IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 000537

FINDING INTO DEATH WITH INQUEST

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

Inquest into the death of TERENCE JOSEPH ROADLEY

Delivered on:	15 December 2014
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing dates:	15 December 2014
Findings of:	Coroner Paresa Antoniadis SPANOS
Assisting the Coroner:	Leading Senior Constable Kelly Ramsey, Police Coronial Support Unit.

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of TERENCE JOSEPH ROADLEY

and having held an inquest in relation to this death on 15 December 2014

in the Coroners Court of Victoria at Melbourne

find that the identity of the deceased was **TERENCE JOSEPH ROADLEY**

born on 25 May 1950

and that the death occurred on 25 January 2014

at the McKenna House Palliative Care Unit, 35 Johnstone Street, Broadmeadows, Victoria 3064

from:

I (a) COMPLICATIONS OF DISSEMINATED TUMOUR (PRIMARY SITE UNKNOWN)

in the following circumstances:

1. Mr Roadley was a 63-year-old man who, at the time of his death, was a palliative care patient at McKenna House Palliative Care Unit [McKenna House] in the terminal stage of metastatic carcinoma. Mr Roadley was admitted to McKenna House on 29 December 2013 for end of life care because his health had deteriorated gradually over the preceding months, and to such an extent, that he could no longer be appropriately cared for at the residential facility at which he ordinarily lived.
2. Mr Roadley was diagnosed with an intellectual disability as a child. He also exhibited behaviours that placed family members and others at risk of serious harm. Due to his disability and behavioural problems, from his teenage years, Mr Roadley became a registered client of the Department of Human Services, Disability Services [DHS], and later, subject to a Supervised Treatment Order pursuant to the *Disability Act* 1986.
3. As an individual subject to a Supervised Treatment Order, Mr Roadley was required to reside and receive treatment, supervision and case management at the direction of the Disability Forensic Assessment and Treatment Service [DFATS]. Accordingly, Mr Roadley resided in group homes throughout his life, and all aspects of his daily life, care and finances were administered by DFATS and DHS until his discharge from the Supervised Treatment Order on medical grounds.
4. With advancing age, Mr Roadley's health declined. He had a medical history that included aortic stenosis, atrial fibrillation, mild heart failure and ischemic stroke.

5. In October 2011, Mr Roadley presented to his general practitioner with haemoptysis (coughing blood). A chest x-ray facilitated a diagnosis of left lower lobe bronchopneumonia, which was treated with antibiotics at the Northern Hospital. Although he continued to experience a cough occasionally, a repeat chest x-ray showed that Mr Roadley's infection had cleared.

6. In February, and again in April 2012, Mr Roadley was troubled by his recurrent cough. The chest x-ray conducted in February was normal but a chest computer assisted tomography (CT) performed in April demonstrated cardiomegaly with a small pericardial effusion, mild pulmonary oedema, no lung pathology and a low-density lesion in his liver. Further radiological testing of Mr Roadley's liver allowed diagnosis of the lesion as a haemangioma (a vascular malformation).

7. Mr Roadley's haemoptysis returned in September 2012 and was again successfully treated with antibiotics at the Northern Hospital. The liver lesion, visible in chest CT scans conducted in the course of managing Mr Roadley's lung infection, was seen to have increased in size, and so further investigations were scheduled.

8. In November 2012, Mr Roadley was admitted to the Northern Hospital where scanning revealed the extent of the liver mass, along with enlarged para-aortic nodes, lung nodules and thickening of his oesophagus. He was diagnosed with metastatic carcinoma with unknown primary site. In consultation with Mr Roadley's family, no further investigation or treatment was pursued due to the advanced nature of his cancer, the toxicity of potential treatment and likely poor clinical outcome.

9. Mr Roadley's health deteriorated slowly throughout 2013 but he remained able to attend day placements and outings until December of that year. By this time, Mr Roadley was experiencing worsening dysphagia (difficulty swallowing) and recurrent aspiration pneumonia and so was admitted to McKenna House on 29 December 2013.

10. Mr Roadley received daily visits from staff and house mates from the group home in which he lived prior to his transfer to McKenna House. Mr Roadley's condition continued to deteriorate with increasing fatigue and functional decline evident. Low doses of medication were administered for the management of pain, cough, dyspnoea and agitation in the terminal stages of his illness. He died on 25 January 2014.

