IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 003619

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**JOHN GALE**
Date of birth:	19 October 1951
Date of death:	4 August 2016
Cause of death:	1(a) ASPIRATION PNEUMONIA IN A MAN WITH DYSPHAGIA AND ACQUIRED BRAIN INJURY
Place of death:	84 Mackie Road, Bentleigh East, Victoria

HER HONOUR:

Background

1. John Gale was born on 19 October 1951. He was 64 years old when he died from natural causes.

2. Little is known of Mr Gale's early life or biological family. He had an acquired brain injury and severe intellectual disability and lived in State care most of his life. From approximately 2005 until his death he lived in a care facility administered by the Department of Health and Human Services (**DHHS**) in Mackie Road, Bentleigh East (**Mackie Road**). His various health conditions including asthma, epilepsy, osteoarthritis, constipation and conjunctivitis, were primarily managed by local general practitioner (**GP**) Dr Andrew Coker at the Mackie Road Clinic.

3. Before his health deteriorated in the months before his death, Mr Gale happily participated in various activities and excursions conducted by his carers at Mackie Road, and enjoyed attending the local pub for dinners and discotheques organised by agencies such as Yooralla.

The coronial investigation

4. Mr Gale's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).

5. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[1]

6. Mr Gale's death was reportable not only because it was unexpected but also because he was in the care of the State at the time of his death. Deaths of persons in the care of the State are reportable to ensure independent scrutiny of the circumstances surrounding their deaths. If

[1] 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.

such deaths occur as a result of natural causes a coronial investigation must take place but the holding of an inquest is not mandatory.

7. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

8. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Gale's death. The Coroner's Investigator investigated the matter on my behalf and submitted a coronial brief of evidence. I also reviewed Mr Gale's medical management with the assistance of the Coroners Prevention Unit (**CPU**). The role of the CPU is to assist coroners investigating deaths, particularly deaths that occur in a healthcare setting.

10. Having considered all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation and was not required.

11. I also determined that as Mr Gale's care was reasonable and he died of natural causes there was no public interest in holding an inquest. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Circumstances in which the death occurred

12. In the 12 months prior to his death, Mr Gale's health deteriorated. In the months prior to his death Mr Gale had blood in his urine and three consecutive positive faecal occult blood tests (**FOBT**s).[2] Dr Coker noted Mr Gale appeared to be in more pain than usual, was losing weight and becoming more lethargic.

13. During May 2016 Dr Coker referred Mr Gale to gastroenterologist, Dr Stephen Pianko, for investigation of his positive FOBTs. Dr Pianko declined to conduct investigations (such as a colonoscopy) as the distress likely to be caused to Mr Gale would outweigh the benefits.

[2] A test which detects the presence of occult (not visibly apparent) blood in the faeces.

14. Mr Gale had oral day surgery on 30 May 2016 to relieve dental discomfort causing a poor appetite. Immediately after the surgery Mr Gale's appetite and health appeared temporarily to improve, however he subsequently became unsteady on his feet, then suffered a fall approximately one week after the surgery. He was urgently admitted to Monash Medical Centre (**MMC**) and was diagnosed with pneumonia, likely secondary to his recent surgery.

15. After a short admission at MMC he was transferred to Kingston Rehabilitation Hospital in Cheltenham. Following discussions between Kingston Rehabilitation Hospital staff and the Mackie Road carers, Mr Gale was transferred back to Mackie Road on 25 July 2016 for palliative management. He was no longer walking and continued to lose weight.

16. Dr Coker saw Mr Gale on 27 July and 2 and 3 August and treated him for a suspected urinary tract infection and a worsening eye infection. He also referred Mr Gale to a urologist and ophthalmologist.

17. An Aged Care Assessment was to be arranged by Dr Coker with a view to locating a facility better suited to providing Mr Gale palliative care and 24 hour nursing care. Before this could be arranged, at approximately 9.30pm on 4 August 2016 Mr Gale was found unresponsive in his room by his carer Edward Kwah. He could not be revived despite Mr Kwah's efforts at cardio-pulmonary resuscitation and was declared deceased by attending emergency services.

