IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2018 1603**

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**GLENN THOMAS KING**
Date of birth:	**11 FEBRUARY 1963**
Date of death:	**6 APRIL 2018**
Cause of death:	**COMMUNITY ACQUIRED PNEUMONIA IN A MAN WITH DOWN SYNDROME**
Place of death:	**AUSTIN HOSPITAL** **145 STUDLEY RD** **HEIDELBERG VICTORIA 3084**

HIS HONOUR:

BACKGROUND

1. Glenn Thomas King was born on 11 February 1963. He was 55 years old at the time of his death. Glenn lived in a residential care home in Viewbank.

2. Glenn had a history of Down syndrome, intellectual disability and asthma. He required a wheelchair for mobility and was visually impaired. He suffered from recurrent chest infections and bronchiectasis.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Glenn's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as immediately before death he was a person placed under the care of the secretary to the Department of Health and Human Services ('DHHS').[1] Ordinarily, a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and the deceased person was immediately before death a person placed in custody or care.[2] However, a coroner is not required to hold an inquest if they consider that the death was due to natural causes.[3]

4. The jurisdiction of the Coroners Court of Victoria is inquisitorial[4]. The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

5. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

6. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

7. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration

[1] Section 4, definition of 'Reportable death', *Coroners Act 2008;* Section 4, definition of 'Person placed in custody or care', *Coroners Act 2008.*
[2] Section 52(2)(b) *Coroners Act 2008.*
[3] Section 52(3A), *Coroners Act 2008.*
[4] Section 89(4) *Coroners Act 2008.*
[5] *Keown v Khan* (1999) 1 VR 69.

of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

8. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

9. Coroners are also empowered:

   (a) to report to the Attorney-General on a death;

   (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

   (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

10. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[6] 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 that they caused or contributed to the death.

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*

11. Glenn Thomas King was visually identified by his brother Peter King on 10 April 2018. Identity is not disputed and requires no further investigation.

[6] (1938) 60 CLR 336.

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

12. On 9 April 2018, Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an inspection on Glenn's body and provided written report dated 9 April 2018, concluding a reasonable cause of death to be "I(a) Community acquired pneumonia in a man with Down Syndrome". I accept his opinion in relation to the cause of death.

13. Dr Lynch noted that he reviewed the post mortem computed tomography (CT) scan which revealed left lung consolidation and patchy calcification within the globus pallidi bilaterally. Dr Lynch was of the opinion that the death was due to natural causes.

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

14. On 29 March 2018, Glenn was treated by General Practitioner Dr Alan Ly for a lower respiratory tract infection. He was commenced on cephalexin and nebulised salbutamol and he was to be reviewed five days later after the Easter break. On 3 April 2018, Dr Ly reviewed Glenn and found his symptoms had not improved. Dr Ly switched antibiotics and requested a chest x-ray, which was performed the following morning.

15. On 4 April 2018, the chest x-ray showed extensive pneumonia despite antibiotic therapy. Glen was transported and admitted to the Austin Hospital, however his condition continued to deteriorate. He was treated initially with intravenous antibiotics and subsequently this was changed to oral therapy. After discussion with his family, Glenn was palliated and he died on 6 April 2018 at 8.45pm.

FINDINGS

16. Having investigated Glenn Thomas King's death and having considered all of the available evidence, I am satisfied that no further investigation is required.

17. I find that the care provided to Glenn Thomas King by the Department of Health and Human Services and Austin Hospital were reasonable and appropriate in the circumstances.

18. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

(a) that the identity of the deceased was Glenn Thomas King, born 11 February 1963;

(b) that Glenn Thomas King, who had Down Syndrome, died on 6 April 2018, at the Austin Hospital 145 Studley Road, Heidelberg Victoria from community acquired pneumonia; and

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

19. I convey my sincerest sympathy to Glenn's family and friends.

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

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

(a) Glenn's family, senior next of kin;

(b) Investigating Member, Victoria Police; and

(c) Interested Parties.

Signature:

MR JOHN OLLE
CORONER
Date: 17 July 2019