FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 3692/07

Inquest into the Death of TERENCE THOMAS WILSON

Place of death: 100 Marine Drive, Safety Beach, Victoria 3936

Hearing Date:	12 March 2010
Representation:	Leading Senior Constable Greigory McFarlane, SCAU, Assisting the Coroner

Finding of:	AUDREY JAMIESON, Coroner
Delivered On:	12 March 2010
Delivered At:	Melbourne

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Court reference: 3692/07

In the Coroners Court of Victoria at Melbourne,

I, AUDREY JAMIESON, Coroner

having investigated the death of:

Details of deceased:

Surname:	WILSON
First name:	TERENCE
Address:	64 Hyslops Road, Main Ridge, Victoria, 3928

AND having held an inquest in relation to this death on 12 March 2010

at Melbourne

find that the identity of the deceased was TERENCE THOMAS WILSON

and death occurred on 18 September 2007,

at 100 Marine Drive, Safety Beach, Victoria 3936

from:

1a. CONSISTENT WITH UPPER AIRWAYS OBSTRUCTION BY FOOD BOLUS IN A MAN WITH ISCHAEMIC HEART DISEASE.

in the following circumstances:

1. Mr Terence Wilson was born on 8 February 1931. He was 76 years old at the time of his death. He lived in Main Ridge with his daughter, Anne Wilson. His son, Peter Wilson, lived in another house on the same property.

2. Mr Wilson had a insignificant medical history until in or around 2006. In May 2006, he underwent a cholesystectomy and around the same time, was diagnosed with ischaemic heart disease of such severity that coronary artery bypass surgery was necessary. He was placed on a waiting list for the surgery and discharged from the hospital.

3. Not long after his discharge from hospital, Mr Wilson began to exhibit unusual behaviour leading to a psychiatric assessment and subsequent admission to Peninsula Psychiatric Service on 23 June 2006, as an involuntary patient for an extended period of time. He was diagnosed with Mania and commenced on Sodium Valporate and Olanzapine. He was discharged on 18 August 2006.

4. In the following months Mr Wilson was non-compliant with his medication regime. An escalation in his behaviour led to his re-admission as an involuntary patient and the commencement of depot medication, Risperidone Consta. He was diagnosed with Bipolar Affective Disorder. He was discharged from Frankston Hospital on a Community Treatment Order (CTO) on 7 December 2006, under the supervision of the Aged Persons Assessment and Treatment Service (APATS) and his general medical practitioner.

5. On 18 September 2007, Mr Wilson was attending a family gathering at 100 Marine Parade, Safety Beach to celebrate his 4 year old grandchild's birthday. A barbecue was cooked and the family sat down around a table to eat the meal. Mr Wilson was observed to be shovelling his food.

6. At approximately 7.15pm Mr Wilson became expressionless, stood up from the table clutching his throat and appeared to be choking. His daughter Debbie grabbed him from behind and squeezed his chest resulting in the dislodgment of some food from his mouth but with little overall effect. Mr Wilson collapsed to the floor, cyanosed and began vomiting. Debbie continued to attempt to clear her father's throat and commenced cardio-pulmonary resuscitation.

7. Emergency Services were contacted and Ambulance Paramedics including a Mobile Intensive Care Ambulance (MICA) Paramedic, arrived soon after. Resuscitation attempts were complicated by an obstructed airway that was unable to be cleared. With no substantial improvement after 45 minutes, resuscitation was ceased. Mr Wilson was deceased.

8. Mr Wilson's death was *reportable*[1] under the *Coroners Act 1985.*

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[1] "reportable death" means a death-
(a) where the body is in Victoria; or
(b) that occurred in Victoria; or
(c) the cause of which occurred in Victoria; or
(d) of a person who ordinarily resided in Victoria at the time of death-
being a death-
(e) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury; or
(f) that occurs during an anaesthetic; or
(g) that occurs as a result of an anaesthetic and is not due to natural causes; or
(h) that occurs in prescribed circumstances; or
(i) of a person who immediately before death was a person held in care; or
(iaa) of a person who immediately before death was a patient within the meaning of the Mental Health Act 1986 but was not a person held in care; or.....

9. An autopsy was performed by Dr Sarah Parsons, Forensic Pathologist, at the Victorian Institute of Forensic Medicine. Natural disease including significant triple vessel coronary atherosclerosis was identified. Dr Parsons attributed the cause of death to be consistent with upper airways obstruction by food bolus in a man with ischaemic heart disease.

10. An Inquest by way of summary was held on the grounds that Mr Wilson remained on a CTO at the time of his death. Although he was not *a person held in care*[2] as it is defined in the *Coroners Act 1985* because he was not *a patient* within the meaning of the *Mental Health Act 1986*, the fact that he was under a supervision order warranted a public hearing of the investigation.

COMMENT:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment connected with the death:

1. I am satisfied on the evidence that there is no relationship between the cause of Mr Wilson's death and the fact that he was an involuntary patient subject to a Community Treatment Order.

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2 "person held in care" means-
(a) a person under the control, care or custody of the Secretary to the Department of Human Services; or
(ab) a person-
(i) in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police; or
(ii) in the custody of a member of the police force; or
(iii) in the custody of a protective services officer appointed under the Police Regulation Act 1958; or
(b) a patient in an assessment or treatment centre under the Alcoholics and Drug-dependent Persons Act 1968; or
(c) **a patient in an approved mental health service within the meaning of the Mental Health Act 1986**;

FINDING:

I accept and adopt the medical cause of death as identified by Dr Parsons and find that TERENCE THOMAS WILSON, a man with ischaemic heart disease, died in circumstances consistent with upper airways obstruction from a food bolus.

Signature:

AUDREY JAMIESON
CORONER

Date: 15 March 2010

Distribution of Finding:

Mr Peter Wilson on behalf of the family
The Chief Psychiatrist
Director of Psychiatry, Peninsula Health