IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 2909

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**MICHELLE HODGSON, CORONER**
Deceased:	**STEPHEN ROSS WAKEFIELD**
Date of birth:	30 April 1951
Date of death:	20 June 2017
Cause of death:	1(a) COMPLICATIONS OF METASTATIC COLORECTAL CANCER (PALLIATED)
Place of death:	8 Roycroft Avenue, Mill Park, Victoria

HER HONOUR:

Background

1. Stephen Ross Wakefield was born on 30 April 1951. He was 66 years old when he died on 20 June 2017 from complications of cancer.

2. Mr Wakefield was born with Fragile X Syndrome with associated intellectual disability. He lived in several disability care facilities from a young age before eventually moving to the residential care facility in Mill Park[1] in 1989.

3. In 2015, Mr Wakefield was diagnosed with cardiomyopathy and bowel cancer, after which his health began to deteriorate. When the bowel tumour was removed, he suffered complications, which required a three-week admission in an intensive care unit. After the surgery, Mr Wakefield began to suffer from recurrent bowel obstructions, which led to multiple hospital admissions. It was not always possible for Mr Wakefield to undergo a scan due to his stress and anxiety (about medical procedures and hospitals), and the need to sedate him.

4. In 2016, Mr Wakefield was also found to have an enlarged prostate, which required a TURP[2] procedure to reduce the inflammation.

The coronial investigation

5. Mr Wakefield's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* **(the Act)**. His death was reportable because he was in the care of the State immediately before the time of his death.[3] 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.

6. 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

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[1] A Department of Health and Human Services run five-bed residential facility.
[2] Transurethral resection of the prostate (TURP) is a surgery used to treat urinary problems due to an enlarged prostate.
[3] See section 4(2)(c) of the *Coroners Act* 2008 (Vic).

the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[4]

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 Wakefield's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses, and submitted a coronial brief of evidence.

10. After considering 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 was not required.

11. 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.

Identity of the deceased

12. Mr Wakefield was visually identified by his cousin, Vivienne Drew, on 20 June 2017. Identity was not in issue and required no further investigation.

Medical cause of death

13. On 21 June 2017, Dr Victoria Francis, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of the body of Mr Wakefield and reviewed a post mortem computed tomography (CT) scan. The CT scan showed a markedly enlarged liver.

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[4] 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.

14. Dr Francis completed a report, dated 22 June 2017, in which she formulated the cause of death as "*1(a) Complications of metastatic colorectal cancer (palliated)*". Dr Francis was also of the opinion that the death was due to natural causes. I accept Dr Francis's opinion as to the medical cause of death.

Circumstances in which the death occurred

15. In late 2016, a CT scan revealed that the bowel cancer had metastasised to Mr Wakefield's liver. Mr Wakefield's carers decided not to proceed with chemotherapy as it would not significantly prolong his life but rather negatively impact his quality of life. He was provided with palliative care at his residential care facility.

16. According to his carer, Jade Spence, at the time of his diagnosis, he was his *"normal self"* and continued to be happy. His condition began to decline in about April 2017, at which time his eating habits changed and he began to sleep more. He subsequently began to lose weight, required more pain medication, and his mobility declined.

17. Mr Wakefield passed away at 10.00 on 20 June 2017, surrounded by his carers.

18. Mr Wakefield's carers remember him as a wonderful, happy, and jovial gentleman, who was full of compliments and full of life. The residential unit is not the same without him.

Findings

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

(a) the identity of the deceased was Stephen Ross Wakefield, born 30 April 1951;

(b) Mr Wakefield died on 20 June 2017 at 8 Roycroft Avenue, Mill Park, Victoria, from complications of metastatic colorectal cancer (palliated); and

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

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

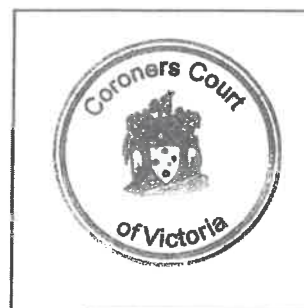
I direct that a copy of this finding be provided to the following:

Vivienne Drew, Senior Next of Kin

Senior Constable Kasey Owen, Coroner's Investigator, Victoria Police

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

Signature:



MICHELLE HODGSON
CORONER
Date: 21 August 2018.