kg. In SIADH, the urine sodium concentration is

[14] Primary polydipsia is a condition where there is an excessive consumption of fluids leading to polyuria with diluted urine and, ultimately, hyponatraemia.

usually above 40 mmol/L, the serum potassium concentration is normal, there is no acid-base disturbance, and the serum uric acid concentration is frequently low.

In normal individuals, plasma ADH levels are very low when the plasma osmolality is below 280 mOsm/kg, thereby permitting the excretion of ingested water, and ADH levels increase progressively as the plasma osmolality rises above 280 mOsm/kg.
ADH regulation is impaired in SIADH; five different patterns have been described (two are very rare and not applicable in this case)

Type A is characterized by grossly elevated levels of ADH unresponsive to osmotic deviations. Plasma ADH levels are often above that required for maximum antidiuresis, so the urine osmolality is typically very high. High hormone levels above the physiologic range suggest ectopic secretion of ADH, most commonly by bronchogenic carcinoma.

Type B is characterized by an abnormally low osmotic threshold for ADH release.

Type C is characterized by ADH levels that are persistently in the physiologic range and are neither suppressed by a low plasma osmolality nor stimulated by a rising plasma osmolality. This pattern differs quantitatively from type A, in which super-physiologic levels of ADH are observed. However, like type A, it can occur in patients with ectopic ADH secretion.

Idiopathic SIADH has been described primarily in older adult patients. However, some cases of apparently idiopathic disease were later found to be caused by an occult tumour (most often small cell carcinoma of the lung or olfactory neuroblastoma) and, in older patients, giant cell (temporal) arteritis.

Mild to moderate symptoms of hyponatraemia are relatively nonspecific and include headache, fatigue, lethargy, nausea, vomiting, dizziness, gait disturbances, forgetfulness, confusion, and muscle cramps. They occur most commonly in patients with chronic hyponatraemia (present for more than 48 hours) that is severe (serum sodium concentration less than 120 mmol/L) and, in such cases, result from brain adaptations that minimize cerebral oedema but alter the composition of brain cells.

Dr Bell sets out the opinion of Dr Lawrence and then goes on to answer a number of questions raised by the family as follows:

> *1. Why, when exhibiting the signs and symptoms of hyponatraemia wasn't he treated for it? Low salt levels were mentioned by staff on 3 occasions (1st, 2nd and 4th of May).*

The standard treatment for hyponatraemia is water restriction. This is slow at correcting the hyponatraemia but avoids the neurological damage (osmotic demyelination syndrome) seen with rapid correction.

2. Why in the 5 days before his fatal fall was Peter not given any medication at all to calm him down? The use of sedatives makes clinical assessment more difficult and has other associated problems. Presumably the medical staff considered the safest course of action was not to sedate.

3. Where was the sitter at the time of Peter's fall and where was she when he was reportedly strolling up and down the hospital corridor? A sitter was allocated and was with Mr Harris at the time of the fall. I note at the time of the fall the sitter was seated in a chair next to where Mr Harris was standing. It appears from the evidence of the sitter, which is considered in detail below, she was with him during the shift.

4. Was he assessed as a falls risk? Mr Harris was assessed as a high falls risk after the fall but at low risk prior to it.

5. Why had Peter not been seen by a psychiatrist after 5 days in hospital? Patients with an organic cause of cerebral dysfunction are not assessable for psychiatric assessment.

Dr Bell concludes as follows:

"The patient met the diagnostic criteria for SIADH. The weight loss raises concern regarding a cancer with secretion of ADH as the cause of the syndrome. The tumour can be small and not found at post mortem examination.

The fall was a sudden and unexpected event, the cause of which cannot be determined. This type of fall is more likely cardiac in origin (see Dr Lawrence comment above) than due to hyponatraemia.

A difficult to manage case and no clear diagnosis of hyponatraemia, or the symptomatology of the patient. There are no medical issues in the care provided."

