IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 004102

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	John Robert Clay
Date of birth:	24 February 1952
Date of death:	29 July 2020
Cause of death:	1(a) STERCORAL PERFORATION IN A MAN WITH CEREBRAL PALSY
Place of death:	Western Health, Footscray Hospital, 160 Gordon Street, Footscray, Victoria, 3011
Keywords:	In care, natural causes death, disability

INTRODUCTION

1. On 29 July 2020, John Robert Clay was 68 years old when he died at Footscray Hospital.

2. At the time of his death, Mr Clay resided in specialist disability accommodation in Airport West.

3. Mr Clay's mother and father died in 1994 and 1995 respectively. He has one brother, Douglas Clay (Douglas) who lives abroad.

Background

4. Born with significant disabilities, including cerebral palsy on 24 February 1952, Mr Clay was placed into the care of the Department of Health and Human Services (**DHHS**)[1] in approximately August 1953 when he was about eighteen months old.

5. According to his brother Douglas, who only learned that he had a brother when he was 18 years old, his parents were unable to provide the necessary care for him and placed him into DHHS care at Kew Cottages in Princess Street, Kew. Mr Clay's mother visited him approximately once a month.

6. After their parents' death, Douglas became Mr Clay's full-time guardian and visited Mr Clay at Kew Cottages once a month. Douglas described Kew Cottages as 'hell'.[2]

7. In 1998, following the closure of Kew Cottages, at Douglas' request, Mr Clay was moved to purpose-built disability accommodation in Airport West where he resided until the time of his death. Douglas visited Mr Clay once a fortnight.

8. In 2003, Douglas relocated to Canada, but maintained contact with Mr Clay's carers via email and visited him on his return trips to Australia. Douglas described the care Mr Clay had received at the Airport West accommodation positively, noting he received 'excellent care and attention from the staff'.[3]

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[1] On 21 February 2021 the Department of Health and Human Services was separated into two new departments, the Department of Health (DH) and the Department of Families, Fairness and Housing (DFFH).

[2] Coronial Brief (CB), Statement of Douglas Clay.

[3] Ibid.

Medical history

9. Mr Clay had multiple complex health issues, including severe brain injury, epilepsy, spasticity contracture of his limbs and dysphagia.[4] He was quadriplegic, non-verbal and required full support for all aspects of daily living, including mealtime support, assistance with toileting and support to take his prescribed medications and supplements. Mr Clay communicated by using gestures, facial expressions, pictures and sounds.

Management of medical conditions

10. Mr Clay was supported by a multidisciplinary treating team. His regular general practitioner, Dr Chin Ho commenced providing care in 2005 and remained his GP until his death. Mr Clay was also under the care of a dietitian, neurologist Dr David Freilich for management of his epilepsy and speech pathologist Dr Jill Lesic for management of his dysphagia.

11. Mr Clay's care team followed specific health management plans prepared by his treating team in order to best manage his conditions.[5] These included epilepsy management, gastric reflux, actinic keratoses, gingivitis, pressure care, nutrition/weight monitoring, constipation/bowel charting, dysphasia, mealtime support and iron deficiency anaemia.

12. In 2019, care of Mr Clay was transferred from DHHS to Scope, an NDIS registered provider of disability support services. His care team remained unchanged.

13. Dr Ho reported that Mr Clay was well looked after by the dedicated care team at his accommodation.[6]

THE CORONIAL INVESTIGATION

14. Mr Clay'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. 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.

15. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was

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[4] CB, Statement of general practitioner Dr Chin Kum Ho.
[5] CB, Statement of Kylie Waterman, Operations Manager at Scope.
[6] CB, Statement of Dr Chin Kum Ho.

as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

16. Immediately before his death, Mr Clay was a person placed in care. However, section 52(3A) of the Act provides an exception to section 52(2), that the coroner is not required to hold an inquest if the coroner considers the death was due to natural causes. Having considered all of the evidence in this matter, and pursuant to section 52(3A) of the Act, I determined not to hold an inquest.

