IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 006194

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	James Owen Lynch
Date of birth:	10 May 1949
Date of death:	13 November 2020
Cause of death:	1(a) Aspiration pneumonia in a man with an intellectual disability
Place of death:	Northeast Health, Wangaratta Hospital, 35-47 Green Street, Wangaratta, Victoria, 3676

INTRODUCTION

1. On 13 November 2020, James Owen Lynch was 71 years old when he died at Wangaratta Hospital. At the time of his death, James lived at 4 Dunlop Drive, Wangaratta (**Dunlop**), a supported residential service where he had been living for the past eight years.

2. James' medical history included an intellectual disability, chronic obstructive airway disease, previous episodes of aspiration pneumonia due to dysphagia, hypercholesteremia, reflux, asthma, balance issues, falls with previous rib fractures and bilateral total hip replacements, benign prostatic hypertrophy, paraumbilical hernia and hiatus hernia.

3. James had frequent episodes of aspiration despite staff monitoring his food intake, as well as speech pathology assessments which recommended a modified diet to lower his risk of aspiration. Whilst most episodes of aspiration were self-limiting, several developed into pneumonia with a history of being admitted to hospital once to twice a year.

4. In January 2020, Dunlop staff noticed that James was more tired and recovering slower after his last major episode of pneumonia. James' general practitioner (**GP**) gave staff clear instructions regarding any deterioration in his breathing and when to call for medical assistance.

5. James was referred to palliative care by his GP however in May 2020 his mood and energy levels improved markedly following resolution of a suspected tooth abscess, a level that remained steady for the next six months.

THE CORONIAL INVESTIGATION

6. James'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.

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.

8. 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.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of James's death. The Coroner's Investigator 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.

10. This finding draws on the totality of the coronial investigation into the death of James Owen Lynch 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.[1]

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

Identity of the deceased

11. On 13 November 2020, James Owen Lynch, born 10 May 1949, was visually identified by his support worker, Deborah Kowald.

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

Medical cause of death

13. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 16 November 2020 and provided a written report of his findings dated 20 November 2020, based on medical notes from Dr Fiona Clements and from North East Health Wangaratta, Victoria Police reports, and post-mortem computed tomography scans conducted at VIFM (**PMCT**).

14. The post-mortem examination showed a marked inflammatory response with lactatemia and metabolic acidosis. PMCT revealed widespread anoxic brain injury and increased bilateral

[1] 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.

basal interstitial lung markings, consistent with aspiration pneumonia[2]. Scans also revealed coronary artery calcification, dilated bowel loops and an elevated left hemidiaphragm. Rib fractures were also noted however these were most likely the result of cardiopulmonary resuscitation (**CPR**).

15. Toxicological analysis of post-mortem samples identified the presence of diazepam and nordiazepam (anxiolytics), midazolam (a sedative, commonly used in medical procedures such as intubation) and chlorpromazine (an anti-psychotic) in therapeutic quantities.

16. Dr Young provided an opinion that the medical cause of death was 1(a) aspiration pneumonia. Based on this, Dr Young concluded that Mr Lynch's death was due to natural causes.

17. I accept Dr Young's opinion.

Circumstances in which the death occurred

18. On 12 November 2020, James' GP prescribed amoxicillin (an antibiotic) in the setting of a fever and left gynaecomastia with tenderness.

19. At approximately 6:30am on 13 November 2020, James was found by staff collapsed in his lounge room. He was unresponsive, and an ambulance was called.

20. CPR was commenced upon arrival of paramedics and return to spontaneous circulation was achieved. James was intubated and transported to Wangaratta Hospital where he required inotropic support.[3]

21. Upon arrival, James had dilated pupils and evidence of a widespread anoxic brain injury.[4] There was also evidence of aspiration pneumonia, which was found to be the likely cause of James' cardiac arrest.

[2] Aspiration occurs when there is inhalation of food, vomit, or other gastric contents into the lungs, usually due to difficulty swallowing (dysphagia). This may lead to infection (pneumonia), respiratory compromise, and death. Individuals with intellectual disabilities are at an increased risk of aspiration.

[3] Inotropic support is the use of catecholamine drugs (including adrenaline, noradrenaline, dopamine and dobutamine) to stabilise blood pressure and cardiac output as well as optimising oxygen supply to a critically-unwell patient (P J Kulka and M Tryba, 'Inotropic support of the critically unwell patient. A review of the agents' (1993) 45(5) *Drugs* 657-667).

[4] Dilated pupils and an anoxic brain injury result from complete cessation of blood flow to the brain following, amongst other things, a cardiac arrest. Outcomes from this type of injury depend on the severity of the injury, but are often poor (Headway, 'Hypoxic and anoxic brain injury' (2021) (https://www.headway.org.uk/about-brain-injury/individuals/types-of-brain-injury/hypoxic-and-anoxic-brain-injury/).

22. James was admitted to the Critical Care Unit however he passed away at 11:21am on 13 November 2020.

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 James Owen Lynch, born 10 May 1949;

    b) the death occurred on 13 November 2020 at Northeast Health, Wangaratta Hospital, 35-47 Green Street, Wangaratta, Victoria, 3676, from aspiration pneumonia in a man with an intellectual disability; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to James'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.

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

Lorraine Porter, Senior Next of Kin

First Constable Jordan Condron, Victoria Police, Coroner's Investigator

Northeast Health

Signature:

Coroner John Olle

Date : 30 September 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.