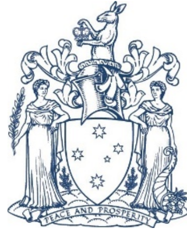

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 007112

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Ronald Jelbert
Date of birth:	25 March 1929
Date of death:	29 December 2019
Cause of death:	1(a) Sepsis in the setting of cachexia in man with multiple comorbidities
Place of death:	Western Health, Footscray Hospital, 160 Gordon Street, Footscray, Victoria, 3011

INTRODUCTION

1. Ronald Jelbert was 90 years old at the time of his death. He resided in the Sunbury disability group home, a Disability Services Residential Accommodation (**DAS**) funded by the Department of Health and Human Services (**DHHS**) since 15 July 1992. The Sunbury disability group home was transferred to Possability[1] on 28 April 2019, while Mr Jelbert was still a resident.

2. Mr Jelbert had a moderate intellectual disability and spent most of his life in institutional care. He did not have a spouse nor children. The State Trustee was his financial administrator and the Office of the Public Advocate made decision for his medical care.

3. He had a medical history of Parkinson, skin cancer, psoriasis[2], eczema, dyslipidaemia, and osteoporosis. He was also diagnosed with advanced prostate cancer during his admission in Footscray Hospital.

4. At the time of his death, Mr Jelbert was managed by multiple healthcare specialists and treated with numerous medications for his conditions.

5. On 29 December 2019, Mr Jelbert died at the Footscray Hospital following his hospital admission on 22 December 2019.

THE CORONIAL INVESTIGATION

6. Mr Jelbert's death was reportable pursuant to section 4 of the *Coroners Act 2008* ("the Act") because he was a person placed in care at the time of his death, even if the death appears to have been from natural causes. Section 3 of the Act states that a person placed "in care" includes a person who is under the control, care or custody of the DHHS.

7. 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.

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[1] Possability is a not-for-profit organisation that is subjected to strict control oversight by the Department of Health and Human Services (**DHHS**) which DHHS have oversight until the end of 2025 with a focus on meeting safety and quality requirement. See Support for Transfer of Services Short Term Accommodation Assistance, Carers Victoria.

[2] Psoriasis is a skin disease that causes red, itchy scaly patches, most commonly on the knees, elbows, trunk and scalp. Psoriasis is a common, long-term (chronic) disease with no cure.

8. Victoria Police assigned Senior Constable Mark Bradley (SC Bradley) to be the Coroner's Investigator for the investigation of Mr Jelbert's death. SC Bradley conducted inquiries on my behalf, including taking statements from witnesses – such as friends, support workers, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. An investigation was also conducted under the auspices *Disability Services Act 2016* by the Disability Services Commissioner ("the Commissioner") with a different scope to that of a coronial investigation. I considered the reporting letter from the Commissioner on the investigation into disability services provided by Possability. The letter was provided to the Court on a confidential basis. Consistent with the Act, a coroner should liaise with other investigation bodies to avoid unnecessary duplication and expedite investigation.[3]

10. This finding draws on the totality of the coronial investigation into the death of Ronald Jelbert including evidence contained in the coronial brief. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[4]

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

Circumstances in which the death occurred

11. On 21 December 2019, Mr Jelbert was transported by ambulance to Footscray Hospital and subsequently presented to the Emergency Department (**ED**) as his support workers had become concerned that he refused consumption of any food. Staff also observed Mr Jelbert had difficulties to get up onto his feet to walk.

12. Mr Jelbert's admission diagnosis at the ED included sepsis in context of suspected colonic thickening and malignancy or colitis, an inflammatory condition. Several blood tests were conducted and indicated a possible urinary tract infection (**UTI**). The results from the blood tests also revealed that Mr Jelbert's kidneys had reduced output. Medical practitioners then commenced antibiotics treatment on Mr Jelbert.

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[3] Section 7 of the *Coroners Act 2008.*

[4] 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.

13. On 22 December 2019, at 1.00am, Mr Jelbert was admitted to Ward 3B, the general ward of Footscray Hospital and was reported to be responding well to the UTI treatment.