11. Apart from a jurisdictional nexus with the State of Victoria, reportable deaths are, generally, deaths that appeared to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury. However, some deaths are reportable irrespective of the nature of the death, based on the status of the person immediately before death. Mr

Roadley's death was reportable as he was a *person placed in custody or care*[1] of the Secretary to the DHS. This is one of the ways in which the *Coroners Act 2008* recognises that people in the control, care or custody of the State are vulnerable, and affords them the protection of the independent scrutiny and accountability of a coronial investigation.

12. Another protection is the requirement for mandatory inquests. While there is a discretionary power to hold an inquest in relation to any death a coroner is investigating,[2] this was a mandatory or statutorily prescribed inquest as Mr Roadley was, immediately before death, a person placed in custody or care.[3]

13. This finding draws on the totality of the material the product of the coronial investigation of Mr Roadley's death, contained in the inquest brief compiled by First Constable Luke Grelis of the Craigieburn Police Station. All this material, together with the inquest transcript, will remain on the coronial file. In writing this finding, I do not purport to summarise all evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

14. Mr Roadley's identity, the date and place of death were never at issue. <u>I find, as a matter of formality, that Terence Joseph Roadley, born on 25 May 1950, aged 63, late of 2 Henderson Court, Bundoora, Victoria 3083, died at McKenna House Palliative Care Unit, 35 Johnstone Street, Broadmeadows, on 25 January 2014.</u>

15. Nor was the medical cause of death contentious. No autopsy was performed but Forensic Pathologist Dr David Ranson of the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination of Mr Roadley's body, reviewed the police report of death to the coroner, and provided a written report of his findings. Dr Ranson advised that it would be reasonable to attribute Mr Roadley's death to *complications of disseminated tumour (primary site unknown)* without the need for an autopsy. Dr Ranson found no evidence of suspicious circumstances and advised that Mr Roadley's death was due to natural causes.

16. Based on Dr Ranson's report, <u>I find that Mr Roadley died as a result of complications of disseminated tumour.</u>

17. Post mortem toxicology testing of blood revealed metoclopramide, midazolam and morphine (free), consistent with therapeutic administration in a palliative setting.

18. The focus of the coronial investigation of Mr Roadely's death was on the adequacy of clinical management and care provided to him in the last months of his life. No concerns about

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[1] See section 3 for the definition of a "person placed in custody or care" and section 4(2)(c) of the definition of "reportable death".

[2] Section 52(1) provides that a coroner may hold an inquest into any death that the coroner is investigating.

[3] Section 52(2) and the definition of "person placed in custody or care" in section 3.

clinical management and care were stated in the initial police report of Mr Roadley's death to the Coroner.[4] Nonetheless, I requested statements from Mr Roadley's treating doctors and the manager of his usual residence prior to his admission to McKenna House.

19. I find that Mr Roadley died from complications of disseminated tumour (primary site unknown) and that his death was due to natural causes.

20. Based on the available evidence, I am satisfied that the health care provided to Mr Roadley by his general practitioner, Dr Kabat, and by the medical and nursing staff at the Northern Hospital, in the period preceding his death was appropriate and consistent with the care provided by the Victorian public health care system. Furthermore, the evidence does not support a finding that there was any want of case management or clinical management and care on the part of residential, medical and nursing staff at either Mr Roadley's ordinary residence or McKenna House, that caused or contributed to his death.

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

Mr Norman Roadley

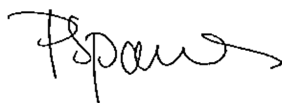
Northern Hospital, Epping

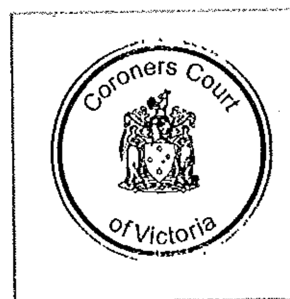
Mr Michael Taylor, House Manager, Department of Human Services

Dr Lyndsay Kabat, Epping Healthcare

First Constable Luke Grelis, Craigieburn Police Station

Signature:





PARESA ANTONIADIS SPANOS
CORONER
Date: 15 December 2014

[4] Victoria Police Form 83 dated 25 January 2014.