IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 3623

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 ERIC VINCENT CRAIG without holding an inquest pursuant to section 52(3A) of the *Coroners Act 2008*:
find that the identity of the deceased was ERIC VINCENT CRAIG
born 4 September 1950
and the death occurred on 25 July 2017
at Calvary Health Care Bethlehem, 476 Kooyong Road, Caulfield South, Victoria, 3162
from:

1 (a) ASPIRATION PNEUMONIA

2. DOWN'S SYNDROME

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

1. Eric Vincent Craig was 66 years of age at the time of his death. He resided at 9 Glencairn Avenue, Brighton East, a Government Housing facility funded by the Department of Health and Human Services (DHHS).

2. In July 2017, Mr Craig's sister, Mary Hurst, received a call from Glencairn Avenue staff advising her that he was in bed and they were unable to move him. Ambulance Victoria were called and he was conveyed to Linacre Private Hospital where he stayed for two weeks. On 24 July 2017, Mr Craig was transferred to Calvary Health Care Bethlehem. His family visited him that day and decorated his room. On 25 July 2017 at approximately 3:45am, Ms Hurst received a phone call from the hospital advising that Mr Craig had passed away.

3. Mr Craig's death was considered reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) ('the Act') because at the time of his death, he was considered 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 DHHS.

INVESTIGATIONS

Forensic pathology investigation

4. Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination upon the body of Mr Craig, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. The post mortem CT scan showed cerebral atrophy and patchy pneumonia. Dr Parsons ascribed the cause of Mr Craig's death to natural causes being aspiration pneumonia, with a contributing factor of Down's syndrome.

Police investigation

5. Constable Luke Harris, the nominated coroner's investigator,[1] conducted an investigation of the circumstances surrounding Mr Craig's death, at my direction, including the preparation of the coronial brief.

6. At birth Mr Craig was born with Down's syndrome. He was non-verbal and given a life expectancy of seven years. During Mr Craig's youth, he primarily lived at home with his family. In 1982, his parents placed him into Caloola housing at Sunbury. Ms Hurst believes this is when he became a ward of the state. Following his parent's death, she became his next of kin.

7. Ms Hurst was very much involved in Mr Craig's life, as were her children and grandchildren. Mr Craig lived in Caloola for ten years without any notable incidents for concern. His sister would visit him every six weeks.

8. In 1992, Caloola closed down. Ms Hurst made the decision to move Mr Craig to Glencairn Avenue in Brighton East. He lived with four other people and 24 hour care was provided by staff. Ms Hurst said the staff were *"caring and good, generally they were excellent and took good care"*[2] of her brother. During his time there, Ms Hurst visited Mr Craig around once a fortnight.

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[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.
[2] Statement of Mary Hurst, Coronial Brief.

9. In July 2012, Mr Craig began suffering from pneumonia, which became more frequent, requiring hospitalisation on a number of occasions. Ms Hurst was always notified by Glencain Avenue when a doctor had been called to see him or when he had been taken to hospital. Ms Hurst praised the treatment Mr Craig received at hospital. Often, doctors would find it difficult to diagnose Mr Craig's underlying issues due to his condition. He was not recommended for sedation out of concerns for his heart.

10. In the two years prior to his death, Mr Craig's health noticeably deteriorated. He had recurrent respiratory problems. In September 2016, Mr Craig required assistance and a wheelchair. In the six months prior to his death, staff at Glencairn Avenue reported that he occasionally dropped to the floor as his legs appeared to collapse beneath him. Mr Craig's ability to transfer and walk became inconsistent and unpredictable. On times, a hoist was used in order to transfer him.

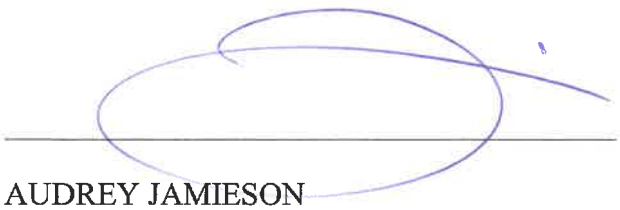
FINDINGS

The investigation identified that Mr Craig suffered from recurrent respiratory problems, particularly in the last few years of his life. He suffered from Down's syndrome, which was found to be contributing factor to the cause of his death. From the evidence, it appears that Mr Craig was well supported and looked after by his sister and family, Glencairn Avenue staff and hospital staff. I accept and adopt the medical cause of death as opined by Dr Sarah Parsons and find that Eric Vincent Craig died from aspiration pneumonia, with a contributing factor of Down's syndrome.

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:
Mary Hurst
Department of Health and Human Services
Constable Luke Harris

Signature:



AUDREY JAMIESON
CORONER
Date: **21 May 2018**