IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 001722

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the ***Coroners Act 2008***

Findings of:	Coroner Kate Despot
Deceased:	Blake Edwards
Date of birth:	31 July 1985
Date of death:	06 April 2019
Cause of death:	1(a) Ventricular arrhythmia associated with cardiomegaly
Place of death:	169 High Street, Berwick, Victoria, 3806
Keywords:	‘in care’

INTRODUCTION

1. On 6 April 2019, Blake Edwards **(Blake)** was 33 years old when he passed away at 169 High Street, Berwick, a respite care centre, operated by the Department of Health and Human Services, now the Department of Families, Fairness and Housing **(the Department).**

2. Blake had a medical history of Tatton-Brown-Rahman syndrome, caused by a DNMT3A gene mutation, and was fitted with a pacemaker. He was prescribed multiple medications for medical conditions that included heart and respiratory issues.[1]

3. Blake lived with his parent's Gary and Carol Edwards at their home in Tooradin and would intermittently attend respite care at 169 High Street, Berwick.

THE CORONIAL INVESTIGATION

4. Blake's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes. For the purposes of my coronial investigation, Blake was a person in care within the definition of the *Coroners Act 2008* **(the Act).**

6. 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.

7. 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.

8. This finding draws on the totality of the coronial investigation into the death of Blake Edwards. Whilst I have reviewed all the material, I will only refer to that which is directly

[1] Form 83.

relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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

Circumstances in which the death occurred

9. On the evening of 5 April 2019, Blake appeared well, having attended respite at 169 High Street, Berwick, where he intended to stay for the weekend.

10. On the morning of 6 April 2019, a staff member provided Blake with several spoonfuls of yoghurt with his medication, that he appeared to swallow.

11. Around 30 minutes later, Blake was noted to be very pale and was not responding appropriately. A short time later he became unconscious and was not breathing. Cardiopulmonary resuscitation was administered; however, Blake was unable to be revived and was declared deceased.

Identity of the deceased

12. On 6 April 2019, Blake Edwards, born 31 July 1985, was visually identified by his father, Gary Edwards.

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

Medical cause of death

14. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 11 April 2019 and provided a written report of his findings dated 7 June 2019.

15. The autopsy findings identified:

    a) Clinical history of DNMT3A gene mutation (Tatton-Brown-Rahman syndrome).

    b) Cardiomegaly[3] with left ventricular dilatation.

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[2] 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] An enlarged heart.

c) Confluent bronchopneumonia.

d) Pacemaker in situ.

e) Mesothelial proliferations within the peritoneum.

f) Marked kyphoscoliosis.

16. Dr Burke advised that individuals with cardiomegaly may suffer sudden cardiac arrhythmias which can lead to death.

17. In subsequent correspondence, Dr Burke confirmed that the pacemaker was working correctly and did not contribute to Blake's death.

18. Toxicological analysis of post-mortem samples identified the presence of oxycodone,[4] amiodarone,[5] carvedilol,[6] frusemide,[7] warfarin, and paracetamol[8] consistent with therapeutic use.

19. Dr Burke provided an opinion that the medical cause of death was 1 (a) *Ventricular arrhythmia associated with cardiomegaly* and that the death was due to natural causes.

20. I accept Dr Burke's opinion.

FURTHER INVESTIGATIONS

21. During the course of the investigation into Blake's death, the Court was advised that the Disability Services Commissioner **(the Commissioner)** was investigating the disability services provided to Blake by the Department.

22. In September 2021, the Court was provided with correspondence from the Acting Deputy Commissioner advising the court that the Commissioner's investigation was complete and that no adverse findings had been made against the Department.

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[4] Oxycodone is a semi-synthetic opiate narcotic analgesic related to morphine used clinically to treat moderate to severe pain.
[5] Amiodarone is a class III antiarrhythmic indicated for severe tachyarrhythmias unresponsive to other therapies.
[6] Carvedilol is used to treat high blood pressure, congestive heart failure, and left ventricular dysfunction.
[7] Frusemide is a loop diuretic used to treat oedema and mild to moderate hypertension.
[8] Paracetamol is an analgesic drug.

FINDINGS AND CONCLUSION

23. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Blake Edwards, born 31 July 1985;

    b) the death occurred on 06 April 2019 at 169 High Street, Berwick, Victoria, 3806, from ventricular arrhythmia associated with cardiomegaly; and

    c) the death occurred in the circumstances described above.

24. I convey my sincere condolences to Blake's family for their loss.

25. Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Mr Gary & Mrs Carol Edwards, Senior Next of Kin

The Disability Services Commissioner

The Department of Families, Fairness and Housing

First Constable L. W. Stewart, Victoria Police

Signature:

Coroner Kate Despot

Date : 09 December 2022

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 investigation. 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.