IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 004640

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of John Edward Hadland (Millar)

Delivered On:	14 April 2023
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank VIC 3006
Hearing Dates:	Thursday 13 April 2023
Findings of:	Coroner Paul Lawrie
Representation:	No appearances
Counsel Assisting the Coroner:	Lauren Bedggood, Senior Coroners' Solicitor
Keywords	Death in care

I, CORONER PAUL LAWRIE,
having investigated the death of JOHN EDWARD HADLAND (MILLAR),
and having held an inquest in relation to this death on 13 April 2023 at Southbank:
find that the identity of the deceased was JOHN EDWARD HADLAND (MILLAR) born on 8 August 1983, aged 38 years,
and that the death occurred on 2 September 2021 at Sale Hospital from:

1a: ABDOMINAL AND CHEST SEPSIS COMPLICATING IATROGENIC LEFT PNEUMOTHORAX AND LAPAROTOMY FOR SMALL BOWEL OBSTRUCTION IN A MAN WITH CHROMOSOME 1 SHORT ARM DELETION SYNDROME AND SCOLIOSIS

I find, under section 67(1) (c) of the ***Coroners Act 2008*** ('the Act') that the death occurred in the following circumstances:

John Hadland (Millar) (**John**) was admitted to Sale Hospital on 26 August 2021 with faecal loading of the colon and rectum and a circumferentially thickened rectal/rectosigmoid junction wall. He developed a small bowel obstruction and received surgical intervention. After extubation, John aspirated and developed aspiration pneumonia and septic shock. He was reintubated and received further treatment. During the insertion of a subclavian central line, John developed an iatrogenic left side pneumothorax. Due to his deteriorating condition a decision was made, in agreement with his mother Bernadette Millar, to palliate John and all active treatment was withdrawn. John passed away on 2 September 2021.

INTRODUCTION

1. On 2 September 2021, John Edward Hadland (Millar) was 38 years old when he died at Sale Hospital. At the time of his death, John lived in an independent supported living facility run by Melba Support Services at 21 Cunningham Street, Sale.

THE CORONIAL INVESTIGATION

2. John'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 is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

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

4. 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.

5. Coroner Sarah Gebert originally held carriage of this investigation. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of John's death. The Coroner's Investigator conducted inquiries on Coroner Gebert's behalf, including taking statements from witnesses – such as family members, the forensic pathologist, treating clinicians and support services personnel – and submitted a coronial brief of evidence.

6. I took carriage of this investigation in October 2022, for the purposes of finalising the inquest and finding.

7. This finding draws on the totality of the coronial investigation into the death John Edward Hadland (Millar) including evidence contained in the coronial brief. The brief will remain on the coronial file, together with the inquest transcript.

8. 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.[1]

BACKGROUND CIRCUMSTANCES

9. John was born in Sale on 8 August 1983 to Bernadette Millar and Harold Hadland. He had two brothers, a sister, and a half-sister. John's parents divorced when he was approximately five years old.

10. John was diagnosed at birth with Chromosome 1 short arm deletion syndrome, as a consequence of which he had an intellectual impairment, short stature, limb contractures and was mostly non-verbal. He also suffered from scoliosis.

11. John attended mainstream primary schools, before attending a special needs high school in Portland, Victoria.

12. When John was approximately 16 years old, he was placed into the care of the department formerly known as the Department of Health and Human Services (**DHHS**).[2]

13. In approximately 2010, John moved into an independent supported living facility run by DHHS in Cunningham Street, Sale. On 15 September 2019, the management of this facility was transferred from DHHS to Melba Support Services (**Melba**). John continued to reside at the facility after this transition.

14. John lived at the Cunningham Street facility with four other residents. The residents were supported by staff on a rotating roster who provided them assistance with daily living, personal care and grooming, mealtime preparation, household tasks, support to attend appointments, and community access.

15. John attended the George Gray Centre during the week and was described by his carers from Melba as very active. They stated that he took part in canoeing for people with

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[1] 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.

[2] Now known as the Department of Families, Fairness and Housing (DFFH).

disabilities, worked, was interested in life and involved in many activities. John's grandmother described him as a happy person who had a passion for life and loved going out.

16. In July 2021, John suffered a bowel obstruction which resulted in him being admitted to Sale Hospital for two nights. He returned home on 10 July 2021 with a bowel management plan, including a prescription for Movicol to treat his constipation.

17. Care records and statements from Melba indicate that John was administered Movicol in accordance with his bowel management plan.

18. Staff at the George Gray Centre noted that, from this time until his death, John appeared tired and was more disengaged from program activities and his peers. He was reportedly not presenting normally and was more subdued, often sitting on the couch quietly by himself for periods of time.

19. On 13 August 2021, John attended an appointment with his regular General Practitioner. At this appointment his treatment plan was changed from having Movicol administered regularly, to only as needed.