I accept the opinions expressed by Dr Bell apart from his opinion with respect to the cause of the fall. In this regard his opinion differs from that of Dr Lawrence. I can make no finding as to the cause of the fall as neither doctor can say with a sufficient degree of probability its cause was hyponatraemia or cardiac in origin.

The THS has provided a number of documents including the patient admission risk identification screening (PARIS) protocol. This protocol is designed to deliver a standardised screening process to assist in the identification of risks for all patients during an inpatient admission. Ms Hodge, the nurse director of acute medical services at the RHH, advised the PARIS assessment was not performed for Mr Harris as he was part of a trial being conducted whereby a Nursing Admission Assessment was done instead. This assessment form was based on the Royal Melbourne Hospital tool with modifications based on consultation at the RHH. This tool is designed to deliver a standardised screening process to assist in the identification of risk for all patients during an admission. The algorithm on the form is used to determine if one or more supporting assessment tools are needed. Those sorting assessment tools include, amongst others, a mini cognitive assessment, a falls risk assessment and an adult pressure injury prevention care plan and skin assessment. The evaluation of the form after trials, in April 2020, proposed a 3 phase development and implementation process. A copy of the evaluation report of the trial has been provided.

In this case a nursing admission assessment was conducted on 1 May 2020. In relation to falls the form indicates there had been no recent experience of dizziness on standing up, no unsteadiness on his feet, difficulty getting in and out of a chair or the need to hold onto walls or furniture when walking. Three falls risk assessments were completed. On 1 and 4 May 2020 Mr Harris was assessed as low risk and on 5 May 2020, after the fall, he was assessed as high risk.

A clinical protocol titled "Assistance for Patients Requiring Specialised Care" has been provided. This protocol defines the expectations and role of Assistants in Nursing (AIN) and Care Assistants (CA) who provide constant observation and assist in the care of patients who are at risk of injuring themselves or others if left unattended. It also sets out how care is to be requested and who and on what basis such care can be authorised. It sets out the responsibilities of various people including the nurse unit manager, registered nurse and the AIN and CA. The responsibilities of the latter 2, include amongst other things, the responsibility to remain with the patient at all times and to assist with meals, diversional therapy and activities of daily living.

In this case a request for assistance for patients requiring specialised care was completed on 4 May 2020. The request form says the use of an AIN or a CA for constant observation and care is an intervention that is intrusive to the patient and therefore requires assessment and planning for use. This, it says, is necessary when risk behaviour exceeds normal observation requirements. A nursing order for constant patient observation and care for a period of 72 hours from 13:15 hours on 4 May 2020 was approved by the nurse unit manager.

The next document is the Patient Safety Observers' Responsibilities. That document indicates the observer receives an assignment from the nurse in charge. Upon arrival to the assigned unit the observer must report to the nurse in charge who provides the patient assignment. The observer then notifies the nurse assigned to that patient of his or her arrival and obtains a report for the patient and a handover from a current patient safety observer if applicable. The observer is to remain with the patient until assistance arrives. The principal duties of the observer includes the provision of assistance to patients with activities of daily living, assisting patients with mobility activities, maintaining infection control and observing the patient in order to ensure the safety of the patient at all times and to check, visually, the general condition of the patient. The 12th duty is in bold type and lists certain behaviours or activities that are not acceptable while undertaking the role of patient safety observer which include sleeping, reading, studying and importantly "using personal computer/tablet/mobile phone or any electronic devices".

