IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006558

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Brian Roy Gallagher
Date of birth:	13 January 1949
Date of death:	6 December 2021
Cause of death:	1(a) Coronary artery atherosclerosis
Place of death:	1 Olivers Road, Benalla, Victoria, 3672
Keywords:	Death in Care; Natural Causes

INTRODUCTION

1. On 6 December 2021, Brian Roy Gallagher (Mr Gallagher) was 72 years old when he died of natural causes.

2. At the time of his death, Brian lived in disability support accommodation at 1 Olivers Road Benalla, operated by National Disability Insurance Scheme service provider Home@Scope.

3. Mr Gallagher is fondly remembered by his long-time disability support workers "*as an absolute character*"[1] and by his brother, John Gallagher, as someone who loved the water and swimming.

THE CORONIAL INVESTIGATION

4. Mr Gallagher's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Mr Gallagher's death was reportable as he was in care immediately before the time of his death.[2] Deaths of persons in care are reportable to ensure independent scrutiny of the circumstances surrounding their deaths. If such deaths occur as a result of natural causes, a coronial investigation must take place, but the holding of an inquest is not mandatory.

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. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Brian'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.

7. This finding draws on the totality of the coronial investigation into the death of Brian Roy Gallagher 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

[1] Coronial Brief [CB], Statement of Julie Quinlan pg 17.
[2] Section 4(2)(c) Coroners Act 2008.

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

BACKGROUND

8. Mr Gallagher was born with a cerebral palsy and related intellectual disability. As a child, Mr Gallagher was well cared for by his parents, in particular his mother. According to his brother, John Gallagher, Mr Gallagher was completely dependent on his mother for all his care needs.[4] Mr Gallagher was non-verbal and was unable to self-ambulate.

9. Although Mr Gallagher was non-verbal, John Gallagher reported his brother was able to recognise faces and would "*light up*" whenever he visited.

10. Sadly, when Mr Gallagher was about 25 years old, his mother suffered a stroke and not long after was unable to care for him. When Mr Gallagher was around 26 or 27 he was admitted to the Sunbury Mental Home. According to John Gallagher, after several years in Sunbury his brother moved to Stawell and in 1996, Mr Gallagher settled into disability support care in the Benalla region. Mr Gallagher required 24-hour care throughout his time at Benalla. John Gallagher stated Benalla was "amazing" for his brother and he would go on trips around Victoria which made him very happy.

11. Mr Gallagher was treated on a regular basis by General Practitioner Dr John Lambert (Dr Lambert) of the Benalla Church Street Surgery clinic. According to Dr Lambert, for the 18 months prior to his death Mr Gallagher's quality of life began gradually deteriorating. Dr Lambert noted Mr Gallagher became more agitated and less interested in activities. Mr Gallagher was commenced on sertraline for depression, prednisolone for possible polymyalgia, and cabimazole for subclinical hyperthyroidism.

12. Mr Gallagher's medical conditions at the time of his death included subclinical hyperthyroidism, iron deficiency, moderate osteoporosis, polymyalgia rheumatica, hypertension and reflux disease. These conditions were treated with a range of medications prescribed by Dr Lambert.

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[3] 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.

[4] CB, Statement of John Gallagher pg 22.

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

Circumstances in which the death occurred

13. Between 2 and 5 December 2021, Mr Gallagher attended a supported holiday with Club Mates Travel. Following his holiday, Mr Gallagher was collected from the Southern Cross Station by Home@Scope staff who noted Mr Gallagher "*appeared very tired and was having trouble weight bearing/ transferring into the car*."[5]

14. Staff from Club Mates Travel reported that Mr Gallagher had a great time on the holiday.[6]

15. At approximately 9.00am on 6 December 2021, Mr Gallagher was conveyed to Yooralla for day service programs. Yooralla Disability Support Worker Kerryn Smith (Ms Smith) stated Mr Gallagher started the morning in the exercise program, however, largely did not participate which was not unusual for him given his physical limitations. According to Ms Smith, Mr Gallagher was quiet in the morning and become more vocal at lunchtime which again was not out of the ordinary.