17. 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.

18. 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.

19. Victoria Police assigned Acting Senior Sergeant Jennifer Lamond to be the Coroner's Investigator for the investigation of Mr Clay's death. Acting Senior Sergeant Lamond conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

20. This finding draws on the totality of the coronial investigation into the death of John Robert Clay 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.[7]

[7] 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.

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

Circumstances in which the death occurred

Mr Clay's declining health

21. In the 12-month period leading to his death, Mr Clay's health deteriorated significantly. According to his Doctor (GP), Dr Chin Ho, Mr Clay suffered from multiple bowel issues, including severe constipation and impacted faeces. During this time, Mr Clay's GP administered treatment for symptomatic relief of his conditions which included manual evacuation of bowels.[8]

22. Collateral information provided to Western Hospital from one of Mr Clay's carers of six years, Kate, suggested that Mr Clay had no quality of life, had been wheelchair bound for the past four years, was incontinent and had a noticeable recent functional decline and weight loss.[9]

23. On 20 September 2019 Mr Clay presented with a distended stomach and attended Royal Melbourne Hospital. He was discharged a few hours later with an increase in laxative medication. His care team continued to monitor his bowel movements as per his constipation/bowel management plans developed by Dr Ho in consultation with a continence nurse.

24. On 27 June 2020 he attended the emergency department at Western Hospital[10], presenting with bilateral swollen feet. Blood test results were consistent with severe iron deficiency anaemia. Taking into account Mr Clay's agitated state, doctors determined the best course of action would be to discharge Mr Clay to the familiar environment of his supported accommodation, and to arrange for an iron transfusion as an outpatient day procedure.[11] Dr Ho prepared an iron deficiency anaemia support plan (signed on 7 July 2020) which indicated that the anaemia was caused by a chronic condition and was not for treatment, due to concerns about the impact treatment would have on Mr Clay's quality of life.[12]

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[8] CB, statement of general practitioner Dr Chin Kum Ho.
[9] Ibid.
[10] Western Hospital is now named Footscray Hospital, and is part of Western Health.
[11] Court File, E-Medical Deposition Form, Western Health.
[12] CB, statement of Kylie Waterman.

Admission to Western Hospital on 29 July 2020

25. On 29 July 2020, Mr Clay's Scope carers observed him to be sweating and with a temperature. He was agitated, visibly guarding his abdomen and was reported to have not had a bowel movement for four days. He was taken to Western Hospital and on assessment, surgical registrar Dr Susan Wang identified a large pneumoperitoneum and extensive faecal loading. Dr Wang advised Mr Clay's carers that he had a perforated bowel and opined that without surgical intervention, Mr Clay's condition was life threatening.

26. The decision was taken to contact Douglas in Canada to inform him of his brother's prognosis. Douglas was informed further that even if Mr Clay were to undergo surgery to repair his perforated bowel, the prospects of a full recovery, given the compromised state of his health, was unlikely and would not improve the quality of his life.[13]

27. The decision was taken to palliate Mr Clay where hospital staff provided symptomatic relief to manage his discomfort. At 3:02pm on 29 July 2020, Mr Clay passed away.

Identity of the deceased

28. On 4 August 2022 at the Victorian Institute of Forensic Medicine, John Robert Clay, born 24 February 1952, was visually identified by Kylie Waterman, Operations Manager of Scope.

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

Medical cause of death

30. Forensic Pathologist, Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 5 August 2020. In addition, she considered the available materials including the Victoria Police Report of Death Form 83, e-Medical Deposition, post-mortem computer tomography (CT) scan and the Coronial Admissions and Enquiries contact log. Dr Archer provided a written report of her findings dated 30 August 2020.

[13] Court File, E-Medical Deposition Form, Western Health.

31. The post-mortem examinations showed cerebral atrophy. Further, it revealed a large pneumoperitoneum[14] with a faecalith at the splenic flexure and rectal faecal loading. Bilateral pleural effusions[15] were also present.

