IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 5611

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**CORONER DARREN J BRACKEN**
Deceased:	**Peter Allen Bain**
Date of birth:	20 February 1987
Date of death:	6 November 2018
Cause of death:	Aspiration Pneumonia
Place of death:	Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria

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HIS HONOUR:

BACKGROUND

1. On 6 November 2018, Peter Allen Bain was aged 31 years when he died in hospital of natural causes. At six years of age, Mr Bain came under the care of the Department of Health and Human Services (**DHHS**) and remained so for the rest of his life.[1] Immediately prior to his death, Mr Bain lived at 45 Lemon Grove, Nunawading (**the DHHS residence**), operated under the auspices of the DHHS. Mr Bain was totally dependent for all care needs.[2] Mr Bain's parents remained involved in all aspects of his life.

2. Mr Bain had a medical history that included severe intellectual disability with autistic tendencies (non-verbal),[3] agitation, constipation, motility disorder and iron deficiency anaemia.[4] Mr Bain's regular medications included Epilim,[5] Sertraline[6] and Zyprexa,[7] and several medications to manage his bowel functioning and gastrointestinal discomfort.[8]

3. On 9 March 2018, Mr Bain was admitted to Box Hill Hospital, Eastern Health (**BHH**) with vomiting and lethargy.[9] Earlier that day, Mr Bain swallowed pool water during his regular hydrotherapy session.[10] Mr Bain was diagnosed with hyponatraemia[11] and aspiration pneumonia and remained in hospital for five weeks. Mr Bain suffered seizures during his stay, and it was queried whether he had had a small seizure whilst in the pool.[12]

4. On 20 May 2018, Mr Bain was admitted to BHH with agitation and fever. Mr Bain was unable to weight bear on his right foot. Despite investigations, the origin of the fever was unascertained, and Mr Bain was discharged five days later.[13]

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[1] Letter from Sally Lutter, DHHS, dated 8 November 2018; Statement of Paula Bain, dated 1 April 2019, Coronial Brief.
[2] Statement of Paula Bain, dated 1 April 2019, Coronial Brief; Statement of Valerio Milone, dated 22 March 2019, Coronial Brief.
[3] Statement of Valerio Milone, dated 22 March 2019, Coronial Brief.
[4] Statement of Dr Kolin Kun-Ying Lu, dated 28 February 2019, Coronial Brief.
[5] Medication used to treat seizures.
[6] Medication used to treat depression.
[7] Medication used to treat mental/mood conditions including schizophrenia and bipolar.
[8] These included Coloxyl with Senna, Microlax Enema, Motilium, and Movicol; Statement of Dr Kolin Kun-Ying Lu, dated 28 February 2019, Coronial Brief.
[9] Medical Records, Box Hill Hospital Discharge Summary dated 20 April 2018.
[10] Medical Records, Box Hill Hospital Discharge Summary dated 20 April 2018; Statement of Paula Bain, dated 1 April 2019, Coronial Brief.
[11] A condition that occurs when the level of sodium in the blood is too low.
[12] Statement of Paula Bain, dated 1 April 2019, Coronial Brief.
[13] Medical Records, Box Hill Hospital Discharge Summary dated 31 May 2018.

5. On 16 October 2018, Mr Bain attended BHH with behavioural changes, including an episode of fixed gaze.[14] Mr Bain was diagnosed with acute behavioural disturbance with a clinical impression of possible absence seizures.[15] He was discharged later that evening.

THE PURPOSE OF A CORONIAL INVESTIGATION

6. Mr Bain's death constituted a '*reportable death*' pursuant to section 4 of the *Coroners Act* (2008) (Vic) ("the Act"), as his death occurred in Victoria, and, immediately before his death, Mr Bain was a person placed in custody or care.[16]

7. The Act requires a coroner to investigate reportable deaths such as Mr Bain's, and, if possible, to find:

   (a) the identity of the deceased.

   (b) the cause of death and

   (c) the circumstances in which death occurred.[17]

8. For coronial purposes, '*circumstances in which death occurred*'[18] refers to the context and background the death including the surrounding circumstances. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, required findings in relation to circumstances are limited to those circumstances which are sufficiently proximate to be considered relevant to the death.

9. The coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[19] It is not the coroner's role to determine criminal or civil liability,[20] nor to determine disciplinary matters.

10. One of the broader purposes 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 making recommendations.

11. Coroners are also empowered to:

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[14] Medical Records, Box Hill Hospital Discharge Summary dated 25 October 2018;
[15] Medical Records, Box Hill Hospital Discharge Summary dated 25 October 2018;
[16] Section 4 *Coroners Act 2008*.
[17] See Preamble and s 67, *Coroners Act* (2008).
[18] Section 67(1)(c).
[19] *Keown v Khan* (1999) 1 VR 69.
[20] Section 69 (1).

(a) report to the Attorney-General on a death;[21]

(b) comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[22] and

(c) 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.[23]

12. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities.[24] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[25]

13. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demand a weight of evidence commensurate with the gravity of the facts sought to be proved.[26] Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[27] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[28]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased - Section 67(1)(a) of the Act

14. On 7 November 2018, Kevin Bain identified the deceased as his son, Peter Allen Bain, born 20 February 1987.

15. Mr Bain's identity is not in dispute and requires no further investigation.

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[21] Section 72(1).
[22] Section 67(3).
[23] Section 72(2).
[24] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[25] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but I note that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brenna, Deane and Gaudron JJ.
[26] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.
[27] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[28] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brenna, Deane and Gaudron JJ.