20. On 20 August 2021, John went on a short holiday to Lakes Entrance, organised by an external service provider, Strive. Notes from Strive indicate that John was in high spirits during this trip, singing and dancing. He returned home at approximately 4.00pm on 22 August 2021 and staff from Melba reported that he appeared well upon his return.

21. On 23 and 24 August 2021, John attended the George Gray Centre from 9.00am to 3.30pm as per his normal routine. Documents from the George Gray Centre indicate he participated in program activities such as bocce, craft projects and board games, but there was nothing recorded concerning his demeanour over these two days. Staff from Melba reported that John appeared well and nothing unusual was noticed on these two days.

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

Circumstances in which the death occurred

22. Notes from Melba indicate that at 3.00am on 25 August 2021, a staff member opened John's door and turned the light on, waking him. However, there is no further information as to why this occurred. John stayed awake until breakfast before attending the George Grey Centre as per his usual routine.

23. On 25 August 2021, when John returned home from the George Gray Centre, he appeared unwell and refused dinner. During the evening he soiled himself, which was unusual. He was taken to the bathroom and had a bowel movement. He then had a shower and was offered a glass of Milo with Movicol included, which he drank before going to bed.

24. The following morning, on 26 August 2021, John was noted to be pale and dry retching. He was also not walking with his usual gait. He refused breakfast but drank Milo and water that was offered to him. At 8.00am staff called an ambulance, and John was conveyed to Sale Hospital.

25. Upon admission it was noted that John had a one-day history of his bowels not opening and that he had been dry retching, vomiting, and refusing oral intake. John was also observed to be clutching his abdomen, which was distended, and grimacing.

26. John's mother, Ms Millar, attended the hospital and was recorded as John's medical power of attorney.

27. John had a fever of 38 degrees and appeared dehydrated and unwell. He was combative and required sedation in the Emergency Department in order for clinicians to properly examine him and obtain intravenous (**IV**) access.

28. Further testing revealed that John had faecal loading of the colon and rectum, and a circumferentially thickened rectal/rectosigmoid junction wall suggesting inflammation of the lining of the rectum. The working diagnosis was proctitis[3] and he was admitted to the Sale Hospital for further care and observations.

29. John was treated with oral lactulose and per rectal fleet enema. He was also commenced on IV antibiotics.

[3] Inflammation of the lining of the rectum.

30. At 1.00pm, staff from Melba contacted Sale Hospital to obtain an update regarding John's condition and were advised that Ms Millar had requested that no information be provided to them.

31. On 30 August 2021, John developed a small bowel obstruction for which he received treatment which included IV fluids and analgesia, and the cessation of oral intake.

32. A discussion took place between the treating team and Ms Millar to discuss the likely challenges in the event that John deteriorated further and required surgery. During this meeting it was noted that he was unlikely to tolerate a nasogastric tube, he was at high risk for aspiration should he vomit, and that post intubation and wound care would be challenging given his combative state. He was also unlikely to be compliant with a stoma. The risks and benefits were considered and shared with Ms Millar who was also advised that, while the surgery was high risk, without an operation there was a likelihood John could clinically deteriorate leading to death.

33. Ms Millar reportedly indicated that she wished for John to have comfort measures only with no invasive interventions. Based on this information, the Head of Surgical Unit and on-call surgeon decided to palliate John.

34. This information was communicated to the Executive Director of Medical Services who advised that the treating clinicians needed to determine whether Ms Millar held a power of attorney for John and was his Medical Treatment Decision Maker (**MTDM**). Further investigations were conducted which revealed that there was no documentation in the medical record to confirm that Ms Millar held this status.

35. John's condition deteriorated further during the day and he experienced increasing abdominal pain. The need for immediate surgery was discussed with Ms Millar who requested ongoing conservative management but there remained a continuing lack of clarity surrounding his MTDM.

36. The treating team then contacted the Office of the Public Advocate (**OPA**), who advised them to treat John based on clinical urgency. The clinical treating team also consulted with the legal team at Latrobe Regional Hospital. Following this, they decided to proceed based

on clinical priority, whilst still recognising that collaborative decision making with Ms Millar was the best way to advance John's care.

37. A further discussion took place between the team and Ms Millar, and Ms Millar gave consent for the surgery to proceed.

38. On 30 August 2021, John underwent an emergency laparotomy, division of adhesion and insertion of a gastronomy tube. He was then transferred to the Critical Care Unit for further management.

39. On 1 September 2021, John was extubated. Shortly afterwards, he aspirated and a decision was made that he be reintubated.

40. The same day a hospital social worker met with Ms Millar and John and made an application to the Victorian Civil and Administrative Tribunal (**VCAT**) for a guardianship order, noting Ms Millar as an interested party.

41. Later that evening John developed right sided aspiration pneumonia and septic shock. He was treated with IV antibiotics and supportive measures. An anaesthetist was summoned to insert a central line for the purpose of starting inotropes. Following the insertion of a subclavian central line John developed an iatrogenic left side moderate sized pneumothorax.

