IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 0231

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Stanley Stewart
Date of birth:	29 April 1929
Date of death:	11 January 2021
Cause of death:	1(a) Cholangiocarcinoma
Place of death:	Northern Hospital, 185 Cooper Street, Epping, Victoria

INTRODUCTION

1. On 11 January 2021, Stanley Stewart was 91 years old when he died at the Northern Hospital in Epping. At the time, Mr Stewart lived at a disability group home at 25 Westward Ho Drive, Sunbury, which is managed by Possability Victoria (**the group home**).

2. Mr Stewart resided in the group home since it first opened in 1992. Prior to that, he resided at another supported independent living accommodation. According to the group home manager, Jacqueline McSparron, Mr Stewart was fully ambulant, was able to eat and drink independently, decide what to wear and was able to make his needs known to staff. However, he required support with relation to medical and financial matters.

3. Mr Stewart's medical history included mild intellectual disability, schizophrenia, type II diabetes, dyslipidaemia, asthma, recurrent urinary tract infections (**UTIs**), liver cholangiocarcinoma, inguinal hernia, and benign prostatic hyperplasia (**BPH**).

THE CORONIAL INVESTIGATION

4. Mr Stewart's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Generally, reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.[1]

5. 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.

6. 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.

[1] See the definition of "reportable death" in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of "person placed in custody or care" in section 3 of the Act.

7. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Stewart'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.

8. This finding draws on the totality of the coronial investigation into Mr Stewart's death, 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.[2]

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

Identity of the deceased

9. On 19 January 2021, Stanley Stewart, born 29 April 1929, was visually identified by Jacqueline McSparron, the manager of the group home where he resided who signed a formal Statement of Identification to this effect.

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

Medical cause of death

11. Forensic Pathologist, Dr Paul Bedford, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 13 January 2021 and provided a written report of his findings dated 21 January 2021.

12. The post-mortem CT scan revealed a biliary stent, fluid around the liver, a calcified liver nodule and bilateral pleural effusions (water on the lungs).

13. Dr Bedford provided an opinion that the medical cause of Mr Stewart's death was *"1(a) Cholangiocarcinoma"* and that his death was from natural causes.

14. I accept Dr Bedford's opinion.

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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.

Circumstances in which the death occurred

15. Mr Stewart was diagnosed with liver cholangiocarcinoma on 9 September 2019. Due to his age and other medical conditions, a decision was made to provide palliative treatment only. Ongoing support and care were provided by his general practitioner as well as the Melbourne City Mission (**MCM**) palliative care team.

16. Mr Stewart was assessed as an oncology outpatient by Northern Health on 1 December 2019. An overall deterioration in condition was noted, including significant weight loss, and this was consistent with his advanced cancer diagnosis.

17. In October 2020, staff at the group home noticed a more significant change in Mr Stewart's health. He experienced a loss of appetite, deceasing weight, fatigue and presented with a jaundiced appearance. The MCM palliative care team provided greater support from that point onwards, in conjunction with the care home and his general practitioner.

18. Mr Stewart was treated by Dr Sobia Tahir from 2 June 2014 until the time of his passing. Dr Tahir or one of her associates saw Mr Stewart approximately once a week in the 12 months prior to his passing. These consultations occurred either in person at the group home or via phone, due to the COVID-19 pandemic. Mr Stewart last saw Dr Tahir in person on 30 December 2020 and had a phone consultation with her on 5 January 2021.

19. Ms McSparron stated that Mr Stewart's case notes indicated his health had declined in the month preceding his death. On 12 December 2020, he slid out of his recliner chair and onto the floor. On 13 December 2020, Mr Stewart was found to have fallen to the floor at the entry to the bathroom. At the time, he stated he lost his footing and landed on his bottom. He sustained some red marks on his right buttock and right wrist, as well as a small abrasion to his wrist and was prescribed Norspan (buprenorphine) patches for pain management

20. As a result of these falls, staff at the group home created a specific health management plan, which was endorsed by Dr Tahir. An urgent referral was made to an occupational therapist to assess Mr Stewart's changing needs.

21. On 5 January 2021, staff found that Mr Stewart had slid out of his bed again and onto the floor, without sustaining any injuries. He was supported to return to his bed and Dr Tahir was contacted. She had a phone consultation with staff and Mr Stewart. Staff were advised to monitor for dizziness or disorientation and to call for an ambulance if any sudden deterioration

was noted. The MCM palliative care team were booked to attend the group home on 11 January 2021.

22. On the morning of 11 January 2021, support workers entered Mr Stewart's room to offer shower support and found him in bed unwell. He was very pale in appearance, his breathing appeared rapid and short, skin felt clammy to touch and he had difficulty speaking. He was assisted to sit up due to vomiting that followed.

23. Support workers called 000 at approximately 8.45am and comforted Mr Stewart while they were waiting for the ambulance to arrive. Mr Stewart was asked if he was in any pain, and he touched his abdomen in response.

24. In consultation with attending paramedics and the MCM palliative care team, it was decided that Mr Stewart would be transported to hospital. He left the group home at approximately 9.50am for the Northern Hospital in Epping. Mr Stewart's next of kin and niece, Wendy Davies, was contacted and was provided with an update.

25. Mr Stewart was initially treated at the Northern Hospital emergency department, before being transferred to the Northern Hospital Palliative Care unit at about 5.00pm that day. At approximately 9.30pm, the group home was contacted by The Northern Hospital Palliative Care Unit and advised that Mr Stewart's condition was deteriorating, and that he was not expected to survive the night. Mr Stewart passed away at 11.05pm and group home staff were notified at 11.23pm.

REVIEW BY THE DISABILITY SERVICES COMMISSIONER

26. On 13 January 2021, the Disability Services Commissioner (**DSC**) commenced an investigation pursuant to section 128I of the *Disability Act 2006* into the disability services provided by Possability to Mr Stewart.

27. The DSC finalised their investigations and made no adverse findings. In a letter dated 24 May 2021, the DSC advised the Coroners Court that Possability conducted their own review into the disability services provided to Mr Stewart at the time of his passing. This review found minor issues with medication records, which did not contribute to Mr Stewart's death. The DSC identified that no further action was required with regard to Mr Stewart's case.

FINDINGS AND CONCLUSION

28. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was Stanley Stewart, born 29 April 1929;

    (b) the death occurred on 11 January 2021 at Northern Hospital, 185 Cooper Street, Epping, Victoria;

    (c) the cause of Mr Stewart's death was natural causes, namely cholangiocarcinoma; and

    (d) the death occurred in the circumstances described above.

I convey my sincere condolences to Mr Stewart'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:

Wendy Davies, senior next of kin
Treasure Jennings, Disability Services Commissioner
The Proper Officer, State Trustees, Victoria
Senior Constable Peter Gallagher, Victoria Police, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos
Date: 05 October 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.