Ms Khadka is a CA who has been employed on a casual basis since May 2017. On 4 May 2020 she was rostered to work the afternoon shift from 15:00 hours until 22:00 hours. At the start of her shift she received a handover from the previous sitter who advised she was to sit with Mr Harris. She was informed Mr Harris was "doing okay, that he had been wandering around the ward, and I needed to follow and redirect him." She then says the following:

- *"Throughout the entire shift Mr Harris was outside of his room and slowly walking and standing in the ward. For example, he stood for an hour and would take a step or 2 and then would keep standing for a long time in one spot. Occasionally he wanted to wander into other patients' rooms.*

- *When I asked him if he was tired, or he wanted to sit down or lay on his bed, he wasn't responding verbally or cooperative physically. Approximately an hour before his fall, I placed a chair behind Mr Harris and asked him to sit down and have a rest. At that time, he stepped away and pushed me away. Actually, a few times during the shift he pushed me away with his elbow. Even when his dinner arrived, he was standing and refused to sit down so I helped him to eat his dinner whilst standing.*

- *Approximately at 7:15 PM, Mr Harris was standing outside the medication room. I tried to redirect him away from the medication room door because staff were entering and exiting, he was very reluctant, but then I managed to convince him to move to the corridor.*

- *Approximately at 7:30 PM Mr Harris had moved towards the exit door. The nurse came with his medication and gave it to him while he was standing before leaving the*

corridor. Mr Harris was standing at the exit door for some time continuously pressing the exit button. I asked him on numerous occasions if he wanted to sit down or go back to his bed to lay down without a response. During this time, I positioned the chair behind him and asked him to sit down. He elbowed my chest to move me out of the way and continued to stand.

- *At about 8:45 PM I was sitting in the corridor next to where he was standing, facing him. Without any indications Mr Harris suddenly fell backwards to the floor. I called for help and immediately jumped up to assist him. Staff were immediately on the scene to assist. Soon after, the medical team arrived to treat him."*

In a subsequent affidavit Ms Khadka says:

"I assisted Mr Harris as he walked about the ward during the day, it was when he decided to stand still I used my phone, the electronic device, to check the time. However that did not distract me as I was still focused on Mr Harris. He fell without any warning and there was nothing I could do to stop his fall."

I have studied the CCTV footage of Mr Harris' fall very carefully. I observed the following:

- At 20:00 hours and 54 seconds Mr Harris is observed in the corridor of the ward facing an open doorway. Ms Khadka is seated in a chair next to and facing Mr Harris. She appears to be leaning to one side with her head down.
- At 20:00 hours and 57 seconds Mr Harris and Ms Khadka are observed in the same position. Ms Khadka appears to be hunched over.
- At 20:00 hours and 58 seconds Mr Harris commences to fall backwards and while Ms Khadka is still seated she has commenced to move towards him.
- At 20:00 hours and 59 seconds Ms Khadka is up out of her chair reaching for Mr Harris. He is upright but falling backwards.
- At 20:01 hours Mr Harris hits the floor with Ms Khadka standing above him.
- At 20:01 hours and 2 seconds Ms Khadka puts her phone on the floor.
- At 20:01 hours and 10 seconds she picks up her phone.

It seems to me Ms Khadka is looking at her phone for longer than would be necessary to check the time. Further her use of her mobile telephone breached the responsibilities of a patient safety observer. Having said that I note Mr Harris fell very suddenly and without

warning after which Ms Khadka moved very quickly. It is unlikely she could have prevented Mr Harris from falling even if she was not using her phone.

At its most basic Ms Khadka was required to watch Mr Harris and alert other medical and nursing staff if she considered he required medical and/or nursing assistance. At the time she commenced her shift medical staff were still trying to diagnose and determine the organic cause of, and treat Mr Harris' condition. That condition manifested itself in Mr Harris being behaviourally disturbed so that he did not respond verbally to Ms Khadka's queries or offers of assistance and he would not cooperate physically by remaining in his own room, on his bed or in a chair. He wandered the ward and stood in fixed positions for significant periods of time. Ms Khadka was required to follow him around, distract him, reorientate him or redirect him if he, for example, entered other patients' rooms, disturbed other patients or impeded staff entering or exiting the medication room. This she did. If she was sitting near or next to Mr Harris immediately prior to his fall and was focussed on him rather than her phone I do not think she could have prevented him from falling. I do not believe the result would have been any different if she had been standing next to or near Mr Harris, as opposed to sitting, when he fell. The footage shows he fell without warning. When Mr Harris begins to fall Ms Khadka commences to move towards him. In addition I note from the details in the post mortem and the footage Mr Harris was a taller person than Ms Khadka so even if she was able to grab a hold of him prior to him hitting the floor it is unlikely she would have been able to lessen the impact of the fall.