Identity of the deceased

18. Mr Gale was visually identified by Edward Kwah on 4 August 2016. Identity was not in issue and required no further investigation.

Medical cause of death

19. On 8 August 2016, Dr Gregory Young, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of the body of John Gale after reviewing a post mortem CT scan.

20. Dr Young completed a report, dated 9 August 2016, in which he formulated the cause of death as '1(a) aspiration pneumonia in a man with dysphagia and acquired brain injury'. Dr Young confirmed that the death was due to natural causes. I accept Dr Young's opinion as to the medical cause of death.

Mr Gale's end-of-life care

21. In statements in the coronial brief Mackie Road staff expressed their frustration and distress that Mr Gale did not receive adequate palliative care before his death. According to one staff member: *'[John] was in a terrible state. His eyes were completely ulcerated. He was refusing to eat. He had blood in his incontinence aide. He was not taking fluids'*. Another carer stated: *'When [John] was sent home from Kingston many staff were very stressed at the state that he was in ... Staff had reported to me that he was in such a poor state that he should have been returned to hospital where he could have had proper nursing care in his final days. We are not trained as nurses'*.

22. The Court also received a complaint from another person (who wishes to remain anonymous) in relation to the Mackie Road facility. The complaint largely pertained to matters concerning the workplace culture at that facility (which fall outside the coronial jurisdiction), however it echoed the concerns above as follows: *'more could have been done to prevent John's death or nurture him through proper palliative care'*.

23. In discussions between Kingston Rehabilitation staff and staff at Mackie Road, Mr Clint Roncon (house supervisor at Mackie Road) raised concerns that Mackie Road was not equipped to provide palliative care to Mr Gale. Kingston Rehabilitation staff stated that an Aged Care Assessment would be arranged to assist in attempting to find an aged care facility that would be better able to manage his palliative care requirements. Unfortunately this assessment did not occur before Mr Gale's death.

24. At my direction the CPU reviewed Mr Gale's medical management and care in light of these concerns. It advised that Mr Gale's medical management was adequate and the decision to palliate Mr Gale was appropriate under the circumstances, regardless of the adequacy or otherwise at Mackie Road. Moreover, CPU observed that Mr Gale reportedly refused to eat anything at all except when provided by Mackie Road carers. Effectively a move to a higher care facility with trained staff may have hastened his demise if he refused to eat as a result of such a change. I accept their advice.

25. I acknowledge that Mr Gale's carers were deeply distressed by Mr Gale's deterioration and felt frustrated at their lack of training to care for him appropriately prior to his death. However as I am satisfied the death was due to natural causes, was not preventable and indeed may have been accelerated by moving Mr Gale to another facility, staff member's

concerns – while disturbing and sadly common in this jurisdiction – fall outside the scope of the Court's inquiry. Therefore I decline to conduct further investigations, or to make recommendations or comments in relation to the death. However, I direct that a copy of this Finding be provided to the DHHS, the Disability Services Commissioner and the Aged Care Complaints Commissioner for their review so they may take any actions they may deem necessary in light of issues highlighted by the circumstances of Mr Gale's death.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was John Gale, born 19 October 1951;

(b) Mr Gale died on 4 August 2016 at Bentleigh East, Victoria, from aspiration pneumonia;

(c) his death was due to natural causes; and

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

Publication

Given this death occurred while the deceased was in care of the Department of Health and Human Services I direct that this finding be published on the internet pursuant to section 73(1B) of the *Coroners Act 2008*.

I convey my sincere condolences to Mr Gale's carers and acknowledge the deep distress felt by them in the face of his deterioration and death.

I direct that a copy of this finding be provided to the following:
Mr Clint Roncon, House Manager, Mackie Road / Senior Next of Kin
Legal Counsel, Department of Health and Human Services
Disability Services Commissioner
Aged Care Complaints Commissioner
Constable Toby Williams, Coroner's Investigator, Victoria Police

Signature:

ROSEMARY CARLIN
CORONER
Date: 17 January 2018