IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 3245

FINDING INTO DEATH WITH INQUEST

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

Deceased:	**ANDREW BOND**
Delivered on:	**13 September 2018**
Delivered at:	**Coroners Court of Victoria,** **65 Kavanagh Street, Southbank**
Hearing date:	**13 September 2018**
Findings of:	**CORONER MICHELLE HODGSON**
Counsel assisting the Coroner:	**Senior Constable Ross Treverton**

Contents

BACKGROUND 1

THE PURPOSE OF A CORONIAL INVESTIGATION 1

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING 2

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008* 2

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008* 3

FINDINGS 5

HER HONOUR:

BACKGROUND

1. Andrew Bond was born on 23 January 1970 with Trisomy 21 (Down syndrome).

2. Down syndrome is a genetic disorder that causes a wide range of developmental delays and physical disability.

3. Andrew had been in the care of the Department of Health and Human Service since infancy.

4. His mother, Marjorie, remained active in care decisions for Andrew throughout his life.

5. Andrew loved socialising, watching Dr Who, and listening to Kylie Minogue, Madonna, and AC/DC. He enjoyed outings to live bands as well as weekly discos.

6. Andrew was also a keen sports fan and played indoor cricket and soccer, watching AFL, and working out with a personal trainer. He also participated in fundraising activities for local charities.

7. Over the years, Andrew had developed a strong relationship with his co residents, their families, and members of staff at his residence.

8. Andrew is survived by his mother, Marjorie, who remained active in care decisions for her son throughout his life.

9. Andrew passed away under palliative care at the Austin Hospital Palliative Care Unit on 6 July 2017.

10. Andrew's health had been deteriorating for a number of months before he ultimately succumbed to aspiration pneumonia.

11. Aspiration pneumonia is defined as a complication of pulmonary aspiration, which occurs when food, stomach acid, or saliva is inhaled into the lungs.

THE PURPOSE OF A CORONIAL INVESTIGATION

12. Andrew's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Further, as Andrew was in the care of the

Department of Health and Human Services (**DHHS**) at the time of his death, an inquest into his death was mandatory.

13. 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]

14. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

15. 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.

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

17. A summary inquest was held on 13 September 2018 and a summary of the Coroner's Investigator's findings was read to the Court.

18. This finding is based on the totality of the material obtained during my coronial investigation, including the inquest. Whilst I have reviewed all material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

19. Andrew Bond was visually identified by his half-sister, Janet Perrot, on 6 July 2017. Identity was not in issue and required no further 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.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

20. On 10 July 2017, Dr Matthew Lynch, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of the body of Mr Bond and reviewed a post mortem tomography (CT) scan.

21. Dr Lynch completed a report, dated 12 July 2017, in which he formulated the cause of death as *"1(a) Aspiration pneumonia in the setting of Down Syndrome"*.

22. I sought clarification from Dr Lynch as to whether the cause of death could be categorised as a natural cause. On 11 April 2018, Dr Lynch stated that:

> *Mr Bond's pre existing medical condition (Down Syndrome) with [its] associated difficulty in swallowing pre disposed him to developing this particular complication i.e. aspiration pneumonia. This condition likely developed as a result of repeated small episodes of aspiration in combination with retention of secretions and hypostasis. This it could be argued is a natural process and is the final pathway in many elderly patients who succumb to pneumonia. Paradoxically if Mr Bond aspirated a large quantity of gastric contents for example during anaesthetic induction, that would reasonably be considered an un-natural process.*

23. The evidence discloses that Andrew's difficulties with feeding were chronic. There is no evidence of Andrew aspirating a large quantity of gastric contents.

24. Therefore, I find that Andrew death was as a result of natural causes.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

25. Andrew had enjoyed good health for most of his life until 2007 when he was diagnosed with oropharyngeal dysphagia, which is a difficulty or abnormality of swallowing.