14. On 24 December 2019, the supervisor of the DAS, Ashley Ryan was informed that Mr Jelbert had been diagnosed with advanced prostate cancer. Ms Ryan was also advised that Mr Jelbert's may not have long to live given Mr Jelbert's degree of frailty, rapid functional decline, and lack of response to empirical antibiotics treatment.

15. Mr Jelbert remained in Ward 3B and subsequently received palliative care. His friends, extended family, housemates, and support workers visited him throughout the last days of his life.

16. On 29 December 2019, a nurse on duty in Ward 3B found Mr Jelbert lying in his bed with no signs of life. He was declared deceased at 3.45pm and the DAS group home was informed of Mr Jelbert's death.

Identity of the deceased

17. On 3 January 2020, Ronald Jelbert, born 25 March 1929, was visually identified by his extended family member, Marcia Edwards. Identity is not in dispute and requires no further investigation.

Medical cause of death

18. On 31 December 2019, Forensic Pathologist Dr Victoria Christabel Mary Francis from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination. Dr Francis also reviewed a post-mortem computed tomography (**CT**) scan and referred to the Victoria Police Report of Death (Form 83) and E-medical disposition form. Dr Francis provided a written report of her findings dated 7 January 2020.

19. The external examination revealed a severely underweight body with a body mass index (BMI) of 13[5].

20. The post-mortem CT scan revealed cerebral atrophy and calcification in the prostate and vertebral crush fractures. The lungs were emphysematous[6].

[5] The BMI is calculated by way of weight-to-height, weight in kilograms divided by the square of the height in meters (kg/m^2). Any BMI less than 18.5 is considered underweight.
[6] Damaged of the air sacs in the lungs (alveoli).

21. No post-mortem evidence of trauma or injuries was found to have caused or contributed to Mr Jelbert's death. Dr Francis formed the opinion, based on the information available to her, that Mr Jelbert's death was due to natural causes.

22. Dr Francis ascribed the medical cause of death was 1 (a) sepsis in the setting of cachexia[7] in a man with multiple comorbidities.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

23. There is no evidence to suggest that there is any public interest in taking this matter to a public hearing Mr Jelbert's medical care and treatment appears reasonable. There are no family concerns in relation to the same. I am satisfied that the Commissioner's investigation did not identify any issues with Mr Jelbert's the delivery of care from the service provider, Possability were casual or connected to Mr Jelbert's death. I am also satisfied that Mr Jelbert's medical care and treatment provided to him by Footscray Hospital had no casual connection between the cause of Mr Jelbert's death.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Ronald Jelbert, born 25 March 1929;

    b) the death occurred on 29 December 2019 at Western Health, Footscray Hospital, 160 Gordon Street, Footscray, Victoria, 3011; and

    c) I accept and adopt the medical cause of death ascribed by Dr Victoria Christabel Mary Francis and I find that Ronald Jelbert died from sepsis in the setting of cachexia in the circumstances which arose in a man with multiple comorbidities;

    d) I further find that Ronald Jelbert's death arose from natural causes; and

    e) I also find that there is no casual connection between the cause of death of Ronald Jelbert and the fact that he was a person placed "in care" as it is defined in the Act.

[7] Cachexia is a condition that causes extreme weight loss and muscle wasting. It is a symptom of many chronic conditions such as cancer, chronic renal failure and multiple sclerosis. Cachexia predominantly affects people in the late stages of serious diseases like cancer.

25. Consequently, the Finding into the death of Mr Jelbert has been finalised without an Inquest, pursuant to section 52(3A) of the Act and the written findings in relation to all deaths which occur "in care" must be published, pursuant to section 73(1B) of the Act.

I convey my sincere condolences to Mr Jelbert's friends for their loss.

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.

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

Lisa Edwards, Senior Next of Kin

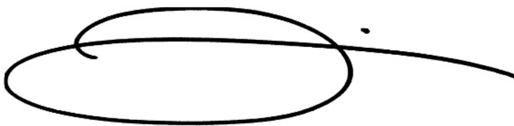
Senior Constable Mark Bradley, Coroner's Investigator

Possability

Western Health

The Disability Services Commissioner

Signature:



AUDREY JAMIESON

CORONER

Date: 10 December 2021

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.