IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2014 6010

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 CLIVE JOHN COOK

without holding an inquest:

find that the identity of the deceased was CLIVE JOHN COOK

born 18 December 1945

and the death occurred on 26 November 2014

at Peninsula Health Palliative Care Unit, 125 Golf Links Road, Frankston Victoria 3199

from:

1 (a) COMPLICATIONS OF ASPIRATION PNEUMONIA IN A MAN WITH INTELLECTUAL DISABILITY (CONGENITAL ACQUIRED BRAIN INJURY)

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

1. Clive John Cook was 68 years of age at the time of his death. Mr Cook ordinarily resided in Cranbourne and had lived in government supported residential care since birth. He communicated non-verbally and had a medical history that included a brain injury acquired at birth with associated intellectual disability and epilepsy. His health had recently deteriorated subsequent to oropharyngeal dysphagia related to his intellectual disability.

2. On 6 November 2014 Mr Cook was transported by ambulance to Frankston Hospital - Peninsula Health, following symptoms of vomiting and diarrhoea and recent issues including functional decline, hypoxia, fevers, poor oral intake and weight loss. He received intravenous fluids and antibiotics for a suspected chest infection but by 10 November 2014 had shown no significant

improvement. He declined oral food, fluids and medications. On 12 November 2014, a meeting was held with family and multidisciplinary clinicians and it was agreed that Mr Cook would be treated conservatively for his aspiration pneumonia with comfort measures.

3. On 14 November 2014, Mr Cook was transferred to Peninsula Health's Palliative Care Unit for end of life care. He remained non-verbal and non-ambulant but was initially responsive to voice and would move his head in the direction of sound. However, Mr Cook became increasingly unresponsive and continued to refuse any oral intake. He remained settled and did not appear to be requiring any pain relief. At 10.20am on 26 November, Mr Cook was declared deceased.

INVESTIGATIONS

Forensic pathology investigation

4. Professor Stephen Cordner, Professor of Forensic Pathology (International) at Monash University and Head of International Programmes at the Victorian Institute of Forensic Medicine, performed an external examination upon the body of Mr Cook, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. Professor Cordner opined that Mr Cook's death was best regarded as being due to natural causes and ascribed his death to complications of aspiration pneumonia in a man with intellectual disability (congenital acquired brain injury).

Police investigation

5. The circumstances of Mr Cook's death have been the subject of investigation by Victoria Police on my behalf. Police obtained statements from Supervisor at Disability Accommodation Services Vijith Vijayaratnam, Acting Team Leader at the Department of Health and Human Services Lauren Bourke, as well as Peninsula Health staff: Senior Medical Officer in palliative medicine Dr Karen Aisling and General Physician Dr Anmol Bassi.

6. Senior Medical Officer Dr Aisling reported that Mr Cook had experienced repeated hospital admissions with recurrent aspiration pneumonias and issues with dysphagia over the past decade.

7. Disability Accommodation Services Supervisor Mr Vijayaratnam stated that Mr Cook originally resided in Kew and had been transferred to his Cranbourne group home approximately 10 years ago. Mr Vijayaratnam stated that Mr Cook had appeared fine to staff on 5 November 2014. He did not eat his cereal but spent the morning walking around. At 2.00am on 6 November 2014, staff called an ambulance because Mr Cook was wandering around, had diarrhoea and was

vomiting. Staff were particularly concerned about Mr Cook's vomiting because he was underweight.

COMMENTS

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

1. Mr Cook's death was reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) ('the Act') because he was immediately before death a person placed in care, as defined by section 3 of the Act. Section 52 of the Act mandates the holding of an Inquest, save for circumstances where the person is deemed to have died from natural causes, pursuant to section 52(3A). In Mr Cook's circumstances, it is therefore appropriate to conclude the investigation by an in-chambers Finding.

FINDINGS

I accept and adopt the medical cause of death as identified by Professor Stephen Cordner and find that Clive John Cook, a man with intellectual disability (congenital acquired brain injury) died from complications of aspiration pneumonia.

AND I find that there is no causal connection between the cause of Mr Cook's death and the fact that he was a person placed in care.

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 Gayle Smith

Ms Mia Janssen, Peninsula Health

Ms Kym Peake, Secretary of the Department of Health and Human Services

Leading Senior Constable Melanie Lean

Signature:

AUDREY JAMIESON
CORONER

Date: **7 June 2016**