IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 6110

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**BRUCE ROBERT ALLAN**, born 5 January 1946
Delivered on:	11 July 2018
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	10 July 2018
Counsel assisting the Coroner:	Rebecca Johnston-Ryan, State Coroner's Legal Officer

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HER HONOUR:

BACKGROUND

1. Mr Bruce Robert Allan (**Mr Allan**) was a 70-year-old man who resided at a Department of Health and Human Services (**DHHS**) managed residential service located at 11 Josephine Grove, Preston at the time of his death.

2. Mr Allan was a long-term resident in DHHS care, requiring care from age 6. Mr Allan resided at Kew Cottages until 2006, at which time he moved to 11 Josephine Grove, Preston (**the Josephine Grove facility**). He is survived by his sister, Ms Vivien Allan, who regularly visited and spent time with Mr Allan.

3. Mr Allan was described as a very happy person who was always smiling. He enjoyed music, going to the swimming pool, and going out for lunch in a location where there was a lot of activity.[1]

4. Mr Allan was non-verbal but expressed himself through hand gestures and facial expressions.[2] He used a wheelchair to mobilise.

5. From December 2015 until the time of his death, Mr Allan was treated by general practitioners Dr Angeline Harindar and Dr Raj Vyravipillai. He had a medical history of dermatitis, and repeat urinary tract infections as a result of benign prostate hypertrophy and vesicoureteral reflux.[3] Mr Allan also had a medical history of epilepsy.[4] Mr Allan was generally seen for routine appointments for medication script renewals and routine blood tests, with the exception of a referral to a specialist some two years prior to his death in relation to a methicillin-resistant Staphylococcus aureus (**MSSA**) infection following a hip surgery in 2014.

THE PURPOSE OF A CORONIAL INVESTIGATION

6. The role of a coroner is to investigate reportable deaths to establish, if possible, the identity, of the deceased, the medical cause of death and, with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently

[1] Coronial brief, Disability Accommodation Service, Individual Resident Profile of Bruce Allan, 2
[2] Statement of Vivien Allan, dated 2 April 2018, 1
[3] Coronial brief, statement of Dr Angeline Harindar, dated 6 July 2017, 1
[4] Coronial brief, statement of Louise Stasnik, dated 25 September 2017, 1

proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame, or determine criminal or civil liability.[5]

7. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[6] The *Coroners Act 2008* (Vic) (**the Act**) provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[7]

8. The Act provides that a coroner must hold an inquest into all deaths which occurred while a person is "*in custody or care*",[8] except in those circumstances where the death is considered to be due to natural causes.[9]

9. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[10] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

10. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

11. For coronial purposes, the phrase "*circumstances in which death occurred,*" refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

12. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

13. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

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[5] In the coronial jurisdiction facts must be established on the balance of probabilities 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

[6] Section 89(4) *Coroners Act 2008*

[7] See Preamble and s 67, *Coroners Act 2008*

[8] Section 52(2)(b) of the *Coroners Act 2008*

[9] Section 52(3A) of the *Coroners Act 2008*

[10] *Keown v Khan* (1999) 1 VR 69

(b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

(c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

14. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[11] 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 that they caused or contributed to the death.

15. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

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

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

16. On 25 December 2016, DHHS Disability Development Support Officer Ms Kylie Morrison (**Ms Morrison**) identified the body of the deceased to be Mr Bruce Robert Allan, born 5 January 1946.

17. Identity is not in dispute in this matter and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

18. On 29 December 2016, Dr Khamis Almazrooei, a Forensic Pathology Registrar practising at the Victorian Institute of Forensic Medicine supervised by Forensic Pathologist Dr Linda Iles, conducted an autopsy upon the body of Mr Allan. Dr Almazrooei provided a written report, dated 12 April 2017 which concluded that Mr Allan died as a result of a cause unascertained.

19. Toxicological analysis of post-mortem specimens detected trace amounts of paracetamol, but no other common drugs or poisons were identified.

