IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 001529

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Craig Ashley Hill
Date of birth:	1 September 1969
Date of death:	22 March 2023
Cause of death:	1(a) Cardiomegaly in a man with obesity and chronic liver disease
Place of death:	Werribee Mercy Hospital 300-310 Princes Highway, Werribee, Victoria, 3030
Keywords:	IN CARE; NATURAL CAUSES; CARDIOMEGALY; OBESITY; DIABETES; CHRONIC LIVER DISEASE; SCHIZOPHRENIA

INTRODUCTION

1. Craig Ashley Hill (**Mr Hill**) was 53 years old when he died on 22 March 2023. At the time of his death, Mr Hill was an inpatient at Werribee Mercy Hospital. Prior to this, he was residing in supported living accommodation at Claro Aged Care Disability Services.

2. Mr Hill had a medical history of schizoaffective disorder and bipolar disorder, hypertension, obstructive sleep apnoea, asthma, chronic obstructive pulmonary disease, cerebellar stroke, type-2 diabetes mellitus, and a past history of intravenous drug use. He was a wheelchair user.

3. Mr Hill had previously been the subject of a Community Treatment Order between April 2021 and February 2022, managed via North Western Mental Health Service Community Mental Health Team. In February 2022, he became a voluntary patient and by September 2022, his care was transferred to his GP.

4. Mr Hill was a participant in the National Disability Insurance Scheme (**NDIS**). His physical and mental health care were managed in the community (in supported accommodation) during periods when he did not require hospitalisation. His NDIS participant plan notes that his goals were to be able to be in the community and participate in activities, as well as to receive support to improve his health and wellbeing.

THE CORONIAL INVESTIGATION

5. Mr Hill's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**), namely because he was a 'person placed in care' under section 3(1) of 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. There is a requirement under section 52(2)(b) of the Act to hold an Inquest into the death of a person who was in custody or care immediately prior to passing, though pursuant to section 52(3A) of the Act, the coroner is not required to hold an Inquest if the coroner considers the death was due to natural causes. I exercise my discretion under this provision not to hold an Inquest in the present case on the basis that Mr Hill's passing was due to natural causes and there are no further issues I have identified that require the hearing of *viva voce* evidence.

7. Then-Deputy State Coroner Hawkins (**DSC Hawkins**) originally had carriage of this investigation. I took carriage of this matter on 16 October 2023 for the purposes of conducting discrete additional investigations, finalising the case, and making findings.

8. 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.

9. 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.

10. This finding draws on the totality of the coronial investigation into the death of Craig Ashley Hill 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.[1]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

11. On 14 March 2023, Mr. Hill was referred to the North Western Mental Health Service Crisis Assessment and Treatment Team (**CATT**) in the context of becoming physically and verbally abusive towards his support workers. Ongoing phone support was provided by CATT.

12. On 18 March 2023, Mr Hill reportedly assaulted a family member. CATT attended and facilitated an admission on an Inpatient Assessment Order to the Werribee Mercy Hospital psychiatric unit, with Mr Hill having first been medically cleared at the Emergency Department.

13. Mr Hill was considered to be suffering from a relapse of bipolar disorder, complicated by increased cannabis use.

[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.

14. On 19 March 2023, Mr Hill was placed on an Inpatient Temporary Treatment Order and treated in the Intensive Care Area of the psychiatric ward. In addition to providing mental health care, Mr Hill was subject to multiple medical reviews in the course of his admission.

15. A physical examination on 19 March 2023 showed clubbing, pitting pedal bilateral oedema, and cellulitis bilaterally of the lower limbs. A cardiovascular and respiratory exam was unremarkable. Alcohol withdrawal monitoring was commenced along with commencement of as-needed diazepam and the continuation of his regular medications.

16. Mr Hill was reviewed by a psychiatric registrar on 20 March 2023 and then by a psychiatrist on 21 March 2023, and was found to be experiencing a psychotic relapse. There were no obvious concerns around self-harm or suicide risk noted.

17. Mr Hill was found lying on the floor at about 7:10pm that night. He did not have any obvious injuries and was assisted to return to his wheelchair.

18. During a routine check at 2:30am on 22 March 2023, Mr Hill was found unresponsive. A code blue was called, and CPR attempted. Mr Hill was confirmed to be deceased at 3:11am.

IDENTITY OF THE DECEASED

19. On 22 March 2023, Craig Ashley Hill, born 1 September 1969, was visually identified by his aunt, Jan Dobai, who signed a formal statement of identification to this effect.

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

MEDICAL CAUSE OF DEATH

21. On 24 March 2023, Forensic Pathologist Professor Noel Woodford (**Professor Woodford**) from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy. Professor Woodford reviewed the Victoria Police Report of Death Form 83, Mercy Health Medical Deposition, VIFM preliminary examination report, and the post-mortem computed tomography (**CT**) scan and provided a written report of his findings.

