



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2018 2100**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

(Amended pursuant to section 76 of the *Coroners Act 2008* as at 2 April 2019)¹

Findings of:	PHILLIP BYRNE, CORONER
Deceased:	BEVAN JOHN STEVENS
Date of birth:	11 APRIL 1945
Date of death:	5 MAY 2018
Cause of death:	I (a) ASPIRATION PNEUMONIA COMPLICATING SIGMOID VOLVULUS IN A MAN WITH DOWN SYNDROME
Place of death:	AUSTIN HOSPITAL, 145 STUDLEY ROAD, HEIDELBERG, VICTORIA, 3084

¹ Paragraph 11, line one, Northern deleted and replaced with Austin.

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I, PHILLIP BYRNE, Coroner, having investigated the death of BEVAN JOHN STEVENS
without holding an inquest:

find that the identity of the deceased was BEVAN JOHN STEVENS

born on 11 April 1945

and the death occurred on 5 May 2018

at Austin Hospital, 145 Studley Road, Heidelberg, Victoria, 3084

from:

1 (a) ASPIRATION PNEUMONIA COMPLICATING SIGMOID VOLVULUS IN A MAN WITH
DOWN SYNDROME

Pursuant to section 67(1) of the **Coroners Act 2008** I make findings with respect to **the following circumstances:**

BACKGROUND

1. Bevan Stevens, 73 years of age at the time of his death, resided in a group home managed by the Department of Health and Human Services (**DHHS**), and, on that basis, I conclude he was “in care” within the meaning of the *Coroners Act 2008*.
2. Mr Stevens has a significant medical history, including dysphagia with recurrent aspiration pneumonia and Down syndrome.

CIRCUMSTANCES SURROUNDING DEATH

3. On 1 May 2018, Mr Stevens was seen by a locum at the facility where he resided and was noted to be drowsy with shortness of breath. He was conveyed to the Austin Hospital where x-rays demonstrated sigmoid volvulus and consolidation in the lower zone of the left lung.
4. Mr Stevens was admitted to the Austin Hospital on 1 May 2018 and commenced on ceftriaxone. On 2 May 2018, a rigid sigmoidoscopy was performed.

REPORT TO CORONER

5. Mr Stevens died at the Austin Hospital on 5 May 2018. His death was reported to the coroner as he was "in care" at the time of his death. I directed an external only post mortem examination.
6. The examination was undertaken by Dr Gregory Young who advised Mr Stevens died due to:

1 (a) aspiration pneumonia complicating sigmoid volvulus in a man with Down syndrome.

7. Dr Young advised Mr Stevens's death was due to natural causes. On that basis, I finalise my investigation by way of this short Finding Without Inquest. I am advised by Forensic Pathologist Dr Gregory Young that the conditions suffered by Mr Stevens "increase the risk of aspiration".

CONCLUSION

8. On the material available, I believe one could not reasonably conclude that the care/treatment of Mr Stevens was other than reasonable and appropriate.

COMMENT

9. Pursuant to section 67 (3) of the *Coroners Act 2008*, I make the following comments connected with the death.
10. In earlier correspondence, I advised the Senior Next of Kin I would leave my investigation in abeyance awaiting the outcome of a review by the office of the Disability Services Commissioner (DSC) in relation to the provision of services to Mr Stevens. Due to developments at the offices of the DSC, I now propose to proceed to finalisation of my coronial investigation.

FINDING

11. I formally find Bevan John Stevens, who had Down syndrome, died at the Austin Hospital on 12 August 2018 due to aspiration pneumonia complicating sigmoid volvulus in a man with Down syndrome.
12. Pursuant to section 73 (1) (B) of the *Coroners Act 2008*, I order that this finding be published on the Coroners Court of Victoria website.

DISTRIBUTION OF FINDING

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

Mr Graeme Stevens, Senior Next of Kin;

Ms Jacinda De Witts, Acting General Counsel and Chief Legal Officer, Legal Services, DHHS;

Ms Lynette Russell, Austin Health; and

First Constable Andrew Moharic, Reporting Officer, Victoria Police

Signature:


PHILLIP BYRNE
CORONER

Date: 2 April 2019

