IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 3598

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008 (Vic)

I, AUDREY JAMIESON, Coroner having investigated the death of LEIGH JAMES CARR PRICE

without holding an inquest pursuant to section 52(3A) of the *Coroners Act 2008* (Vic):

find that the identity of the deceased was LEIGH JAMES CARR PRICE

born 11 July 1972

and the death occurred on 24 July 2017

at Footscray Hospital, 160 Gordon Street, Footscray, 3011

from:

1 (a) PNEUMONIA IN A MAN WITH MUCOPOLYSACCHARIDE-III

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

1. Leigh James Carr Price was 45 years of age at the time of his death. He resided at 37 Marigold Avenue, Altona North, in a Disability Accommodation Service (**DAS**) group home funded by the Department of Health and Human Services (**DHHS**). His parents

visited him twice weekly. Due to a congenital illness, mucopolysaccharide-III, Mr Price was immobile, non-verbal and required assistance with all aspects of daily life.

2. On the morning of 23 July 2017, concerned about Mr Price's increased breathing difficulties, support staff requested an ambulance to transport him to hospital. He was admitted to Footscray Hospital with a productive cough, fever, shortness of breath and fast heartrate. The presumptive diagnosis was aspiration pneumonia. Mr Price was treated in the emergency department with intravenous antibiotics and fluids then transferred to the respiratory ward for ongoing treatment.

3. Despite adequate antibiotic coverage and maximal oxygen therapy, Mr Price's condition deteriorated, and he continued to experience respiratory distress. On the evening of 23 July 2017, the direction of care was altered to provide comfort care measures and Mr Price was pronounced deceased at 9.20am on 24 July 2017.

CORONIAL JURISDICTION

4. Mr Price's death is reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) (**'the Act'**) because he was a person placed in care at the time of his death. Section 3 of the Act states that a person placed in care includes a person who is under the control, care or custody of DHHS.

5. Section 52(3A) of the Act provides, *inter alia*, that a Coroner is not required to hold an Inquest into the death of a person who was in custody or care immediately before their death, if the Coroner considers that their death was due to natural causes. Mr Price's death falls under the auspices of this section of the Coronial legislation and, consequently, I have determined that it was appropriate to finalise my Investigation by way of a Form 38 *Finding into a Death with Circumstances.* Such a Finding must be published, pursuant to section 73(1B) of the Act.

INVESTIGATIONS

Forensic pathology investigation

6. Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination upon the body of Mr Price, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of

Death, Form 83. The post mortem CT scan showed cerebral atrophy with large ventricles and pneumonia. Dr Parsons was of the opinion that the death was due to natural causes and ascribed the cause of Mr Price's death to pneumonia in a man with mucopolysaccharide-III.

Police investigation

7. First Constable (FC) Jason Kokas was the nominated Coroner's investigator.[1] At my direction, FC Kokas investigated the circumstances surrounding Mr Price's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by his mother Noreen Price, Western Health physician Dr Daniel Waugh, DHHS support worker Jerry Ogden, and FC Kokas. On my direction, Victoria Police obtained further statements from locum doctors Dr Amir Saeedullah and Dr Martin Bingham.

8. During the investigation, police learned that Mr Price had resided in DHHS care since he was about 20 years of age due to the congenital illness mucopolysaccharide-III. At the time of his death Mr Price experienced significant degenerative disabilities and required full assistance with all activities of daily living. Mr Price was largely confined to his bed but could be moved via a hoist and wheelchair operated by support staff.

9. On the evening of 21 July 2017, a support worker requested the attendance of a locum doctor as Mr Price was presenting with cold like symptoms and they were concerned he had developed a chest infection. Dr Bingham examined Mr Price and assessed him to be generally well. Mr Price had a normal temperature and respiratory rate. His chest sounded clear with no signs of infection. Dr Bingham's working diagnosis was upper respiratory tract infection (head cold virus) and advised staff to monitor Mr Price's symptoms, and request medical review if they had further concerns or if he had not improved in two days.

10. On the evening of 22 July 2017, support staff were still concerned by Mr Price's cough and requested the attendance of a locum doctor. Dr Saeedullah attended and examined Mr Price. On examination Mr Price had normal temperature and pulse and no signs of

[1] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

cyanosis or respiratory distress. Ear, nose and throat examination was normal. Chest examination showed scattered bilateral coarse crackles. Dr Saeedullah's provisional diagnosis was aspiration pneumonia. Given Mr Price was afebrile and hemodynamically stable, Dr Saeedullah considered him appropriate for management within the home setting. He prescribed cephalexin, an antibiotic, and advised support staff that Mr Price should be reviewed in three days, or earlier if they had further concerns.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. There is no evidence to suggest that there is any public interest in taking this matter to a Hearing by way of an Inquest. Mr Price's medical care and treatment appears reasonable; there have been no issues identified in relation to his medical care and treatment. There are no family concerns in relation to the same.

2. Mr Price's mother noted her disappointment that she was not notified of the decline in her son's health until after he was transported to hospital. The sense of loss by way of the missed opportunity to be involved in care and decision making in the final days of her son's life is understandable. However, the facility's omission to notify Mrs Price of her son's ill-health prior to his transport to hospital is not considered causal to Mr Price's death. Indeed, their requests for locum doctors, and the subsequent medical assessments, indicated that DHHS staff may not have perceived or anticipated the severe decline in Mr Price's condition until the morning they arranged for him to be transported to hospital.

FINDINGS

This investigation has identified that Leigh James Carr Price suffered from a congenital illness, mucopolysaccharide-III, of which pneumonia is a known complication. In the years prior to his death, Leigh James Carr Price's degenerative illness made him progressively more immobile and reliant on support workers for his increased care needs.

I accept and adopt the medical cause of death indicated by Dr Sarah Parsons, Forensic Pathologist, and I find that Leigh James Carr Price died from pneumonia which arose on a background of mucopolysaccharide-III.

I find there is no causal connection between the cause of Leigh James Carr Price's death and the care provided to him by the Department of Health and Human Services by way of the Marigold Avenue shared supported accommodation.

I further find there is no causal connection between the cause of Leigh James Carr Price's death and the care provided to him by locum doctors Dr Martin Bingham and Dr Amir Saeedullah.

I further find that there is no causal connection between Leigh James Carr Price's death and the medical care and treatment provided by Western Health at Footscray Hospital.

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

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

Noreen Price, Senior Next of Kin
First Constable Jason Kokas, Coroner's Investigator
Department of Health and Human Services

Signature:

AUDREY JAMIESON

CORONER

Date: **25 July 2019**