IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 002032

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*
*Section 67 of the **Coroners Act 2008***

I, JUDGE SARA HINCHEY, State Coroner, having investigated the death of ANDREW SIMON BEARE

without holding an inquest:

find that the identity of the deceased was ANDREW SIMON BEARE

born on 30 September 1981

and that the death occurred on 26 April 2015

at [redacted] Carrum Victoria 3197

**from:**

I (a) CEREBRAL HAEMORRHAGE
CONTRIBUTING FACTORS
LOWES SYNDROME.

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mr Beare was a 33-year-old man who lived in Department of Health and Human Services (DHHS) supported accommodation at the time of his death.
2. Mr Beare had a complex medical history that included Lowes syndrome (a rare genetic disorder associated with congenital blindness and intellectual disability), Franconi's syndrome (a renal condition resulting in increased urination, dehydration, metabolic acidosis due to loss of bicarbonate), epilepsy, weak muscle tone and associated feeding difficulties, and delayed motor skills including for sitting, standing and walking. He required full-time care and assistance with all aspects of daily life.

3. Just prior to his death, Mr Beare had been admitted to hospital from 14 to 22 April 2015 at the Monash Medical Centre, due to altered level of consciousness and poor oral intake. The focus of the admission was on Mr Beare's oral intake and bowel issues (distension and constipation/obstruction). Pathology investigations were stable at that time and all other examination findings were unremarkable. His bowel activity improved and he underwent speech pathology testing.

4. Mr Beare was discharged back to his accommodation on 22 April 2015 with a discharge plan in place. His prescribed medications were administered by Disability Support Worker (DSW) staff as directed.

5. On 26 April 2015, Mr Beare was at his home with his carers and fellow residents. One of the DSWs, Ms Prabhjot Dhaliwal, stated that she saw Mr Beare sitting in his wheelchair at his usual spot at the dining table at 3.30pm, and that he appeared fine. Ms Dhaliwal went to assist another resident to the bathroom, and returned to the dining area at about 3.40pm to find Mr Beare unresponsive. She called out to her colleague to assist her. Paramedics were called and it was confirmed that Mr Beare was deceased.

6. An external examination of Mr Beare's body and post mortem CT scanning (PMCT) were performed by Forensic Pathologist Dr Jacqueline Lee, who formed the opinion that the cause of his death was *cerebral haemorrhage* with *Lowes syndrome* as a contributing factor.[1] Dr Lee formed the opinion that Mr Beare's death was due to natural causes.

7. Dr Lee stated that PMCT revealed the presence of an intracerebral haemorrhage.[2] No free intra-abdominal air was noted. External examination of the body showed healing scratch marks on the left side of the face, but no other evidence of injury.

8. Post mortem toxicological analysis of blood revealed the presence of atenolol at ~0.2mg/L, carbamazepine at ~4mg/L and levetiracetam at ~5mg/L, consistent with therapeutic administration.

9. Apart from a jurisdictional nexus with the State of Victoria, reportable deaths are, generally, deaths that appeared to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury. However, some deaths are reportable irrespective of the nature of the death, based on the status of the person immediately before death. Mr

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[1] Report of Dr Lee dated 16 June 2015.

[2] Dr Lee stated that an autopsy would be required to find the cause of the haemorrhage. However, it was determined that no autopsy be performed consistent with the wishes of Mr Beare's family. The precise cause of the haemorrhage therefore remains unknown.

Beare's death was reportable as he was a *person placed in custody or care*,[3] as he was in DHHS care at the time of his death. This is one of the ways in which the *Coroners Act 2008* (Vic) recognises that people in the control, care or custody of the State are vulnerable, and affords them the protection of the independent scrutiny and accountability of a coronial investigation.

10. While there is a discretionary power to hold an inquest in relation to any death a coroner is investigating, an inquest is mandated when a person dies whilst in the care or custody of the State, unless a coroner considers that the death is due to natural causes. A death may be considered due to natural causes if the coroner has received a report from a medical investigator that includes an opinion that the death was due to natural causes. I have received a report from Dr Lee that includes such opinion, and I therefore determined that an inquest should not be held.

11. The focus of the coronial investigation of Mr Beare's death was on the adequacy of clinical management and care provided to him proximate to his death. No concerns about clinical management and care were stated in the initial police report of Mr Beare's death to the coroner. The Coroner's Investigator, SC James Hutton, was also asked to prepare a coronial brief of evidence focusing on his clinical course and the events of 26 April 2015.

12. I note Mr Beare's hospital admission proximate to his death for bowel, feeding and swallowing difficulties. I also note that these were found not to have contributed to his death.

13. The evidence does not support a finding that there was any want of clinical management and care on the part of DSW staff at DHHS or medical and nursing staff at the Monash Medical Centre, or that any such want of clinical management or care caused or contributed to Mr Beare's death.

**Findings pursuant to section 67 of the *Coroners Act 2008***

14. I find that:

    a. the identity of the deceased was Andrew Simon Beare;

    b. Mr Beare's death was due to natural causes; and the cause of his death is cerebral haemorrhage with Lowes syndrome as a contributing factor, on 26 April 2015, at [redacted] Carrum Victoria 3197, in the circumstances described above.

[3] See section 3 *Coroners Act 2008* (Vic) for the definition of a 'person placed in custody or care' and section 4(2)(c) of the definition of 'reportable death'.

I convey my sincere condolences to Mr Beare's family and friends.

Pursuant to section 73(1B) of the *Coroners Act 2008*, a copy of this finding must be published on the Court website.

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

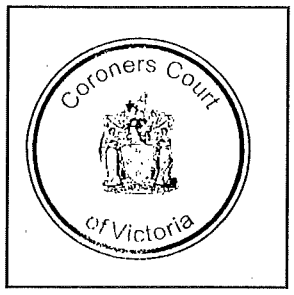
**Ms Margaret Stewart, Senior Next of Kin**

**Mr Stephen Beare, Senior Next of Kin**

**Ms Susan Van Dyk, Monash Health**

**SC James Hutton, Victoria Police, Coroner's Investigator.**

Signature:




JUDGE SARA HINCHEY
STATE CORONER
Date: 4 March 2016