IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2013 / 4376

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: DAVID LIAM GOOLD

Delivered On:	24 November 2014
Delivered At:	MELBOURNE
Hearing Dates:	24 November 2014
Findings of:	IAIN WEST, DEPUTY STATE CORONER
Police Coronial Support Unit	INSPECTOR PAUL HAYES

I, IAIN WEST, Deputy State Coroner having investigated the death of David Liam Goold

AND having held an inquest in relation to this death on 24 November 2014

at Melbourne

find that the identity of the deceased was David Liam Goold

born on 6 July 1991

and the death occurred on 29 September 2013

at Northern Hospital 185 Cooper Street, Epping 3076, Victoria

from:

1 (a) ISCHAEMIC BOWEL

in the following circumstances:

1. David Goold, aged 22 years, was a client of the Department of Human Services and resided in supported accommodation at 43 Winn Grove, Fawkner. He moved into the care facility in November 2011 and returned home to his family two nights a week. David's "in care" status was due to him suffering spastic quadriplegia and cerebral palsy. In addition, David had a past medical history that included spinal fusion performed at the Alfred Hospital and epilepsy.
2. On the 28 September 2013, David was transported to the Northern Hospital after staff noticed he looked unwell. He presented with an acute abdominal condition and was assessed for urgent laparotomy which was arranged at 11.30pm. David was found to have extensive non-viable ischaemic small and large bowel and was subsequently admitted to the Intensive Care Department for palliation. David's condition continued to deteriorate and he died at 4.30 am on the 29 September 2013.
3. David underwent a preliminary examination at the Victorian Institute of Forensic Medicine by Forensic Pathologist, Dr Sarah Parsons. Dr Parsons recommended an autopsy examination as she believed it may assist in determining the cause of the ischaemia. The family objected on the basis that David had suffered enough, with the objection being upheld by the coroner.
4. I find that David Goold died from ischaemic bowel and that his management whilst in the care of the Department of Human Services and as a patient at Northern Hospital, was within the parameters of reasonable health care practice.

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

Ms Jane Lucas, mother of David Goold

Constable Christian Briant, Coroner's Investigator

Signature:

IAIN WEST
DEPUTY STATE CORONER
Date: **24 November 2014**