42. The clinical treating team contacted the OPA again and advised them of the current circumstances. A further discussion was held with Ms Millar concerning the need to insert a chest tube into John. Ms Millar was reportedly reluctant for him to receive this invasive intervention and raised concerns about his prognosis and the chances of a meaningful recovery given his deteriorating state.

43. The treating team contacted the OPA again, who advised that given the delay in appointing a MTDM, if the team were convinced that Ms Millar was acting in John's best interests, then she could be delegated as the MTDM. The clinical treating team collectively decided that Ms Millar could be delegated as the MTDM for John and the VCAT application was withdrawn.

44. The clinical treatment team and Ms Millar together decided to transfer John to palliative care and withdraw all active treatment. John was extubated and passed away on 2 September 2021.

Identity of the deceased

45. On 2 September 2021, John Edward Hadland (Millar), born 8 August 1983, was visually identified by his mother, Bernadette Millar.

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

Medical cause of death

47. Forensic Pathologist Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (VIFM), conducted an autopsy on 15 September 2021 and completed a written report of his findings on 9 November 2021.

48. The post-mortem examination and CT scan confirmed a left sided pneumothorax and evidence of a recent laparotomy which was complicated by peritonitis. There was no evidence of proctitis or colitis. There was bilateral bronchopneumonia.

49. The post-mortem biochemistry revealed markedly elevated inflammatory markers (C-reactive protein and procalcitonin), consistent with severe sepsis/systemic infection. A pathogen was not identified in lung swabs or blood culture. However, it was noted that antimicrobial therapy was administered in hospital which may have precluded the detection of a pathogen. The biochemistry profile showed only mild dehydration.

50. Dr Bouwer provided an opinion that the medical cause of death was 1 (a) ABDOMINAL AND CHEST SEPSIS COMPLICATING IATROGENIC LEFT PNEUMOTHORAX AND LAPAROTOMY FOR SMALL BOWEL OBSTRUCTION IN A MAN WITH CHROMOSOME 1 SHORT ARM DELETION SYNDROME AND SCOLIOSIS.

51. I accept Dr Bouwer's opinion.

FAMILY CONCERNS

52. Ms Millar indicated in her written statement that she had concerns about the care provided to John by Melba in the lead up to his death. In particular, she was concerned that they had neglected his care needs and provided him with inappropriate foods and drinks following his bowel obstruction in July 2021.

53. Ms Millar outlined her concerns in further detail in an email to the court, alleging that the Melba staff at the Cunningham Street residence were psychologically and verbally abusive and negligent towards John in the lead up to his death.

54. At the hearing of this inquest, on 13 April 2023, Ms Millar addressed the Court and restated her principal concerns as detailed in her statement and email.

FURTHER INVESTIGATIONS AND CPU REVIEW

55. Given the concerns outlined by Ms Millar in her written statement and email, I conducted further investigations and referred this matter to the Coroners Prevention Unit[4] (**CPU**) Health and Medical Investigations Team for a review of the care provided to John prior to his death. They identified no concerns with respect to the care provided.

56. After John's admission to hospital in July 2021, the Bowel Care Management Plan prepared by staff at Melba called for Movicol twice per day for one week, which was then to be reviewed on 16 July and 23 July. It was noted that monitoring of bowel movements was 'to the best of our ability, given that John is independent with toileting'.

57. John was the subject of a staff meeting on 25 August 2021 where a range of health issues were discussed. It was recorded that is 'bowels seem to be back to normal'.

58. Having considered the matters detailed in the statement and email provided by Ms Millar, the opinion of the CPU, the medical records and statements provided by John's treating clinicians and Melba Support Services, I am satisfied that the care provided to John by Melba Support Services and the Sale Hospital was appropriate. I am also satisfied that staff

[4] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

from Melba complied with the bowel management plan that had been developed with John's treating clinicians after his hospital admission in July 2021.

FINDINGS AND CONCLUSION

59. Having held an inquest into the death of John and having applied the appropriate standard to the available evidence, I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008* (Vic):

    a) the identity of the deceased is John Edward Hadland (Millar), born 8 August 1983;

    b) the death occurred on 2 September 2021 at Sale Hospital, from 1(a) abdominal and chest sepsis complicating iatrogenic left pneumothorax and laparotomy for small bowel obstruction in a man with chromosome 1 short arm deletion syndrome and scoliosis;

    c) the death occurred in the circumstances described above.

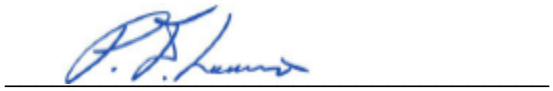
60. Pursuant to section 73(1) of the Act, this finding will be published on the Internet in accordance with the rules.

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

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

Bernadette Millar, Senior Next of Kin
Harold Hadland, Senior Next of Kin
Melba Support Services
Central Gippsland Health
Bianca Pitts, National Disability Insurance Scheme Quality and Safeguards Commission
First Constable Ashling Da Silva, Coroner's Investigator

Signature:



Coroner Paul Lawrie

Date: 11 May 2023

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 inquest. 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.