IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2018 5510**

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**DAVID JOHN FARLECH**
Date of birth:	**20 AUGUST 1970**
Date of death:	**31 OCTOBER 2018**
Cause of death:	**I(a) DILATED CARDIOMYOPATHY** **CONTRIBUTING FACTORS** **ACUTE RENAL IMPAIRMENT**
Place of death:	**NORTHERN HEALTH** **25 WILLANDRA DRIVE** **EPPING VICTORIA 3076**

HIS HONOUR:

BACKGROUND

1. David John Farlech was born on 20 August 1970. He was 48 years old at the time of his death. David lived in a group home in Mill Park and was employed as a packing worker at Hi-city.

2. David had an intellectual disability and Down's Syndrome and was diagnosed with a number of medical conditions including hypothyroidism-primary, dilated cardiomyopathy and non-ST-Elevation Myocardial Infarction.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. David'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.

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[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.

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 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. David John Farlech was visually identified by his case worker Albert Yung Man Wong on 1 November 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 2 November 2018, Dr Melanie Archer, Forensic Pathology Registrar supervised by Dr Michael Burke Senior Pathologist at the Victorian Institute of Forensic Medicine, conducted an inspection on David's body and provided written report dated 7 November 2018, concluding a reasonable cause of death to be "I(a) Dilated cardiomyopathy contributing factors acute renal impairment". I accept her opinion in relation to the cause of death.

13. Dr Archer noted the post mortem computed tomography (CT) scan showed bilateral pleural effusions and a pericardial effusion consistent with the history of cardiac failure. The external examination did not show any evidence of an injury of a type likely to have caused or contributed to death.

14. Dr Archer stated that on the basis of the information available to her, she 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*

15. On 5 October 2018, David complained to the staff at his group home, of abdominal, rib cage and heart pain. David was seen by General Practitioner Dr Miller who ordered an x-ray and prescribed Buscopan. On 6 October 2018, David was reviewed by General Practitioner Dr Amy Doyle who diagnosed him with a chest infection and prescribed Amoxycillin. On 8 October 2018, David was reviewed by General Practitioner Dr David Festa, his regular doctor, who ordered blood tests and a computed tomography (CT) scan. Dr Festa informed the staff at the group home of the signs of deterioration and advised them to call an ambulance, if this occurred. On 10 October 2018, Dr Festa reviewed the results of the tests noted that David had been ill for two to three weeks and the CT scan showed pneumonia. Dr Festa changed the antibiotic medication and prescribed Keflex.

16. On 13 October 2018, David's condition continued to deteriorate and after a consultation with Dr Festa, he was transported by ambulance to Northern Hospital, where he was admitted. David did not respond to treatment and on 17 October 2018, after consultation with his family, he was transferred to palliative care.

17. On 31 October 2018, David succumbed to his illness and died surrounded by his family.

FINDINGS

18. Having investigated David John Farlech's death and having considered all of the available evidence, I am satisfied that no further investigation is required.

19. I find that the care provided to David John Farlech by the Department of Health and Human Services and Northern Health was reasonable and appropriate in the circumstances.

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

    (a) that the identity of the deceased was David John Farlech, born 20 August 1970

    (b) that David John Farlech died on 31 October 2019, at Northern from dialated; and

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

21. I convey my sincerest sympathy to David's family and friends.

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

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

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

    (b) Investigating Member, Victoria Police; and

    (c) Interested Parties.

Signature:

MR JOHN OLLE

CORONER

Date: 6 September 2019

Coroners Court of Victoria