26. Many people with Down syndrome experience eating, drinking, and swallowing difficulties. As a result, he was placed on a modified diet.

27. Andrew's general health also began to decline in around 2013 when medical investigations disclosed that he was suffering from mild depression and early onset dementia.

28. Declines in Andrew's cognitive and physical functioning led ultimately to a diagnosis of Alzheimer's disease.

29. Risks associated with a 'normal' diet are a well-recognised complication of Alzheimer's disease as the sufferer experiences a reduced level of consciousness, dysphagia,[2] and loss of gag reflex.

30. In March 2017, a significant choking incident took place, which prompted a further assessment by speech pathologist, Kristie Constance, who noted a progressive deterioration of Andrew's swallowing skills and recommended that his diet be modified to include minced food and mildly thick fluids.

31. Aspiration pneumonia was first diagnosed in May 2017 and successfully treated with Augmentin Duo Forte.[3]

32. Around this time, Ms Constance found a further deterioration of Andrew's eating and swallowing skills had occurred and recommended that he progress to a pureed food diet with extremely thick liquids.

33. Gastric feeding is an option that may reduce the risk of aspiration pneumonia in those suffering from such difficulties.

34. However, a decision to move to gastric feeding was one that would have profoundly decreased the quality of life that Andrew was enjoying at this time. This included his anticipation and pleasure at consuming his favourite foods and drinks, such as chocolate custard and thickened Coke, as well as participating in the social event of eating. The deterioration in his capacity to eat orally without risk occurred against a background of further physical and cognitive decline as he aged.

35. Balancing all of those matters, Andrew's family made the decision to continue with an enhanced mealtime assistance plan, pureed food, and thickened fluids.

36. Until Andrew's admission to hospital on 22 June 2017, his house supervisor, Doug Elser, recounted that Andrew had enjoyed a trip to Northland Shopping Centre shopping for clothes and having lunch in the food court, only the day before.

37. One of Andrew's great joys was music and he appeared quite energised and singing along with music and interacting with his co residents.

38. Andrew became fatigued and quickly declined during the late morning of 22 June 2017.

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[2] Difficulty swallowing
[3] An antibiotic belonging to the penicillin group of antibiotics.

39. Dr Suzy Matthews attended Andrew's home and noting a decline in his blood oxygen levels ordered an ambulance to be called.

40. Upon arrival at emergency, he was found to be breathing abnormally rapidly and deprived of oxygen with a reduced conscious state and rigours.

41. A chest x-ray confirmed a lung infection. Blood tests revealed an elevated white cell count and further markers of inflammation.

42. Given Andrew's already frail state, it was acknowledged at the commencement of treatment that prospects of recovery were limited even with aggressive treatment.

43. Intravenous antibiotics were commenced and he began to respond to treatment, although his supplementary oxygen requirements remained high. His treatment was changed to oral antibiotics but his condition deteriorated and intravenous antibiotics were restarted.

44. On 4 July 2017, a decision was made to provide comfort care to Andrew and he was transferred to the Palliative Care Unit on 6 July 2017 where he passed away peacefully in the evening.

FINDINGS

45. Having investigated the death of Andrew and having held an Inquest in relation to his death on 13 September 2018 at Melbourne, I make the following findings connected with the death, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Andrew Bond, born 23 January 1970;

    (b) that Andrew died on 6 July 2018, at Austin Hospital, 145 Studley Road, Heidelberg, Victoria from aspiration pneumonia in the setting of Down syndrome; and

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

46. I convey my sincerest sympathy to Andrew's family and friends.

47. Pursuant to section 73(1) of the *Coroners Act 2008,* I order that this finding be published on the internet.

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

(a) Janet Perrot, senior next of kin;

(b) Secretary to the Department of Human Services; and

(c) Senior Constable Joshua Carrick, Coroner's Investigator, Victoria Police

Signature:

MICHELLE HODGSON

CORONER

Date: 13 SEPTEMBER 2018