16. At approximately 3.00pm, Julie Quinlan (Ms Quinlan) attended Yooralla to collect Mr Gallagher. As Ms Quinlan arrived, she observed Mr Gallagher lying on his back and Yooralla staff advised her that he had vomited. Ms Quinlan, with the assistance of Yooralla staff, repositioned Mr Gallagher on his side and she observed he appeared "*exhausted and unwell*."[7] Yooralla staff placed Mr Gallagher in a wheelchair as Ms Quinlan transported other residents back to Home@Scope.

17. Ms Quinlan returned approximately 15 minutes later. Mr Gallagher was now in a wheelchair and Ms Quinlan noted he was slumped but conscious and alert. Mr Gallagher was transported into the minibus and on the short trip back he vomited again.

18. On arrival back to Home@Scope Mr Gallagher "*appeared pale in colour and not fully responsive*."[8] Emergency services were contacted. Mr Gallagher was rapidly deteriorating.

19. Ms Quinlan checked Mr Gallagher for a pulse but was unable to locate one. He was placed on the floor and Home@Scope staff commenced cardiopulmonary resuscitation (CPR). Ambulance Victoria Paramedics arrived and continued CPR. Sadly, and despite all efforts,

[5] CB, Statement of Andrea Skelton pg 13.
[6] As above.
[7] CB, Statement of Julie Quinlan pg 17.
[8] CB, Statement of Andrea Skelton pg 13

Mr Gallagher was unable to be revived and was formally pronounced deceased at 4.07pm on 6 December 2021.

Identity of the deceased

20. On 6 December 2021, Brian Roy Gallagher, born 13 January 1949, was visually identified by his carer, Andrea Skelton, who signed a formal Statement of Identification.

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

Medical cause of death

22. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy upon the body of Mr Gallagher on 10 December 2021 and provided a written report of her findings dated 8 April 2021.

23. The autopsy showed severe atherosclerosis of two coronary arteries (left anterior descending coronary artery and the left circumflex coronary artery), fatty liver, and single horseshoe kidney with benign nephrosclerosis (commonly associated with hypertension).

24. With respect to the coronary artery atherosclerosis, Dr Ho provided the following comments:

    i. Coronary artery atherosclerosis occurs when there is a build-up of cholesterol and other material in the blood vessels that supply oxygen and other nutrients to the heart. This accumulation of material narrows the vessels and when this occurs, the amount of oxygen supplied to the heart is compromised and the ability of the heart to supply the body with oxygenated blood. This causes a condition known as ischaemia which predisposes to the development of cardiac arrhythmias and sudden death.

25. Toxicological analysis of post-mortem samples identified the presence of Sertraline[9] (~ 0.4 mg/L) and trace amounts of paracetamol. No alcohol or any other commons drugs or poisons were detected.

26. Dr Ho provided an opinion that the medical cause of death was 1 (a) Coronary artery atherosclerosis. Dr Ho considered that Mr Gallagher's death was due to natural causes

27. I accept Dr Ho's opinion.

[9] Sertraline is an anti-depressant drug for use in cases of major depression.

FINDINGS AND CONCLUSION

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

    i. the identity of the deceased was Brian Roy Gallagher, born 13 January 1949;

    ii. the death occurred on 06 December 2021 at 1 Olivers Road, Benalla, Victoria, 3672, from Coronary artery atherosclerosis; and

    iii. the death occurred in the circumstances described above.

29. As noted above, Mr Gallagher's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before his death, he was a person in care. Section 52 of the Act requires an inquest to be held, except in circumstances where the death was due to natural causes. I am satisfied that Mr Gallagher died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an inquest into his death.

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:

National Disability Insurance Scheme

Sergeant Melanie Walker, Coroner's Investigator

Signature:

Coroner Kate Despot

Date : 25 June 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.