IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 5998

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**PAUL HARDY**
Date of birth:	27 April 1980
Date of death:	18 December 2016
Cause of death:	Complications of Cerebral Palsy
Place of death:	Wantirna Health, 251 Mountain Highway, Wantirna South, Victoria 3152
Catchwords:	Deceased person in custody/care; natural causes.

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HER HONOUR:

BACKGROUND

1. Paul Harding **(Mr Hardy)** was a 36-year-old man who resided at 8 Polaris Drive, Doncaster East, Victoria at the time of his death.

2. His known past medical history included cerebral palsy which rendered him physically and intellectually disabled. He was non-verbal, suffered from blindness, epilepsy which involved seizures and had recently lost approximately 15 kg in body weight.

3. Leading up to his death, Mr Hardy's eating ability had diminished and was admitted to hospital on two occasions. He suffered aspiration pneumonia and had two seizures whilst in care.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. The role of a coroner is to independently investigate reportable deaths to establish, 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. The law is clear that coroners establish facts; they do not lay blame, or determine criminal or civil liability.[1]

5. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The *Coroners Act 2008* (Vic) **(the Act)** provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3]

6. Paul Hardy's death constituted a '*reportable death*' under the Act, as the death occurred in Victoria and, at the time of their death he was a person considered to be "*in custody or care*".[4]

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[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.

[2] Section 89(4) *Coroners Act 2008.*

[3] See Preamble and s 67, *Coroners Act 2008.*

[4] Section 3 and 4 *Coroners Act 2008.*

7. The Act mandates that a coroner must hold an inquest into all deaths deemed to have occurred while a person is "*in custody or care*",[5] except in those circumstances where the death is considered to be due to natural causes.[6]

8. In accordance with section 52(3B) of the Act, a death may be considered to be due to natural causes if the coroner has received a report from a medical investigator, in accordance with the rules, that includes an opinion that the death was due to natural causes. I have received such a report in this case. Therefore, I limit my findings with respect to the circumstances in which the death occurred and exercise my discretion not to hold an inquest.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE FINDING

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

9. Mr Hardy was visually identified by his resident support worker, Lindy Phillips on 18 December 2016. Identity was not in issue and required no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

10. On 20 December, Professor Stephen Cordner **(Professor Cordner)**, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon Mr Hardy's body and provided a written report, dated 16 January 2017. In that report, Professor Cordner concluded that a reasonable cause of death was '*complications of cerebral palsy*'.

11. Professor Cordner commented that Mr Hardy's loss of weight, reduced oral intake, consequences of cerebral palsy and development of a chest infection, precipitated his admission to hospital.

12. Toxicological analysis of the post mortem samples taken from Mr Hardy were positive for drugs used in the treatment of Mr Hardy's condition. These drugs included clonazepam, fentanyl, lignocaine and morphine. Professor Cordner stated that these drugs did not play a significant role in his death.

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[5] Section 52(2)(b) of the *Coroners Act 2008*.
[6] Section 52(3A) of the *Coroners Act 2008*.

13. On the basis of the information available at the time of completing his report, Professor Cordner provided an opinion that Mr Hardy's death was due to natural causes.

14. I accept the cause of death proposed by Professor Cordner.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

15. On 8 December 2016, Mr Hardy was admitted to Wantirna Health Palliative Care Unit at 251 Mountain Highway, Wantirna South, Victoria.

16. On 18 December 2016, Mr Hardy was found unresponsive in his bed by nursing staff.

17. Mr Hardy was last seen alive at approximately 7:05am 18 December 2016 and was found deceased at approximately 7:15am the same day by palliative care unit staff member, Ms Barbara Nixon.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

18. I am satisfied that Mr Hardy's death was due to natural causes. I am satisfied that the medical care and management provide to Mr Hardy prior to his death was reasonable and appropriate in the circumstances.

19. Having considered the evidence, I am satisfied that no prevention issues arise from this matter and consequently that no further investigation is required.

FINDINGS AND CONCLUSION

20. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) the identity of the deceased was Paul Hardy, born 27 April 1980;

    (b) the death occurred on 18 December 2016 at Wantirna Health, 251 Mountain Highway, Wantirna South, Victoria, from Complications of Cerebral Palsy; and

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

21. I convey my sincerest sympathy to Mr Hardy's family.

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

    (a) Ms Helen Goodinge, Senior Next of Kin;

    (b) First Constable Russell Hams, Coroner's Investigator.

23. Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet in accordance with the rules.

Signature:

JUDGE SARA HINCHEY

STATE CORONER

Date: 17 June 2017