IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 005288

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Jacqui Hawkins, Deputy State Coroner
Deceased:	Paul Henry Green
Date of birth:	1 December 1937
Date of death:	5 October 2021
Cause of death:	1(a) Unascertained (natural causes)
Place of death:	51 Armadale Street, Thornbury, Victoria, 3071
Keywords:	NDIS; RESIDENTIAL CARE; INTELLECTUAL DISABILITITY; ARTHRITIS; DIALYSIS; NATURAL CAUSES

INTRODUCTION

1. Paul Henry Green was 83 years old when he was found deceased on 5 October 2021.

2. In about 1995, Mr Green went into a residential care home run by Scope Australia. He resided there up until his death. Scope Australia is now classified under the National Disability Insurance Scheme (**NDIS**).

3. Mr Green has been described as a kind soul who was passionate about the Collingwood Football Club. He was diagnosed at birth with an intellectual disability. Mr Green suffered hearing and sight disabilities, asthma, hypertension, paroxysmal atrial fibrillation, hypercholesterolaemia, previous parotid carcinoma, and renal failure. He had been treated with haemodialysis since 2015.

4. In the years prior to his death, Mr Green's eyesight deteriorated which affected his mobility and balance. He required constant support in the community for the last two years of his life. Home at Scope care workers advised they would submit incident reports and seek medical attention for him following any incidents.

THE CORONIAL INVESTIGATION

5. Mr Green'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.

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. Victoria Police assigned First Constable Matthew Wickstead to be the Coroner's Investigator for the investigation of Mr Green'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.

9. This finding draws on the totality of the coronial investigation into the death of Mr Green 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]

IDENTITY OF THE DECEASED

10. On 5 October 2021, Paul Henry Green, born 1 December 1937, was visually identified by his brother, Peter Green, who signed a formal statement of identification to this effect.

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

MEDICAL CAUSE OF DEATH

12. On 6 October 2021, Dr Heinrich Bouwer, Forensic Pathologist from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination. Dr Bouwer reviewed the medical records, post-mortem computed tomography (**CT**) scan, and Victorian Police Report of Death Form 83 and provided a written report of his findings.

13. The post-mortem CT scan showed an incidental colloid cyst of the third ventricle with no evidence of acute obstructive hydrocephalus, contracted cystic kidneys, probable cardiomegaly with coronary artery calcification, minor lung changes and buckle anterior rib fractures (due to CPR).

14. Although Mr Green received the second dose of the AstraZeneca COVID-19 vaccine approximately three weeks earlier, there was no evidence to suggest an acute complication of the vaccination and there were no reported problems following the administration of the vaccine. Dr Bouwer considered it very unlikely that Mr Green died from any complications relating to vaccine administration.

15. The external examination was consistent with the reported circumstances.

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[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.

16. Routine toxicological analysis detected Metoprolol, an anti-hypertensive medication.

17. Dr Bouwer was of the opinion that Mr Green's death was due to natural causes.

18. In the absence of a full post-mortem examination, and on the basis of the information available, Dr Bouwer concluded that the medical cause of death was 1 (a) Unascertained (natural causes).

19. I accept Dr Bouwer's opinion.

Circumstances in which the death occurred

20. In the week prior to his death, Mr Green was required to isolate in his room as he had been in contact with a person who had COVID-19.

21. On 4 October 2021, Mr Green was observed to act as he normally would. At about 8:00pm he was provided his medication and was seen to be chatty and well. Mr Green discussed his future and an upcoming holiday. He mentioned some pain in his hands and his calf. His care worker stated she did not consider this unusual as he suffered from arthritis.

22. The next day, a care worker went to wake Mr Green for breakfast at 7:00am. He was found unresponsive in bed. His lips were blue, and he felt cold. The care worker contacted emergency services and began CPR.

23. Ambulance Victoria and Victoria Police attended and provided assistance, however Mr Green was confirmed to be deceased at 7:45am.

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 Paul Henry Green, born 1 December 1937;

    b) the death occurred on 05 October 2021 at 51 Armadale Street, Thornbury, Victoria, 3071, from unascertained (natural causes); and

    c) the death occurred in the circumstances described above.

25. I convey my sincere condolences to Mr Green's family for their loss.

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

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

    Peter Green, Senior Next of Kin

    Robyn Shea, Austin Health

    First Constable Matthew Wickstead, Coroner's Investigator

Signature:

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Jacqui Hawkins, Deputy State Coroner

Date : 19 October 2022