Comments and Recommendations

The circumstances of Mr Harris' death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mr Harris.

Dated: 12 September 2023 at Hobart in the State of Tasmania.

Robert Webster
Coroner

IN THE MAGISTRATES COURT OF TASMANIA
CORONIAL DIVISION

IN THE MATTER OF AN INQUEST INTO THE DEATH OF PETER BLACKWELL HARRIS

Ruling

Introduction

The circumstances of the death of Peter Blackwell Harris (Mr Harris) raise the question as to whether or not a coroner is required to hold a public inquest into his death. The short answer to this question is no and my reasoning follows. However before considering this issue it is necessary to briefly explain a coroner's jurisdiction in cases such as this.

Jurisdiction

A coroner's jurisdiction to investigate a death is provided for in s21 of the *Coroners Act* 1995 (the Act). That section provides:

"(1) A coroner has jurisdiction to investigate a death if it appears to the coroner that the death is or may be a reportable death.
(2) Unless the Attorney-General directs otherwise, a coroner need not investigate a death if an investigation or inquest is held in another State or in a Territory."

Subsection 2 is not relevant to this case. Accordingly a coroner is only permitted to investigate the death of Mr Harris if, in accordance with subsection (1), it appears his death is or may be a reportable death.

So far as is, or maybe, relevant to this case the term *reportable death* is defined in s3 of the Act as meaning:
"(a) a death where –
(i) the body of a deceased person is in Tasmania; or
(ii) the death occurred in Tasmania; or
(iii) the cause of the death occurred in Tasmania; or
(iiia) ... –

being a death –

(iv) that appears to have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury; or

(v)…; or

(vi) . . .

(vii)…; or

(viii)…; or

(ix) of a person who immediately before death was a person held in care or…; or

(x) …; or

(xi) …; or

(b)…; or

(c) …; or

(d) …;"

The circumstances surrounding Mr Harris's death satisfies subparagraphs (a)(ii) and (iv) and it may also satisfy subparagraph (ix). His death is therefore reportable and I have jurisdiction to investigate it.

Mental Health Orders Made With Respect to Mr Harris

The records of the Royal Hobart Hospital (RHH) disclose Mr Harris was taken into protective custody, by police, at 11:30 pm on 30 April 2020. He arrived at that hospital at midnight on 30 April 2020. At 1:06 am on 1 May 2020 Dr Gale examined Mr Harris and determined Mr Harris needed to be assessed against the assessment criteria or the treatment criteria. It appears that assessment did not take place. Instead he was assessed at 5:45 am on 1 May 2020 and admitted to the general medical unit where his goals of care were recorded as A; that is he was for full resuscitation. It was considered at that time Mr Harris may have had delirium which had a number of possible organic causes. The discharge summary suggests Mr Harris was initially admitted to the RHH with several weeks of unusual behaviour and persecutory beliefs. On admission he was identified to have hyponatraemia[1] which was treated as the syndrome of inappropriate anti-diuresis[2] (SIADH). It was this organic condition which was most likely to be the cause of his strange behaviour which was labelled a delirium.

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[1] Hyponatraemia means the sodium level in the blood is below normal. A person needs sodium for fluid balance, blood pressure control, as well as for nerves and muscles. The normal blood sodium level is 135 to 145 mmol/L. Hyponatraemia occurs when the sodium level in the blood falls below 135 mmol/L.

[2] The syndrome of inappropriate anti-diuresis is a disorder which causes impaired water excretion due to an inability to suppress the secretion of antidiuretic hormone. If water intake exceeds the reduced urine output, the ensuing water retention leads to the development of hyponatraemia.

