IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 4649

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Deceased:	**MATTHEW GLENISTER BLAKE CLARK**
Delivered on:	15 December 2020
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	15 December 2020
Findings of:	**SARAH GEBERT, CORONER**
Counsel assisting the Coroner:	**Ms Eleanor Downie, Coroner's Solicitor, Coroners Court of Victoria**
Other matters:	*Person placed in care*

HER HONOUR:

INTRODUCTION

1. Matthew Glenister Blake Clark[1], born 31 January 1967, was 51 years of age at the time of his death. When he was young, Matthew spent time living in an Aboriginal community with his parents and considered himself to be of Aboriginal heritage enjoying Aboriginal cultural events and activities. Matthew's parents predeceased him. His father died when he was 4 years of age and his mother when he was 45 years of age.

2. Matthew was able to live with his mother until he was 42 years old after which he moved into a care arrangement.

3. At the time of this death, Matthew resided in a Department of Health and Human Services (**DHHS**) managed group home in Rowville and had done since around 2010.

4. Matthew enjoyed swimming, bowling, shopping and spending time with his housemates.

5. He received individual support from Eastern Access Community Health (**EACH**) which were funded via a combination of NDIS and self-funding. Matthew used these supports to participate in a range of activities of his choosing.

6. Matthew was able to make decisions and choices in relation to his daily direct support needs but required support to make decisions relating to medical treatment. He had a medical guardian appointed by the Office of the Public Advocate.

7. On 14 September 2018, Matthew died at the Wantirna Health palliative care unit having been transferred for end of life care.

The Coronial Investigation

8. Matthew's death was reported to the coroner as he was considered to be *a person placed in custody or care* under section 3(1) of the *Coroners Act 2008* **(the Act)** and so fell within the definition of a reportable death under the Act. A reportable death also includes a death that appears to be unnatural or violent, or to have resulted, directly or indirectly, from an accident or injury. Therefore, his death was also reportable under this category.

9. A coroner independently investigates 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

[1] Referred to as 'Matthew' unless more formality is required.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[2]

10. Victoria Police assigned First Constable Trent Latham (**FC Latham**) to be the Coroner's Investigator for the investigation. FC Latham conducted inquiries on my behalf[3], including taking statements from witnesses and submitting a coronial brief of evidence. The brief includes statements from a DHHS disability worker, treating physicians, the forensic pathologist who examined him and investigating officers, as well as other relevant documentation.

11. The Court also obtained Matthew's medical records from Eastern Health as well as his DHHS client file.

Disability Services Commissioner

12. I also considered the *Investigation Report into disability services provided by Eastern Access Community Health and DHHS to Mr Clark* prepared by the Disability Services Commissioner (**DSC**) which was provided to the Court on a confidential basis. The DSC investigation was conducted under the auspices of the *Disability Act 2006* with a different scope to that of a coronial investigation (although it can overlap). Consistent with the Act, a coroner should liaise with other investigative bodies to avoid unnecessary duplication and expedite investigations.[4]

13. I note that the DSC investigation revealed concerns about the adequacy of the provision of disability services provided to Matthew and that it determined that it was necessary to issue a Notice to Take Action to EACH and DHHS pursuant to s.128 of the Disability Act.

14. The DSC also permitted me to include part of the Investigation Report in my Finding.

15. As part of the coronial investigation, advice was also sought from the Coroners Prevention Unit (**CPU**) regarding the care provided to Matthew proximate to his death. The CPU is staffed by healthcare professionals, including practicing physicians and nurses, who are not associated with the health professionals and institutions under consideration and are therefore able to give independent advice to coroners.

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[2] 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.

[3] The carriage of the investigation was transferred from Deputy State Coroner English.

[4] S.7 of the Act.

16. When a person dies *'in care'* an inquest into the death is mandatory (unless it is a death from natural causes). After reviewing all the material, I determined that the circumstances of Matthew's death were adequately revealed by the coronial brief and the other documents gathered as part of my investigation, which meant that the investigation could be concluded. I also determined that no witnesses were required to give evidence at the Inquest.

17. 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.

Background

18. Matthew's primary disability was Down syndrome. He also had several health concerns, including: cirrhosis of the liver (secondary to Hepatitis B), ascites, oesophageal varices splenomegaly, narrow oesophagus, sleep apnoea (requiring Continuous Positive Air Pressure [CPAP] machine at night), Willis-Ekbom disease, depression, constipation, osteoporosis, gamma heavy chain disease, hypothyroidism and chronic pancytopenia.

19. Matthew had congenital dislocation of both hips and had bilateral total hip replacements in 2011. He used a walker for safety and a wheelchair for most outings.

20. Matthew had a hearing impairment and used hearing aids when out in the community. He communicated verbally and was able to express his likes and dislikes, but required staff support when in the community as his speech was slow and sometimes hard to understand. He also liked to use sign language.

