IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2019 1081**

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**PHILLIP BYRNE, CORONER**
Deceased:	**JOHANNES GERHARDUS JANSEN**
Date of birth:	**11 OCTOBER 1952**
Date of death:	**28 FEBRUARY 2019**
Cause of death:	**I (a) ASPIRATION PNEUMONIA COMPLICATING A SEIZURE IN A MAN WITH DYSPHAGIA AND PHENYLKETONURIA**
Place of death:	**ST VINCENT'S HOSPITAL, 41 VICTORIA PARADE, FITZROY, VICTORIA, 3065**

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*Section 67 of the **Coroners Act 2008***

I, PHILLIP BYRNE, Coroner having investigated the death of JOHANNES GERHARDUS JANSEN
without holding an inquest:
find that the identity of the deceased was JOHANNES GERHARDUS JANSEN
born on 11 October 1952
and the death occurred on 28 February 2019
at St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065

from:

1 (a) ASPIRATION PNEUMONIA COMPLICATING A SEIZURE IN A MAN WITH DYSPHAGIA AND PHENYLKETONURIA

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

Background

1. Mr Johannes Jansen, 66 years old at the time of his death, resided in a Department of Health and Human Services (DHHS) Disability Accommodation Residence at 8 Botanic Drive, Kew. Mr Jansen suffered a severe intellectual disability (phenylketonuria). At the time of his death, Mr Jansen was in the control/care of the secretary of the Department of Health and Human Services.

Circumstances of the death

2. On 2 February 2019, Mr Jansen was admitted to St Vincent's Hospital in status epilepticus complicated by aspiration pneumonia. The E-Medical Deposition form submitted to the Court by St Vincent's Hospital describes Mr Jansen's presentation as being "*in the setting of missed anti-epileptic medications at Care Facility.*"

3. While at St Vincent's Hospital, Mr Jansen's Glasgow Coma Scale (GCS)[1] fluctuated between 5 and 9, and multiple MET calls occurred.[2] In spite of active treatment, including intravenous (IV) antibiotic therapy, Mr Jansen's condition continued to deteriorate and on 24 February 2019 he was palliated. In the palliative ward, Mr Jansen was commenced on syringe driver for management of pain and nausea. His condition deteriorated further, and he died at 8.30am on 28 February 2019.

Report to the coroner and post-mortem examination

4. The matter was appropriately referred to the Coroner as Mr Jansen was "in care" at the time of his death.

5. In initial contact with the Coronial Admissions and Enquiries (CA&E) office, the Senior Next of Kin, Mr Jansen's brother Mr Benjamin Jansen, advised that the family would not object to an autopsy if the coroner considered one necessary, and further advised that the family had no concerns with the care provided.

6. Having considered the circumstances and having conferred with a forensic pathologist, I directed an external only post-mortem examination and ancillary tests. An external examination was performed by Forensic Pathologist Dr Joanna Glengarry of the Victorian Institute of Forensic Medicine. Dr Glengarry advised that the immediate cause of Mr Jansen's death was:

   I (a) Aspiration pneumonia complicating a seizure in a man with dysphagia and phenylketonuria

7. Dr Glengarry further advised that Mr Jansen's death was due to natural causes.

Further investigation

8. I was advised that the Disability Services Commissioner (DSC) proposed to undertake a Disability Death Review of the DHHS management of Mr Jansen. The Court made the totality of the coronial material available to the DSC to facilitate their review. Noting that a fundamental objective of the *Coroners Act 2008* (Vic), section 7(a), is to avoid unnecessary duplication of inquiries and investigations, I determined to leave further investigation of Mr Jansen's death in abeyance.

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[1] The Glasgow Coma Scale (GCS) is a practical method for assessing impairment of a patient's level of consciousness in response to various stimuli. An individual with score of less than 8 or 9 on the GCS has generally sustained a severe brain injury.

[2] The MET call (Medical Emergency Team) is a rapid response system in hospitals whereby emergency medical treatment is provided to patients whose vital signs indicate a rapid deterioration in their condition.

9. Having regard to a relatively recent amendment to the *Coroners Act 2008* (Vic), as Mr Jansen's death was due to natural causes, I am not required to hold a mandatory inquest, but must complete a finding which is required to be put on the Court's website.

10. On 17 April 2019, the Court advised Mr Benjamin Jansen of the DSC review and further advised I would leave my investigation in abeyance and notify him if there were any further developments. Subsequently, I was advised by our Disability Death Review Case Investigator that the DSC did not object to me proceeding to finalise my investigation, subject to me providing to them a copy of my proposed finding.

11. Having carefully considered all of the available evidence, I am satisfied that there is sufficient information to finalise my investigation by way of this finding without inquest.

Finding

12. I formally find that on 28 February 2019 at St Vincent's Hospital, Mr Jansen died from aspiration pneumonia, complicated by a seizure, in the setting of his ongoing dysphagia and phenylketonuria, natural causes.

13. I direct that this finding be published on the Coroners Court of Victoria website pursuant to section 73(1B) of the *Coroners Act 2008* (Vic).

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

    Mr Benjamin Jansen, Senior Next of Kin;

    Office of the Disability Services Commissioner; and

    Constable Stephen Toth, Coroner's Investigator, Victoria Police.

Signature:

PHILLIP BYRNE
CORONER

Date: 13 August 2019