IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 6386

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Simon McGregor, Coroner
Deceased:	**Douglas John Angus**
Date of birth:	14 September 1945
Date of death:	20 December 2017
Cause of death:	Subdural haematoma in a man receiving warfarin treatment
Place of death:	The Royal Melbourne Hospital 300 Grattan Street, Parkville, Victoria

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INTRODUCTION

1. Douglas John Angus was a 72-year-old man who lived in Ararat at the time of his death.

2. Mr Angus had an intellectual disability and lived at a property where he received 24-hour support from House Supervisors employed by the Department of Health and Human Services (DHHS).[1]

3. On 18 December 2017 Mr Angus was taken to the Royal Melbourne Hospital after a collapse. He did not recover and he died in hospital on 20 December 2017.

PURPOSE OF A CORONIAL INVESTIGATION

4. Mr Angus was 'a person placed in custody or care' for the purposes of the *Coroners Act 2008* as he was a person under the control, care or custody of the Secretary to the Department of Health and Human Services. His death was therefore a 'reportable death' under the Act and was reported to the coroner.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. 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.

7. The Coroner's Investigator, Senior Constable Kelvin Laugesen of Victoria Police, prepared a coronial brief in this matter. The brief includes statements from witnesses including DHHS staff, the forensic pathologist who examined Mr Angus, treating clinicians and investigating officers.

8. 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

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[1] Statement of Melissa Rose dated 30 April 2018, Coronial Brief.

not required. 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.

9. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[2]

BACKGROUND CIRCUMSTANCES

10. Mr Angus had been diagnosed with severe three vessel coronary artery disease.[3] On 28 September 2017 he underwent an aortic valve replacement, a mitral valve replacement, and coronary artery bypass grafting. He was then prescribed the anticoagulant warfarin among other medications.[4]

11. He was seen regularly at the Ararat Medical Centre over the following months. Dr Prasad Fonseka states that his INR (International Normalised Ratio, a measure of blood clotting) was stable except for a few occasions in October.[5]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

12. On 18 December 2017 Mr Angus was at a work placement at Wood 'n' Crete. During the morning, his supervisor observed him to be '*a bit off*' and around midday Mr Angus vomited on himself and appeared vague and unsteady.[6]

13. Mr Angus' supervisor took him to the Ararat Medical Centre and he vomited again while underway. Once he arrived at the Centre he was seen by Dr Kylie Rix.[7]

14. Mr Angus became weak and collapsed during the examination.[8] There is no evidence that he struck his head during this collapse.

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[2] This is 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.

[3] Letter from Mr Cheng-Hon Yap to Dr Chris Hengel dated 14 September 2017, Royal Melbourne Hospital Medical Records.

[4] Statement of Dr Prasad Fonseka dated 27 March 2018, Coronial Brief; Barwon Health MR33 Operation Record dated 28 September 2017, Royal Melbourne Hospital Medical Records.

[5] Statement of Dr Prasad Fonseka dated 27 March 2018, Coronial Brief.

[6] Statement of Russell Streeter dated 11 May 2018, Coronial Brief.

[7] Ibid.

[8] Ibid.

15. His condition deteriorated and Ambulance was called. Mr Angus was brought to Ararat Hospital and then taken by Air Ambulance to the Royal Melbourne Hospital (RMH).[9]

16. On arrival at the RMH a CT scan of Mr Angus' brain showed a '*very large*' acute left subdural haemorrhage. There was no indication of any bone fractures.[10]

17. The RMH Neurosurgery team examined Mr Angus and, along with Intensive Care specialists, concluded that Mr Angus' condition was not survivable. Mr Angus was given palliative care and died at 2.45am on 20 December 2017.[11]

IDENTITY AND CAUSE OF DEATH

18. On 21 December 2017, Melissa Rose, Operations Manager for the DHHS Disability Accommodation Services Department, visually identified the body of Douglas John Angus, born 14 September 1945. Identity is not in dispute and requires no further investigation.

19. Dr Joanna Glengarry, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination of Mr Angus' body and reviewed a post mortem computed tomography (CT) scan. Dr Glengarry completed a report, dated 27 December 2017, in which she formulated the cause of death as '*I(a) Subdural haematoma in a man receiving warfarin treatment*'.

20. Dr Glengarry noted that the CT scan confirmed an acute left subdural haematoma and that neither the CT scan nor the external examination showed evidence of an injury to the head. She commented that '*in those who are elderly, and particularly in those receiving anticoagulation treatment, a subdural haematoma may occur after relatively minor trauma for which there may be no history and no external signs of injury*'.

21. Dr Glengarry concluded:

    '*On the basis of the information available to me at this time, I am of the opinion that this death is due to natural causes*'.

22. I accept Dr Glengarry's opinion as to the medical cause of death.

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[9] Ambulance Victoria Electronic Patient Care Records, Coronial Brief.
[10] Statement of Associate Professor Brian Le dated 8 May 2018, Coronial Brief.
[11] Ibid.

FINDINGS AND CONCLUSION

23. As Mr Angus was 'a person placed in custody or care', section 52 of the Act requires that I hold an inquest into Mr Angus' death unless I consider his death was due to natural causes. Based on Dr Glengarry's opinion expressed in her report, I consider that Mr Angus' death was due to natural causes.

24. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

    (a) The identity of the deceased was Douglas John Angus, born 14 September 1945;

    (b) The death occurred on 20 December 2017 at the Royal Melbourne Hospital in Parkville from a subdural haematoma while receiving warfarin treatment; and

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

25. Pursuant to section 73(1B) of the Act, I direct that this finding be published on the Internet.

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

    (a) Mr Jeffrey Angus, senior next of kin.

    (b) Disability Services Commissioner.

    (c) Senior Constable Kelvin Laugesen, Victoria Police, Coroner's Investigator.

Signature:

SIMON McGREGOR
CORONER
Date: 28.11.2018

Coroners Court of Victoria