IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 000319

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**WAYNE DAVID BALDI**
Date of birth:	18 May 1967
Date of death:	22 January 2016
Cause of death:	1(a) SEPSIS IN THE SETTING OF ASPIRATION PNEUMONIA AND BOWEL OBSTRUCTION
Place of death:	Dandenong, Victoria

HER HONOUR:

Background

1. Wayne David Baldi was born on 18 May 1967. He was 48 years old when he died from natural causes after his health deteriorated.

2. At the time of his death, Mr Baldi lived at Turner Street Group Home, under the auspices of the Department of Health and Human Services.

3. Mr Baldi was born severely disabled with cerebral palsy and was also diagnosed with an intellectual disability. He was placed in care at an early age and suffered from a number of health issues.

The coronial investigation

4. Mr Baldi'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. The role of a coroner is to 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. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

7. 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.

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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.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Baldi's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses, and submitted a coronial brief of evidence.

9. Mr Baldi's death was reportable 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 such deaths occur as a result of natural causes a coronial investigation must take place but the holding of an inquest is not mandatory.

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

Identity of the deceased

11. Mr Baldi was visually identified by his house supervisor Jennifer Owers on 22 January 2016. Identity was not in issue and required no further investigation.

Medical cause of death

12. On 25 January 2016, Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of Mr Baldi after reviewing a post mortem CT scan. The CT scan revealed dilated bowel loops.

13. Toxicological analysis of post mortem specimens taken from Mr Baldi identified therapeutic quantities of lignocaine, morphine and Panadol.

14. After reviewing toxicology results, Dr Lynch completed a report, dated 27 January 2016, in which he formulated the cause of death as '1(a) sepsis in the setting of aspiration pneumonia and bowel obstruction'. I accept Dr Lynch's opinion as to the medical cause of death.

Circumstances in which the death occurred

15. During late 2014 and 2015, Mr Baldi's health gradually deteriorated. In January 2016 his health rapidly declined.

16. On 20 January 2016, Mr Baldi was admitted to Dandenong Hospital with abdominal pain for investigation, and aspiration pneumonia. He was treated with antibiotics and discharged. His condition deteriorated and he was readmitted to hospital where a CT scan suggested small bowel obstruction and possible sigmoid volvulus. Sigmoidoscopy was attempted but was unsuccessful. The decision was made in consultation with his family to treat him palliatively and he died on 22 January 2016.

17. Mr Baldi's sister Christine Parrott provided a statement to the Court, quoted below. It is abundantly clear from this statement that Mrs Parrott loved her brother dearly. The statement also describes the fine care he received at the Turner Street Group Home:

In November 2014, Wayne's health started to deteriorate. During this time Jennifer and her fellow carers did everything in their power to help improve Wayne's quality of living. All this time they kept my family in close contact so we had a say in Wayne's care as well.

Unfortunately in January this year Wayne's health went downhill at a great rate. Jennifer and her group of carers spent time at the hospital and made sure Wayne was well cared for and his welfare was always put first. Wayne passed away with us en-route to the hospital but he didn't die alone. He had wonderful caring company and 20 minutes before Wayne passed away the carer staying with Wayne gave me the biggest gift I'll ever receive and that was a telephone call made to me so I could talk to Wayne and tell him how much he was loved.

We are so grateful to these people for their loving care of Wayne.

18. I am satisfied that Mr Baldi's care at Turner Street Group Home and Dandenong Hospital was appropriate and satisfactory. There are no public health and safety or prevention issues arising from the circumstances of this death.

Findings

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

(a) the identity of the deceased was Wayne David Baldi, born 18 May 1967;

(b) Mr Baldi died on 22 January 2016 at Dandenong, Victoria, from sepsis in the setting of aspiration pneumonia and bowel obstruction; and

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

I convey my sincere condolences to Mr Baldi's family.

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

Elizabeth Baldi, Senior Next of Kin

Christine Parrott, sister of deceased

Catrina Boemo, Legal Services, Department of Health and Human Services

Leading Senior Constable Robert Atkins, Coroner's Investigator, Victoria Police

Signature:

ROSEMARY CARLIN
CORONER
Date: 4 May 2017