IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005725

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Wayne Thomas Jamieson
Date of birth:	9 March 1967
Date of death:	14 October 2023
Cause of death:	1(a) Aspiration pneumonia, complicated by myocardial infarction and right heart failure <u>Contributing factors</u> Osteogerma Dysblastica and intellectual disability
Place of death:	Northeast Health Wangaratta (NHW) 35/47 Green Street Wangaratta Victoria 3677
Keywords:	In Care; Natural Causes

INTRODUCTION

1. On 14 October 2023, Wayne Thomas Jamieson was 56 years old when died at Northeast Health Wangaratta (NHW).

2. At the time of his death, Wayne received support through the National Disability Insurance Scheme (NDIS). Wayne lived with a profound intellectual disability, Osteogerma Dysblastica, and experienced numerous complexities in relation to his health and behaviours. He required full support for all activities of daily living and exhibited declining cognitive ability in the period proximate to his death.

3. Wayne lived in Supported Disability Accommodation (**SDA**) at 4-6 Younger Street, Wangaratta, Victoria with several other NDIS participants. Wayne's brother, Peter, had previously resided in the same facility until he died in July 2022.[1]

THE CORONIAL INVESTIGATION

4. Wayne's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act).

5. This is because, immediately before death, Wayne was a person "in care", meaning that she was an SDA resident residing in an SDA enrolled dwelling. 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.

6. Generally, the Coroner must hold an inquest into the death of a person "in care". However, under section 51(3A) and (3B) of the Act, the Coroner is not required to hold an inquest if the Coroner considers that the death was due to natural causes, on the basis of a report from a medical investigator which includes an opinion as such.

7. In this instance, I am satisfied on the basis of a report from Forensic Pathologist Dr Brian Beer of the Victorian Institute of Forensic Medicine (VIFM) dated 18 October 2023 that Wayne's death was due to natural causes and therefore that an inquest is not required. The report of Dr Beer is discussed further below in relation to the medical cause of death.

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

[1] Coroner Kate Despot, Finding into the death of Peter Jamieson (COR 2022 003717), 17 August 2023.

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 Wayne Thomas Jamieson, including information contained in the Police Report of Death (Form 83), the Medical Deposition, and Wayne's NDIS Participant Plan.

11. 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.[2]

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

Circumstances in which the death occurred

12. On 1 October 2023, Wayne was admitted to Wangaratta Hospital in response to concerns regarding his general oral intake, increasing difficulty swallowing and suspicion of an aspiration pneumonia. His chest x-ray showed evidence of aspiration pneumonia.

13. Wayne was treated with antibiotics. He received dietician input and 1:1 Nursing/special assistance. However, his intake failed to improve and he did not make any significant functional improvement

14. Wayne's course was complicated by a rising troponin level, electrolyte abnormalities, hypoglycaemia and fluid overload (this manifested as ascites and bilateral pleural effusions). He had multiple MET calls for hypotension that were managed with IV crystalloid and colloid.

[2] 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.

15. Despite treatment, Wayne's condition continued to deteriorate. On 10 October 2023, there was a dual medical consultant decision to transition to palliative care measures. It was determined that Wayne would remain as a hospital inpatient.

16. On 13 October 2023, Wayne sustained a witnessed fall from a low/crawling position.

17. Wayne subsequently died at 1.40pm on 14 October 2023.

Identity of the deceased

18. On 14 October 2023, Wayne Thomas Jamieson, born 9 March 1967, was visually identified by his support worker, Timothy Bright.

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

Medical cause of death

20. On 17 October 2023, Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and reviewed the medical deposition and a post mortem CT scan.

21. Dr Beer provided a written report of his findings dated 18 October 2023.

22. Taking into account all available information, Dr Beer provided an opinion that Wayne's death was due to natural causes and that a reasonable formulation for the medical cause of death was:

> *1(a) Aspiration pneumonia, complicated by myocardial infarction and right heart failure*
>
> *Contributing factors: Osteogerma Dysblastica and intellectual disability*

23. Dr Beer noted that the witnessed fall on 13 October 2023 was considered not to have contributed to the death.

24. I accept Dr Beer's opinion.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Wayne Thomas Jamieson, born 9 March 1967;

b) the death occurred on 14 October 2023 at Northeast Health Wangaratta (NHW) 35/47 Green Street Wangaratta Victoria 3677, from aspiration pneumonia, complicated by myocardial infarction and right heart failure, with contributing factors of Osteogerma Dysblastica and intellectual disability; and

c) the death occurred in the circumstances described above.

26. Having considered all of the circumstances, I am satisfied that Wayne died of natural causes and have not identified any concerns in relation to the quality of care provided in the period proximate to his death.

I convey my sincere condolences to Wayne'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:

William Jamieson, Senior Next of Kin
National Disability Insurance Agency

Signature:

Coroner Leveasque Peterson

Date : 25 January 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.