Is a Public Inquest Mandatory in this Case?

Section 24(1) of the Act sets out the circumstances in which an inquest must be held. The term inquest is defined in s3 to mean, amongst other things, a public inquiry held by a coroner in respect of a death. Section 24(1) relevantly provides:

> *"(1) Subject to section 25[3], a coroner who has jurisdiction to investigate a death* ***must*** *hold an inquest if the body is in Tasmania or it appears to the coroner that the death, or the cause of death, occurred in Tasmania or that the deceased ordinarily resided in Tasmania at the time of death and –*
>
> .....
>
> *(b) The deceased was immediately before death a person* ***held in care*** *or a person held in custody; ..."* ***(my emphasis)***

The opening words of s24(1) are satisfied in this case. The question is whether Mr Harris was, immediately before his death, a person held in care. That phrase is defined in s3 to mean:

"person held in care *means –*
(a) a child, within the meaning of the Children, Young Persons and Their Families Act 1997 , in the custody or under the guardianship of the Secretary, within the meaning of that Act;
(b) a person detained or liable to be detained in an approved hospital within the meaning of the Mental Health Act 2013 or in a secure mental health unit or another place while in the custody of the controlling authority of a secure mental health unit, within the meaning of that Act;"

Subparagraph (a) of that definition is not relevant in this case. In subparagraph (b) the term *detained or liable to be detained* is not defined. I will discuss its meaning shortly.

Under s140 of the *Mental Health Act* 2013, an approved hospital is one which is notified by the Minister in the Gazette. In addition, s4(1) of the *Mental Health (Transitional and Consequential Provisions) Act* 2013 operates to recognise hospitals that were approved under the previous *Mental Health Act* 1996 as approved hospitals under the current *Mental Health Act* 2013.

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[3] Section 25 is not relevant to the circumstances of this case.

Under section 9 of the *Mental Health Act* 1996, the Minister approved the RHH as a hospital under that Act.[4] It follows that Mr Harris died at an approved hospital under the *Mental Health Act* 2013. The Whittle Ward, where Mr Harris died, is part of the RHH Repatriation Centre.

Mr Harris was taken into protective custody because the mental health officer (MHO) who assessed him believed he had a mental illness, that he should be examined to see if he needs to be assessed against the assessment criteria or the treatment criteria and his safety or the safety of other persons is likely to be at risk or is likely to be at risk if he was not taken into protective custody. It is noted in the records his behaviour, when assessed at 11:30 pm on 30 April 2020 was irrational and well outside what was typical for him and he had a worryingly high blood pressure.

The power to take somebody into protective custody is set out in s17 of the *Mental Health Act* 2013. That section provides:

" (1) An MHO or police officer may take a person into protective custody if the MHO or police officer reasonably believes that –
(a) the person has a mental illness; and
(b) the person should be examined to see if he or she needs to be assessed against the assessment criteria or the treatment criteria; and
(c) the person's safety or the safety of other persons is likely to be at risk if the person is not taken into protective custody.
Note
Mental illness has the meaning set out in section 4 . The assessment and treatment criteria are set out in section 25 and section 40 respectively.
(2) For the purposes of subsection (1) –
(a) no form of warrant is required; and
(b) the MHO or police officer is not required to confirm whether, under this or any other Act, another process is in train in respect of the person; and
(c) the custody and escort provisions apply, and continue to apply while the person remains in protective custody."

Mr Harris was then escorted to an approved assessment centre; that is the RHH and handed over to staff at that facility in accordance with s18 of the *Mental Health Act* 2013. Section 19 provides Mr Harris had to be examined by a medical practitioner within 4 hours of his arrival to see whether he needed to be assessed against the assessment criteria or the treatment criteria. As noted above this occurred well within that timeframe at 1:06 am. Section 20 then provides for the circumstances in which a person is released from protective custody. That section is as follows:

"(1) An MHO or police officer who has a person in protective custody must release the person from the protective custody if –
(a) before or during the authorised detention period –
(i) informed consent is given to assess or treat the person; or
(ii) an assessment order or treatment order is made in respect of the person; or
(iii) the MHO or police officer reasonably forms the belief that the person no longer meets the criteria for being taken into protective custody, as specified in section 17(1) ; or
(b) the authorised detention period expires and none of the things referred to in paragraph (a) has occurred.