22. Professor Woodford noted that the cause of death most probably related to significant cardiovascular and hepatic pathology. The mechanism of death has most likely been one of ventricular rhythm disturbance and arrest.

23. There were no injuries identified of a type likely to have caused or contributed to death.

24. Post-mortem toxicology showed the presence of a number of drugs prescribed to treat his medical and psychiatric disorders. None of these were present at excessive levels. No blood alcohol was identified.

25. Professor Woodford noted that Mr Hill's history included obesity, schizoaffective disorder, hypertension, obstructive sleep apnoea, asthma, chronic obstructive pulmonary disease, cerebellar stroke, type-2 diabetes mellitus (insulin requiring), and a past history of injecting drug use. He had recently been treated for lower leg cellulitis.

26. Biochemical analysis showed evidence of preserved renal function. Serological analysis showed a C-reactive protein level that was not suggestive of a significant infective or inflammatory process.

27. The heart was enlarged (above the normal range predicted for a male of the deceased's height). Professor Woodford noted that, given the case circumstances and autopsy findings, there are a number of possible causes for this. This includes obesity, hypertension, and chronic excessive alcohol use. There was no evidence of coronary artery atherosclerosis of significance. Cardiac enlargement may predispose someone to the relatively sudden onset of cardiac rhythm disturbance and arrest (heart attack). There was no evidence of pulmonary embolism.

28. Another finding of significance was the presence of a markedly enlarged liver, with evidence of micronodular cirrhosis and pronounced fatty change. The liver showed evidence of chronic inflammation. Possible explanations for these findings include chronic excessive alcohol use and chronic viral hepatitis. Hepatic disease of the type seen in this case, may predispose to significant biochemical and metabolic derangements.

29. Professor Woodford concluded that on the basis of the information available, the death was due to natural causes.

30. Toxicological analysis of post-mortem samples identified therapeutic levels of diazepam, quetiapine, olanzapine, zuclopenthixol, metformin, and metoprolol.

31. Professor Woodford provided an opinion that the medical cause of death was *1 (a) cardiomegaly in a man with obesity and chronic liver disease*.

32. I accept Professor Woodford's opinion.

ADDITIONAL INVESTIGATION

33. Noting that Mr Hill was a person placed 'in care' immediately before death, and in order to determine whether there were any issues associated with his care in the lead-up to his passing at the hospital, a statement was requested from Mercy Mental Health, along with medical records from both the community and Mr Hill's in-patient treatment.

34. On 30 November 2023, a statement was provided by Dr Michael Lograsso, Acting Clinical Services Director/Consultant psychiatrist at Mercy Mental Health, outlining the care provided to Mr Hill and the series of medical reviews that were conducted in relation to his physical and mental health between 18 March 2023 and his death. Having reviewed that statement and the materials provided, I am satisfied that there are no issues with the care provided to Mr Hill at Werribee Mercy Hospital during his short in-patient stay that warrant further investigation and that his care was appropriate in the circumstances. In particular, I concur with Dr Lograsso that Mr Hill's chronic health conditions (which were noted by Professor Woodford upon autopsy) would not have been conducive to active management during his acute presentation phase in the psychiatric ward.[2]

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Craig Ashley Hill, born 1 September 1969;

    b) the death occurred on 22 March 2023 at Werribee Mercy Hospital 300-310 Princes Highway, Werribee, Victoria, 3030, from cardiomegaly in a man with obesity and chronic liver disease; and

    c) the death occurred in the circumstances described above.

[2] In this regard, as noted at paragraph 149 by State Coroner Judge Cain in the finding into the 2019 death of Daniel Richards (available here), four out of every five people living with mental illness have a co-existing physical illness and compared to the general population are, amongst other things, two times more likely to have cardiovascular disease, respiratory disease, metabolic syndrome, diabetes, and osteoporosis. Further, people with a serious mental illness, are six times more likely to die from cardiovascular disease and four times more likely to die from respiratory disease. Approximately 66% of people living with mental illness and a coexisting physical health condition are overweight or obese and half of males and almost two-thirds of females with psychosis are obese. Health services delivering psychiatric care are therefore required to be cognisant of the need to consider not only mental health but also physical health conditions (including those that are chronic) in developing treatment plans and communicating with other health service providers. However, in the present case, there is no suggestion in relation to Mr Hill that more could have been done during the very short period he was in the care of the hospital. His care and management were appropriate.

36. Having considered the evidence, I find that Mr Hill's death was due to natural causes.

I convey my sincere condolences to Mr Hill'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.

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

Gail & Darryl Hill, Senior Next of Kin

Dr Michael Lograsso, Mercy Mental Health

Simon Cooke, Mercy Hospital

Signature:

Coroner Ingrid Giles

Date: 19 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.