21. One of Matthew's longtime carers, Kelly Aitken, a qualified nurse employed by DHHS as the House Supervisor, commented in her statement to the Court that,

Probably partly due to Matthews (sic) *disability, he coped really well with all his medical conditions. I think he really liked all the attention he got. He always really engaged with everyone he came into contact with and had long conversations with people.*[5]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

22. On 8 June 2018, three months prior to his death, Matthew was admitted to the Angliss Hospital with abdominal pain, which was managed as a suspected bowel obstruction.

23. Complications of intra-abdominal sepsis secondary to a perforated small bowel was diagnosed on 15 June 2018 and on 16 June 2018, he was transferred to Maroondah Hospital,

[5] Dated 8 February 2019.

where he underwent surgery to remove a 'foreign object' (*suspected to be a chicken bone*[6]) from his bowel and repair a perforated bowel. He remained in intensive care until 19 June 2018. He was also diagnosed with pneumonia during the perioperative episode.

24. Matthew was subsequently transferred back to the Angliss Hospital for reconditioning on 26 June 2018. Matthew developed non-ST elevation myocardial ischaemia on 27 June and was transferred to the coronary care unit at Box Hill Hospital for monitoring and medical management between 30 June and 10 July 2018. Right heart failure was an additional pathology diagnosed during this period. Matthew was transferred back to Angliss Hospital on 10 July and discharged home on 25 July 2018.

25. On 26 July 2018, Matthew became ill again with stomach pain, vomiting and fever and was admitted to Box Hill Hospital via ambulance where he remained until 12 September 2018.

26. A meeting was held with medical staff, the group home supervisor and Matthew's Medical Guardian from the Office of the Public Advocate on 11 September 2018. It was established that all medical treatment avenues had been exhausted.

27. Matthew was transferred to Eastern Health Supportive and Palliative Care (Wantirna Health) the following day.

28. Matthew subsequently passed away at 3.00pm on 14 September 2018, surrounded by a number of his long time carers.

29. Matthew had been supported to prepare a document entitled 'My End of Life Wishes'. This document contained information such as Matthew's wishes with regard to his funeral and disbursement of his ashes.

IDENTITY

30. On 14 September 2018, Kelly Aitken visually identified Matthew Glenister Blake Clark, born 31 January 1967, who she had known for 10 years.

31. Identity is not in dispute and requires no further investigation.

CAUSE OF DEATH

32. On 17 September 2018, Dr Heinrich Bouwer, a specialist forensic pathologist practicing at the Victorian Institute of Forensic Medicine, performed an external examination and provided a written report dated 10 October 2018. In that report, Dr Bouwer concluded that a

[6] Statement of Dr Ann Farrell dated 24 January 2019.

reasonable cause of Matthew's death was *Complications of Recurrent Small Bowel Obstruction (palliated).*

33. The external examination showed a markedly cachectic man. There was evidence of recent abdominal surgery and an early sacral skin breakdown.

34. The post mortem CT scan showed marked brain atrophy with basal ganglia calcifications, fatty and cirrhotic liver, marked splenomegaly, bilateral pleural effusions, bilateral total hip joint replacements and gallstones.

35. I accept and adopt Dr Bouwer's opinion as to Matthew's medical cause of death.

Further investigations

36. Following a review of the medical care following Matthew's admission on 8 June 2018, the CPU did not identify any issues with the provision of health care or medical management of Matthew.

37. With respect to the presence of foreign material suspected to be a chicken bone, Ms Aitken said that Matthew had been on *vitamised* food since he developed Oesophagus Varies. An examination of his DHHS file revealed that according to an undated Diet Plan for Matthew he required soft, easy to chew, food diet and *must NEVER eat any hard foods or any foods which 'glob' such as bread.* He was encouraged to chew his food very well before swallowing and sit upright when eating (including 30 minutes after eating) and avoid bending forward.

38. Ms Aitken said, *I find it very hard to believe that Matthew would ever have eaten anything of the size of a chicken bone, because he knew how bad it felt in his body and he was used to eating vitamised food now. He also knew what he could and could not eat due to his condition.*

FINDINGS

39. Having investigated the death of Matthew and having held an inquest in relation to his death on 15 December 2020, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

(a) the identity of the Deceased was Matthew Glenister Blake Clark, born 31 January 1967;

(b) Matthew died on 14 September 2018 at Wantirna Health, 251 Mountain Highway, Wantirna, Victoria, from *Complications of Recurrent small bowel obstruction (palliated)*; and

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

PUBLICATION

40. Pursuant to section 73(1) of the Act, I order that this Finding be published on the internet.

41. I convey my sincere condolences to Matthew's friends and carers for their loss. Ms Aitken said,

I would describe my relationship with Matthew as just like family. We were very close. Even members of my one family would come to visit him quite often. ...

I was very sad when Matthew passed away. Our biggest fear was that he'd be alone when he died, so it was nice that we could be there with him.

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

State Trustees

Wantirna Health

First Constable Trent Latham, Victoria Police, Coroner's Investigator

Signature:

SARAH GEBERT

CORONER

Date: 15 December 2020

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.