IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 2759

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of CLIFFORD NORRIE WALL

without holding an inquest pursuant to section 52(3A) of the *Coroners Act 2008*:
find that the identity of the deceased was CLIFFORD NORRIE WALL
born 5 January 1937
and the death occurred on 18 June 2016
at St Vincent's Hospital Melbourne, 41 Victoria Parade, Fitzroy Victoria 3065
from:

1 (a) ASPIRATION PNEUMONIA IN THE SETTING OF SMALL BOWEL OBSTRUCTION

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

1. Clifford Norrie Wall was 79 years of age at the time of his death. Mr Wall lived in a high care facility in Kew. He was a registered client of Disability Accommodation Services at the Department of Health and Human Services (DHHS). Mr Wall suffered from an intellectual disability and a number of co-morbidities including atrial fibrillation, epilepsy, chronic obstructive pulmonary disease, asthma and previous cerebrovascular accidents.

2. On 9 June 2016, Mr Wall vomited while eating breakfast; his local General Practitioner Dr Hiran Edirisinghe was contacted and was not concerned. Mr Wall vomited again at 12.00pm. Dr Edirisinghe attended at 3.00pm, at which time Mr Wall vomited for a third time. It was suspected Mr Wall had a bowel obstruction and staff contacted emergency services. Ambulance paramedics attended at 4.01pm and Mr Wall was subsequently transported by ambulance to the St Vincent's Hospital Emergency Department. Upon admission, Mr Wall was noted to be in

rapid atrial fibrillation with a heart rate of 120 beats per minute. A computed tomography (CT) scan showed a small bowel obstruction, and a nasogastric tube was inserted. Mr Wall was not deemed suitable for surgery, given his multiple comorbidities. Aspiration pneumonia was also diagnosed and treated with intravenous antibiotics. However, Mr Wall had increasing oxygen demands and experienced worsening respiratory failure. The Office of the Public Advocate were contacted and advised that Mr Wall had no nominated next of kin, and any step towards palliation was a medical decision. After a review by the general medical team, Mr Wall was transferred to palliative care on 16 June 2016. He was declared deceased on 18 June 2016, at 8.00pm.

3. Mr Walls's death was considered reportable pursuant to section 4 of the Coroners Act 2008 (Vic) ('the Act') because he was immediately before his death, considered to have been a person placed in care. Pursuant to section 3 of the Act, a person placed in care includes a person who is under the control, care or custody of the Department of Health and Human Services.

INVESTIGATIONS

Forensic pathology investigation

4. Dr Melissa Baker, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination upon the body of Mr Wall, reviewed a post mortem CT scan, medical records and an e-Medical Deposition Form from St Vincent's Hospital and referred to the Victoria Police Report of Death, Form 83. On the post mortem CT scan, Dr Baker observed consolidation of Mr Wall's left lung base and bilateral pleural effusions. Anatomical findings were consistent with the clinical history. Dr Baker ascribed the cause of Mr Wall's death to natural causes, being aspiration pneumonia in the setting of small bowel obstruction.

Police investigation

5. Senior Constable (SC) Ray Khanlarian, the nominated coroner's investigator,[1] conducted an investigation of the circumstances surrounding Mr Wall's death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, a statement made by St Vincent's Hospital Department of Surgery Fellow Dr Synn Chin. SC Khanlarian subsequently obtained additional statements from General Practitioner Dr Hiran Edirisinghe, DHHS staff:

[1] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

Care Facility Supervisor Rene Labaro and Disability Development and Support Officer Gopesh Malhotra.

6. In the course of the investigation, police ascertained that Mr Wall had been in care for most of his adult life, due to his cognitive disability and large number of medical co-morbidities. General Practitioner Dr Hiran Edirisinghe stated that he treated Mr Wall from 2011, and described him as a man with severe intellectual and physical disabilities. Supervisor Rene Labaro stated that Mr Wall had been a resident at his DHHS group home in Kew for approximately five years.

7. Police learned that Mr Wall did not have any known next of kin or immediate family members. Dr Synn Chin stated that during Mr Wall's admission at St Vincent's Hospital, staff were aware he did not have a next of kin, but kept his cousin updated on his status.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death:

1. Section 52 of the Act mandates the holding of an Inquest if the deceased was, immediately before death, a person placed in care, save for circumstances where the person is deemed to have died from natural causes, pursuant to section 52(3A). In the circumstances, as Dr Baker has ascribed Mr Wall's death to natural causes, being aspiration pneumonia in the setting of small bowel obstruction, I have determined it is appropriate to conclude this investigation by way of an in-chambers Finding.

FINDINGS

Mr Wall had a significant number of medical co-morbidities. On the evidence available to me, I have not identified a causal relationship between his death and the fact that he was a person in care. I find that the provision of care to Mr Wall appears to have been reasonable and appropriate.

I accept and adopt the medical cause of death as ascribed by Dr Melissa Baker, and find that Clifford Norrie Wall died from natural causes, being aspiration pneumonia in the setting of small bowel obstruction.

Pursuant to section 73(1B) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

Mrs Margot and Mr Ron Hindaugh
Ms Melanie Kyezor, St Vincent's Health
Senior Constable Ray Khanlarian

Signature:

AUDREY JAMIESON
CORONER

Date: **27 June 2017**