Cause of death - Section 67(1)(b) of the Act

16. On 9 November 2018, Dr Michael Burke, a Senior Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination upon Mr Bain's body. Dr Burke provided a written report, dated 9 November 2018, in which he opined that the cause of Mr Bain's death was '*aspiration pneumonia*'. I accept Dr Burke's opinion.

17. Post mortem imaging showed a right pleural effusion and increased lung markings. The external examination was otherwise unremarkable. In accordance with the preference of Mr Bain's family, an autopsy was not performed.

18. Dr Burke advised there was no evidence to suggest the death was due to anything other than natural causes.

Circumstances in which the death occurred - Section 67(1)(c) of the Act

19. On 26 October 2018, Mr Bain attended his regular General Practitioner, Dr Kolin Kun-Ying Lu, with blank episodes of minimal response, loose bowels and a sore throat.[29] He was diagnosed with a viral upper respiratory infection and advised to rest.

20. Mr Bain's symptoms did not improve and at 6.00pm on 2 November 2018, staff at the DHHS Residence called an ambulance.[30] Mr Bain was transferred to BHH where he was admitted to the Intensive Care Unit (**ICU**) and treated with intravenous antibiotics for aspiration pneumonia.[31]

21. Mr Bain's condition continued to deteriorate in the ICU and the decision was taken, in conjunction with his family, to cease active treatment.[32] Mr Bain passed away peacefully surrounded by family at 6.10pm on 6 November 2018.[33]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

22. At the time of his death, Mr Bain was a '*person placed in custody or care*' as defined in section 3 of the *Coroners Act 2008* (**the Act**) because he was in the care of the DHHS immediately prior to his death.[34]

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[29] Statement of Dr Kolin Kun-Ying Lu, dated 28 February 2019, Coronial Brief.
[30] Statement of Valerio Milone, dated 22 March 2019, Coronial Brief.
[31] E-Medical Deposition Form; Medical Records, Box Hill Hospital ICU Admission Note dated 3 November 2018.
[32] E-Medical Deposition Form; Statement of Paula Bain, dated 1 April 2019, Coronial Brief.
[33] Statement of Dr John Dyett, dated 22 February 2019, Coronial Brief; Statement of Paula Bain, dated 1 April 2019, Coronial Brief.

23. Mr Bain's designation as a '*person placed in custody or care*' is significant. This is because the Act recognised that people in the control, care or custody of the State are vulnerable and therefore, irrespective of the nature of the death, requires it to be reported to the Coroner and so subject to the independent scrutiny and accountability of a coronial investigation.

24. As an additional protection, until the insertion of section 52(3A) into the Act in November 2014, all deaths of people placed in custody or care required a mandatory inquest. Now, the Coroner is no longer required to hold an inquest if satisfied that the death was due to natural causes but must publish Findings made concerning natural causes death of people in custody or care.[35] Of course, the Act preserves a discretionary power to hold an inquest in relation to any death a Coroner is investigating.[36]

25. In his autopsy report, Dr Burke commented that, during Mr Bain's final admission at BHH, clinicians inserted a nasogastric tube in an incorrect position (in the oropharynx) which caused coughing. Mr Bain's coughing resolved, however he continued to deteriorate the following day and active treatment was ceased.

26. In his statement dated 22 February 2019, Dr John Dyett of Eastern Health responded to Dr Burke's comment. Dr Dyett stated that at 8.38am on 5 November 2018, clinicians attempted a routine insertion of a nasogastric tube to facilitate enteral nutrition. At about 4.00pm, following the onset of feeds, Mr Bain was noted to yawn and the nasogastric tube was observed to be coiled in the back of his mouth. The tube was removed immediately. Dr Dyett noted there was no evidence that the nasogastric tube was incorrectly positioned, to the contrary, a chest x-ray performed at 12.55pm confirmed that the tip of the tube was appropriately situated below the diaphragm.[37] A subsequent chest x-ray at 6.25pm showed bilateral consolidation. Accordingly, Dr Dyett considered that Mr Bain's deterioration on the evening of 5 November 2018 was more likely due to the natural progression of his pneumonia rather than the insertion of the nasogastric tube or enteral feeding.[38]

27. Relying on the advice provided by Dr Burke and the subsequent statement of Dr Dyett, I am satisfied that Mr Bain's death was due to natural causes. The available evidence does not support a finding either that there was any want of care on the part of DHHS or the staff at the

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[34] See section 3 for the definition of a "person placed in custody or care" and section 4(2)(c) of the definition of "reportable death".
[35] Section 73(1B).
[36] Section 51(1).
[37] E-medical deposition Form.
[38] Statement of Dr John Dyett, dated 22 February 2019, Coronial Brief.

DHHS Residence, was a cause of Mr Bain's death, or that any want of clinical management or care on the part of the staff at BHH was a cause of his death.

28. I am satisfied, having considered all of the available evidence, that no further investigation into Mr Bain's death is required.

FINDINGS AND CONCLUSION

29. 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 Peter Allen Bain, born 20 February 1987;

    (b) Mr Bain's death occurred;

        i. on 6 November 2018 at Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria;

        ii. from Aspiration Pneumonia; and

        iii. in the circumstances described in paragraphs 19 – 21 above.

30. Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet in accordance with the rules.

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

    (a) Paula Bain, senior next of kin.

    (b) Kevin Bain, senior next of kin.

    (c) Dr Yvette Kozielski, Eastern Health.

    (d) Leading Senior Constable Anthony Magner, Coroner's Investigator, Victoria Police.

Signature:

DARREN J BRACKEN

CORONER

Date: 30 October 2019