[4] Tasmania, Gazette, 3 October 2007, 1518

Note
The assessment criteria and the treatment criteria are set out in section 25 and section 40 respectively.
(2) In this section –
***authorised detention period** means a period, not exceeding 4 hours, calculated from the precise time of the person's arrival at the approved assessment centre."*

The effect of this provision is that somebody can only lawfully be kept in detention for a maximum period of four hours; in this case until 4:00 am on 1 May 2020[5]. If the patient is to receive further mental health treatment then he or she either, within that four hours, has to provide informed consent or alternatively an assessment order or a treatment order is made under Part 3 of the *Mental Health Act* 2013. Alternatively a patient is released from protective custody if they no longer meet the criteria set out in s17(1). Finally a patient is released from protective custody if the authorised detention period of four hours expires and none of the things referred to in s20(1)(a) has occurred. This is what took place in this case. Mr Harris was therefore neither detained or liable to be detained at the RHH. That is there was no formal order in place compelling his detention at the RHH and notwithstanding the absence of an order the RHH could not control or compel Mr Harris to be detained. He could have left the RHH if he so chose but it seems from the medical notes he was too unwell for this to occur.

Accordingly immediately prior to his death Mr Harris was not a person held in care and therefore an inquest is not mandatory.

The Rationale for not Proceeding Further Under the Mental Health Act 2013

Involuntary assessment and treatment orders permitting detention of a person under the *Mental Health Act* 2013 may only be made in respect of a person who has a mental illness.[6] 'Mental illness' is defined in s4 of the *Mental Health Act* 2013 as follows:

"(1) For the purposes of this Act –
(a) a person is taken to have a mental illness if he or she experiences, temporarily, repeatedly or continually –
(i) a serious impairment of thought (which may include delusions); or
(ii) a serious impairment of mood, volition, perception or cognition; and
(b) nothing prevents the serious or permanent physiological, biochemical or psychological effects of alcohol use or drug-taking from being regarded as an indication that a person has a mental illness.
(2) However, under this Act, a person is not to be taken to have a mental illness by reason only of the person's –
(a) ...; or
(b)...; or
(c...; or
(d)...; or

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[5] The authorised detention period of 4 hours commenced from the time Mr Harris arrived at the RHH; ie at midnight.
[6] *Mental Health Act* 2013 ss 25 and 40

(e…; or
(f)…; or
(g)…; or
(h)…; or
(i)…; or
(j)…; or
(k) intoxication (however induced); or
(l) intellectual or physical disability; or
(m) acquired brain injury; or
(n) dementia; or
(o) temporary unconsciousness."

Mr Harris had none of the conditions listed in subsection 2. Dementia is a gradual neurodegenerative process which leads to a slow progressive cognitive decline. The medical records suggest his unusual behaviour and persecutory beliefs were however caused by delirium. That is an acute confusional state which is usually based on clinical observation of behaviours and cognition because no diagnostic tests are available. It can be characterised by inattention or distraction, and disorganised thinking or an altered level of consciousness which may include hallucinations or delusions. It can be caused by many physical ailments which included infection, dehydration, kidney failure, liver failure, brain tumours or other head trauma. Unlike dementia, delirium is usually reversible if the underlying cause is treated. Mr Harris' impaired thought and/or mood had an underlying physical or organic cause and therefore he did not have a mental illness as defined and therefore he was not assessed against the assessment criteria or the treatment criteria. The result was the protective custody order lapsed.

Dated: 12 September 2023 at Hobart in the State of Tasmania.

Robert Webster
Coroner