IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 4768

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Simon McGregor, Coroner
Deceased:	**James Daniel Bankin**
Date of birth:	21 March 1978
Date of death:	31 August 2019
Cause of death:	Aspiration pneumonia in the setting of tuberous sclerosis
Place of death:	Golf Links Road Rehabilitation Centre 125 Golf Links Road, Frankston, Victoria

INTRODUCTION

1. James Daniel Bankin was a 41-year-old man who lived at a Supported Residential Service in Rosebud at the time of his death. He died in hospital on 31 August 2019.

THE PURPOSE OF A CORONIAL INVESTIGATION

2. Mr Bankin's death was reported to the Coroner. Immediately before his death Mr Gerrard was a person in the care of the Department of Health and Human Services and so his death fell within the definition of a reportable death in the *Coroners Act 2008.*

3. 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.

4. 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.

5. Senior Constable Peter Evans of Victoria Police made a report of the death for the coroner. I have also obtained medical records, a medical deposition and a report from a Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**).

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.[1]

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

8. In considering the issues associated with this finding, I have been mindful of Mr Bankin's 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.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

9. Mr Bankin suffered from tuberous sclerosis and epilepsy. His seizures were often associated with vomiting and a high risk of aspiration pneumonia.

10. On 1 July 2019 Mr Bankin had a prolonged tonic-clonic seizure at his home. He was brought to the Emergency Department at Frankston Hospital and admitted for inpatient care.

11. While in hospital his condition declined. When it was determined that there was a very small likelihood of Mr Bankin returning to baseline functioning, he went into palliative care on 19 August 2019.

12. He continued to decline and was found deceased at 5.40am on 31 August 2019.

IDENTITY AND CAUSE OF DEATH

13. On 31 August 2019, Mr Bankin's mother visually identified his body. Identity is not in dispute and requires no further investigation.

14. On 5 September 2019, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination of Mr Bankin's body and reviewed a post mortem computed tomography (CT) scan, medical records and the Police Report of Death for the Coroner. Dr Lynch provided a written report, dated 9 October 2019, in which he formulated the cause of death as '*I(a) Aspiration pneumonia in the setting of tuberous sclerosis*'.

15. I accept Dr Lynch's opinion as to cause of death.

REVIEW OF CARE

16. As Mr Bankin was receiving a disability service at the time of his death, his death was investigated by the Disability Services Commissioner (**DSC**).

17. The DSC investigation did not find any issues directly related to Mr Bankin's death and determined that no action was required beyond actions already taken by the service provider.

FINDINGS AND CONCLUSION

18. I express my sincere condolences to Mr Bankin's family for their loss.

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

20. 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 James Daniel Bankin, born 21 March 1978;

    (b) The death occurred on 31 August 2019 at the Golf Links Road Rehabilitation Centre at 125 Golf Links Road, Frankston, from aspiration pneumonia in the setting of tuberous sclerosis; and

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

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

    (a) Mrs Janette Bankin, senior next of kin;

    (b) Mr Peter Bankin, senior next of kin;

    (c) Amber Salter, Peninsula Health; and

    (d) Senior Constable Peter Evans, Victoria Police.

Signature:

SIMON McGREGOR

CORONER

Date: 6 March 2020