[11] (1938) 60 CLR 336

20. Dr Almazrooei commented:

> *"Mr Bruce [Allan] was wheel chair bound and had reduced physical mobility. He was found in a position which was described as "hunched over with his head tucked under his body". He was moved from that position in an attempt for resuscitation, therefore there were no scene photos showing the deceased in that position. However, such position could impede adequate respiratory movement and lead to death. He also had severe coronary artery atherosclerosis and myocardial fibrosis which can lead to arrhythmia and death. It is difficult to ascertain whether Mr Bruce [Allan] had died from positional asphyxia or as a result of an arrhythmic event secondary to the ischaemic heart disease or both."*[12]

21. I accept the cause of death proposed by Dr Almazrooei.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

22. On 25 December 2016 at approximately 5.00am Ms Morrison attended Mr Allan's room at the Josephine Grove facility and found him out of bed with his body positioned over his head in a slumped position. Ms Morrison rolled Mr Allan onto his back and commenced cardiopulmonary resuscitation.[13]

23. Emergency services were called to attend. Victoria Police members and Ambulance Victoria paramedics attended the scene at approximately 5.14am. Mr Allan was unable to be revived, and he was declared deceased at the scene.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

24. Ms Vivien Allan's statement to the Court describes the staff and clients at Mr Allan's shared home facility as "*a part of Bruce's family*".[14] Ms Allan commented that when she visited Mr Allan he would show his happiness through laughing and blinking his eyes. Ms Allan held no concerns regarding Mr Allan's care and treatment at the Josephine Grove facility, noting that family and friends were always welcomed to the facility and staff were helpful, friendly and approachable.[15]

25. DHHS Manager of Disability Accommodation Services, Ms Ondine Stachnowski, has provided a statement to the Court outlining Mr Allan's involvement with the DHHS over the

[12] Coronial brief, Autopsy Report, 12
[13] Coronial brief, statement of Kylie Morrison, dated 25 September 2017, 1
[14] Above n 2
[15] *Ibid*, 1-2

course of his time residing at the Josephine Grove facility. Following a fall in December 2014 which resulted in a broken hip, Forensic Medical Consultant Dr Edward Ogden recommended a review of Mr Allan's records to ensure:

(a) that an appropriate falls prevention program was in place including consideration of hip protectors;

(b) Mr Allan be screened for fracture risks including bone density, Vitamin D levels and calcium levels; and

(c) Mr Allan be routinely administered Vitamin D and consume a diet with adequate levels of calcium or calcium supplements.[16]

26. Mr Allan was noted to be a very sound sleeper and was not known to make attempts to get out of bed at night according to staff at the Josephine Grove facility. Mr Allan was checked throughout the night at hourly intervals. As he was a sound sleeper, a bed guard rail was not identified as a special need for his bed. Ms Stachnowski reported that bed rails can only be installed following careful consideration by an Occupational Therapist who checks the bed according to DHHS's bed standards.[17]

27. Following a thorough review of the coronial brief of evidence and the statements of Ms Allan and Ms Stachnowski, I am satisfied that Mr Allan's medical care and management was reasonable and appropriate.

28. In the course of my investigation, I did not identify any prevention matters requiring further investigation which arose from the circumstances of Mr Allan's death.

FINDINGS AND CONCLUSION

29. Having investigated the death and having held an Inquest in relation to his death on 10 July 2018 at Melbourne, I make the following findings pursuant to section 67(1) of the Act:

(a) the identity of the deceased was Bruce Robert Allan, born 5 January 1946;

(b) the death occurred on 25 December 2016 at 11 Josephine Grove, Preston, Victoria, from a cause unascertained; and

(c) the death occurred in the circumstances described above.

[16] Statement of Ondine Stachnowski, dated 11 April 2018, 2
[17] *Ibid,* 2-3

30. I convey my sincerest sympathy to Mr Allan's family.

31. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

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

    (a) Ms Vivien Allan, Senior Next of Kin;

    (b) Department of Health and Human Services; and

    (c) Constable Warren Robinson, Victoria Police, Coroner's Investigator.

Signature:

JUDGE SARA HINCHEY

STATE CORONER

Date: 11 July 2018