IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 3510

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Jacqui Hawkins
Deceased:	Dale Roberts
Date of birth:	11 September 1963
Date of death:	19 July 2018
Cause of death:	I(a) Aspiration pneumonia
Place of death:	Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria, 3128

BACKGROUND

1. Dale Roberts was 54 years old at the time of his death. He lived in supported accommodation in Kew, in a home managed by the Department of Health and Human Services (DHHS). Mr Roberts was close to his twin brother, Glenn who regularly visited him and was his substitute decision maker. Mr Roberts also had a sister who would visit him.

2. Mr Robert's medical history included cerebral palsy, a severe intellectual disability, epilepsy, seizures, asthma, hyponatremia, a left hemiplegia and severe dysphasia leading to recurrent aspiration and infections. Mr Roberts communicated with gestures, vocal sounds and few known words. He used a wheelchair and required support in all aspects of his care.

3. Mr Robert's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* as he lived in the care of DHHS.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame or determine criminal or civil liability.[1]

5. In writing this Finding, I do not purport to summarise all the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

IDENTITY OF THE DECEASED

6. Dale Roberts was visually identified by his twin brother, Glenn Roberts, on 19 July 2018. Identity was not in issue and required no further investigation.

MEDICAL CAUSE OF DEATH

7. On 23 July 2018, Dr Joanna Glengarry, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination on the body of Mr Roberts and reviewed the Form 83 Victoria Police Report of Death, medical records from Templestowe

[1] In the coronial jurisdiction facts must be established on the balance of probabilities 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.

District Medical Centre and Park Orchards Family Practice, the medical deposition from Box Hill Hospital and the post mortem computed tomography (CT) scan.

8. Dr Glengarry reported that the external examination showed features consistent with the clinical history. She commented that on the information available to her, Mr Robert's death was due to natural causes.

9. Dr Glengarry provided an opinion that the medical cause of death was 1(a) *aspiration pneumonia*.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

10. On 17 July 2018, Mr Roberts was admitted to Box Hill Hospital at 11.03pm unwell, with aspiration pneumonia and seizures. Throughout his admission he was treated with intravenous antibiotics and oxygen. He was reviewed by a speech pathologist in relation to his swallowing and advice was given about a modified diet. Anti-seizure medication was delayed until it could be given intravenously, as he was unable to swallow.

11. On 19 July 2018, at 1am a Medical Emergency Team (MET) call was made as Mr Roberts had suffered a brief seizure. He was charted for anti-seizure medication. He had another MET call at 7am, with low oxygen levels, low heart rate and increased difficulty with breathing. He rapidly deteriorated and was unable to be resuscitated. He was pronounced deceased at 7.51am.

12. There were no concerns raised in relation to Mr Robert's care and management. Having considered the evidence I am satisfied that no further investigation is required.

FINDINGS

13. Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

    (a) the identity of the deceased was Dale Roberts born 11 September 1963; and

    (b) Mr Roberts died on 19 July 2018 from 1(a) *aspiration pneumonia*; and

    (c) in the circumstances described above.

I order pursuant to section 73(1B) of the *Coroners Act 2008*, that this finding be published o the Coroners Court of Victoria Website.

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

Mr Glenn Roberts;

Department of Health and Human Services; and

Interested parties.

Signature:

JACQUI HAWKINS
Coroner
Date: 22 April 2020