IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 5813

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Simon McGregor, Coroner
Deceased:	**Michael Davies**
Date of birth:	1 November 1976
Date of death:	23 October 2019
Cause of death:	Aspiration pneumonia complicating small bowel ileus in a man with cerebral palsy
Place of death:	Sunshine Hospital 176 Furlong Road, St Albans, Victoria

INTRODUCTION

1. Michael Davies was a 42-year-old man who lived in supported accommodation at the time of his death. Mr Davies died in hospital after becoming ill on 21 October 2019.

THE PURPOSE OF A CORONIAL INVESTIGATION

2. Mr Davies' death was reported to the Coroner. Immediately before his death Mr Davies 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. First Constable Altaf Hussain of Victoria Police made a report of death for the coroner. I have also received a medical deposition from Dr Emily De Luca of Western Health 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 Davies' 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 Davies lived in a residential care facility in St Albans operated by Scope. He required full-time care and had a medical history including cerebral palsy and epilepsy.

10. On 21 October 2019 Mr Davies became ill at home with vomiting, abdominal distension and pain. He was taken to the Emergency Department at Sunshine Hospital.

11. Investigations suggested at least partial obstruction of the small bowel. He was admitted to hospital for inpatient care under the General Medicine team.

12. Mr Davies's condition deteriorated and on 23 October 2019 there were indications he had aspiration pneumonia. He began to develop multiorgan failure that day.

13. Medical staff discussed his case and determined that Mr Davies would be unlikely to survive surgery. Due to signs of discomfort, they moved him to palliative care.

14. Mr Davies passed away at 11.53pm on 23 October 2019.

IDENTITY AND CAUSE OF DEATH

15. On 23 October 2019, Mr Davies' carer Vicki Hearn visually identified his body. Identity is not in dispute and requires no further investigation.

16. On 25 October 2019, Dr Yeliena Baber, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination of Mr Davies' body and reviewed a post mortem computed tomography (CT) scan, a medical deposition and the Police Report of Death for the Coroner.

17. She noted that the CT scan showed a grossly dilated small bowel with air/fluid levels and evidence of aspiration pneumonia.

18. Dr Baber provided a written report, dated 12 November 2019, in which she formulated the cause of death as '*I(a) Aspiration pneumonia complicating small bowel ileus in a man with cerebral palsy*'.

19. I accept Dr Baber's opinion as to cause of death.

FINDINGS AND CONCLUSION

20. I express my sincere condolences to Mr Davies' family for their loss.

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

22. 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 Michael Davies, born 1 November 1976;

    (b) The death occurred on 23 October 2019 at Sunshine Hospital, 176 Furlong Road, St Albans, from aspiration pneumonia complicating small bowel ileus in a man with cerebral palsy; and

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

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

    (a) Mr Peter Davies, senior next of kin; and

    (b) First Constable Altaf Hussain, Victoria Police.

Signature:

SIMON McGREGOR
CORONER
Date: 17 March 2020