IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 0983

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Simon McGregor, Coroner
Deceased:	Mr E.A
Date of birth:	May 1977
Date of death:	1 March 2018
Cause of death:	Unascertained
Place of death:	Wesley Mission Victoria, Wesley Neurological Support Services, 515 Highbury Road, Burwood East

INTRODUCTION

1. Mr E.A was a 40-year-old man who lived at the Wesley Mission Victoria, Wesley Neurological Support Services (Wesley Mission), 515 Highbury Road, Burwood East at the time of his death. Mr E.A had an Individual Support Package through the Department of Health and Human Services.[1]

2. Mr E.A was found unresponsive in his bed at approximately 5.40am on 1 March 2018.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mr E.A was 'a person placed in custody or care' for the purposes of the *Coroners Act 2008* as he was a person under the control, care or custody of the Secretary to the Department of Health and Human Services. His death was therefore a 'reportable death' under the Act, and it was appropriately reported to the coroner.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

7. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[2]

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[1] Wesley Mission Neurological Services patient file:

[2] This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless

8. In considering the issues associated with this finding, I have been mindful of Mr basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

BACKGROUND

9. Mr E.A was diagnosed with Huntington's disease approximately 14 years prior to his death. He was admitted to Wesley Mission on 6 April 2016.[3]

10. Staff reported to Victoria Police that Mr E.A's eating patterns and his general health had been good in the period leading up to his death. He had not been acting out of character.[4]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

11. On 1 March 2018, the usual checks were conducted by the Wesley Mission district nurse at approximately 3.00am. The nurse observed that Mr E.A was breathing and laying on his side.[5]

12. At approximately 5.40am[6], the same nurse observed Mr E.A still laying on his side. The nurse went to change Mr E.A pad and noticed that he was not breathing.[7] Mr E.A was still warm to the touch.[8] The nurse commenced cardiopulmonary resuscitation and called in the disability support worker.[9]

13. Ambulance Victoria were called and arrived at approximately 5.55am. They took over resuscitation attempts however, Mr E.A was unresponsive. Mr E.A was declared deceased by Ambulance Victoria at 6.02am.[10]

14. Mr E.A regular general practitioner, Dr Peter Coulton attended and assessed Mr E.A's body. He did not report any trauma, marks or bruising.[11]

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the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[3] Victoria Police, Police Report of Death for the Coroner, dated 1 March 2018.
[4] Ibid.
[5] Ibid.
[6] Wesley Mission Neurological Support Services resident file: Mr E.A Progress Notes dated 1 March 2018.
[7] Victoria Police, Police Report of Death for the Coroner, dated 1 March 2018.
[8] Wesley Mission Neurological Support Services resident file: Mr E.A Progress Notes dated 1 March 2018.
[9] Ibid.
[10] Ibid.
[11] Victoria Police, Police Report of Death for the Coroner, dated 1 March 2018.

IDENTITY AND CAUSE OF DEATH

15. On 1 March 2018, Mr P.A visually identified the body of his cousin, Mr E.A , born May 1977. Identity is not in dispute and requires no further investigation.

16. On 5 March 2018, Dr Paul Bedford a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr E.A's body and reviewed a post mortem computed tomography (CT scan) and the Police Report of Death for the Coroner. Dr Bedford provided a written report, dated 5 November 2018, in which he formulated the cause of death as '*I(a) Unascertained*'.

17. Toxicological analysis of post mortem samples taken from Mr E.A identified the presence of valproic acid[12], risperidone and its metabolite hydroxyrisperidone[13], quetiapine[14] and mirtazapine[15].

18. Dr Bedford commented that the post mortem and ancillary testing did not identify a clear cause of death. Toxicology was non-contributory to the cause of death, although a minor increase in C reactive protein raised the possibility of an unrecognised infection. As there were no suspicious elements identified the cause of death has been listed as "unascertained-natural causes".

19. Dr Bedford further commented that it should be noted that the literature comments that although Huntington's is a disease of the central nervous system, mortality surveys indicate that heart disease is a leading cause of death. The nature of such cardiac abnormalities remains unknown.

20. I accept Dr Bedford's opinion as to cause of death.

FINDINGS AND CONCLUSION

21. As Mr E.A was 'a person placed in custody or care', section 52 of the Act requires that I hold an inquest into Mr E.A's death unless I consider his death was due to

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[12] Valproic acid (as sodium valproate) is a carboxylic acid used therapeutically as an anticonvulsant, treatment for manic depression or in some instances for neurogenic pain.

[13] Risperidone is an atypical antipsychotic and is a selective monoaminergic antagonist with a high affinity for serotoninergic $5HT_2$-receptors and dopaminergic D_2-receptors, prescribed for schizophrenia and some behavioural disorders (delusions, aggression).

[14] Quetiapine is an antipsychotic drug used in the treatment of schizophrenia.

[15] Mirtazapine is indicated for the treatment of depression.

natural causes. Based on Dr Bedford's opinion expressed in his report, I consider that Mr EA's death was due to natural causes.

22. I express my sincere condolences to Mr E.A's family for their loss.

23. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was Mr E.A born May 1977;

    (b) The death occurred on 1 March 2018 at Wesley Mission Victoria, Wesley Neurological Support Services, 515 Highbury Road, Burwood East from an unascertained cause; and

    (c) The death occurred in the circumstances described above.

24. Pursuant to section 73(1B) of the Act, I direct that this finding be published on the Internet.

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

    (a) senior next of kin

    (b) Constable Kristina Lucic, Victoria Police, Coroner's investigator

Signature:

SIMON McGREGOR
CORONER
Date: 23 July 2019