32. Dr Archer's observations were confirmed by the VIFM Forensic Radiologist, Dr Chris O'Donnell.

33. The examination showed fixed flexures of the elbows and knees, in keeping with the available evidence that Mr Clay was wheelchair bound.

34. There was no evidence of any injury that could have caused or contributed to Mr Clay's death.

35. Toxicological analysis was not undertaken.

36. Dr Archer provided an opinion that the medical cause of death was 1 (a) stercoral perforation in a man with cerebral palsy.

37. Having carefully considered the evidence in this matter, I am satisfied the weight of the available evidence supports the conclusion reached by Dr Archer that Mr Clay's death was due to natural causes, and as such, an inquest was not required to be held.

DSC INVESTIGATION

38. On 14 October 2020 the Disability Services Commissioner **(DSC)** advised that they were investigating Mr Clay's death.

39. In pursuing their own investigation, the DSC requested that Home@Scope[16] undertake a review of the services provided to Mr Clay which the DSC then assessed as reasonable and appropriate in the circumstances. The DSC did not identify any issues with the services which Home@Scope provided to Mr Clay and, according to the DSC, Home@Scope's services were 'provided in a manner that sufficiently promoted [Mr Clay's] rights, dignity, wellbeing and safety'.[17] Consequently, the DSC determined that no further action on their part would be required in investigating Mr Clay's death any further.

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[14] Pneumoperitoneum is the presence of air or other gas in the abdominal cavity, most often caused by gastrointestinal perforation.

[15] Pleural effusion is an abnormal build-up of fluid in the cavity surrounding the lungs.

[16] Home@Scope is a subsidiary of Scope, an NDIS registered provider of disability services. Home@Scope provides disability support services within accommodation, both short-term and supported independent living.

[17] Letter from Treasure Jennings, Disability Services Commissioner to State Coroner His Honour Judge John Cain, dated 24 January 2023.

40. On 12 October 2022, the DSC advised the Court that, following their review of Mr Clay's death, any adverse findings against any carer or entity would not be likely.[18]

41. On 24 January 2023, the DSC confirmed that their investigation was now complete and further that no adverse findings had been made.[19]

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was John Robert Clay, born 24 February 1952;

    b) the death occurred on 29 July 2020 at Western Health, Footscray Hospital, 160 Gordon Street, Footscray, Victoria, 3011.

    c) I accept and adopt from medical cause of death as ascribed by Dr Archer and I find that John Robert Clay died from STERCORAL PERFORATION IN A MAN WITH CEREBRAL PALSY; and

    d) The weight of the available evidence does not support a conclusion that there was a causal nexus or relationship between the fact that John Robert Clay was 'in care' at the time of his death and the medical cause of his death and, on the evidence available to me, I am unable to find that the care that John Robert Clay received at the time of his death contributed to or is connected with the medical cause of his death.

    e) AND FURTHER, having considered all the evidence, the weight of the available evidence supports a conclusion that the medical care John Robert Clay received at the time of his death was reasonable and appropriate in the circumstances and I find that John Robert Clay died from natural causes.

I convey my sincere condolences to Mr Clay's family 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.

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[18] Email from Suzanne Priestly, Senior Review Officer, Disability Services Commissioner to the Court dated 12 October 2022.

Letter from Treasure Jennings, Disability Services Commissioner to State Coroner His Honour Judge John Cain, dated 24 January 2023.

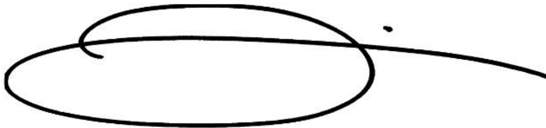
I direct that a copy of this finding be provided to the following:

Douglas Clay, Senior Next of Kin

Acting Senior Sergeant Jennifer Lamond, Coroner's Investigator

Disability Services Commissioner

Signature:



AUDREY JAMIESON

CORONER

Date: 22 February 2023

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.