IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2022 001527

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Andrew John Martin
Date of birth:	25 February 1965
Date of death:	21 March 2022
Cause of death:	1(a) Aspiration pneumonia complicating large bowel volvulus in a man with chronic dysphagia and cerebral palsy
Place of death:	Wantirna Health Palliative Care Unit, 251 Mountain Highway, Wantirna, Victoria
Key words:	In care, disability, cerebral palsy, large bowel volvulus, dysphagia, aspiration pneumonia, palliative care

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INTRODUCTION

1. On 21 March 2022, Andrew John Martin was 57 years old when he passed away in hospital. At the time, Mr Martin lived in Box Hill in disability support accommodation managed by Life Without Barriers. He was known to family and friends as 'Dewey'.

2. When he was a young child, doctors told Mr Martin's mother, Patricia Martin, that her son had severe brain damage and was not expected to walk or talk. There was a suggestion that he had not received enough oxygen at birth. Mr Martin thereafter transitioned into formal out of home care where his mother visited him regularly.

3. Mr Martin's medical history included cerebral palsy, epilepsy, and chronic dysphagia.

4. Mrs Martin stated that her son's quality of life had deteriorated in the years leading to his death and she had signed a directive care plan indicating that he should be made as comfortable as possible if any medical issues arose.

THE CORONIAL INVESTIGATION

5. Mr Martin'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. 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]

6. While Mr Martin's death was reported to the Coroner, I note with concern that, as funding for disability services shifted from the Department of Families, Fairness and Housing (**DFFH**) to the National Disability Insurance Scheme (**NDIS**), the definition of a person placed in custody or care in section 3(1) of the Act to include 'a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health' no longer adequately captured the group of vulnerable people in receipt of disability services as envisaged by the legislation when it was passed. Where the deaths of those people are from natural causes and not otherwise reportable, then, although this cohort is as vulnerable as ever,

[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.

their deaths and the circumstances in which they died – including the quality of their care – would not be subjected to coronial scrutiny.[2] [3] [4]

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. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Martin'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 Mr Martin'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.[5]

[2] On 11 October 2022, this lacuna in the legislation was rectified when amendments to the Coroners Regulations 2019 came into effect. Sub-regulation 7(1)(d) provides that a 'person placed in custody or care' now includes *"a person in Victoria who is an SDA resident residing in an SDA enrolled dwelling".* Mr Martin would now likely meet the new definition of person placed in custody or care.

[3] 'SDA resident' has the same meaning as in the *Residential Tenancies Act 1997* (Vic) and captures a person who is an SDA recipient (that is, an NDIS participant who is funded to reside in an SDA enrolled dwelling).

[4] 'SDA enrolled dwelling' also has the same meaning as in the *Residential Tenancies Act 1997* and is defined as a: *"long term accommodation for one or more SDA resident and enrolled as an SDA dwelling under the National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016 of the Commonwealth as in force from time to time or under other rules made under the National Disability Insurance Scheme Act 2013 of the Commonwealth."*

[5] 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

Identity of the deceased

11. On 21 March 2022, Andrew John Martin, born 25 February 1965, was visually identified by mother, Trisha Martin, who signed a formal Statement of Identification to this effect.

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 inspection on 23 March 2022 and provided a written report of his findings dated 25 March 2022.

14. The post-mortem examination revealed a distended tense abdomen, but no unexpected signs of trauma. A post-mortem computed tomography (**CT**) scan of the whole body undertaken at VIFM confirmed dilated bowel loops without any evidence of perforation; increased markings in the lungs; fatty changes in the liver; kyphoscoliosis of the spine; and no intracranial haemorrhage.

15. Dr Young explained that aspiration pneumonia is an infection of the lungs that occurs after inhaling (aspirating) foreign material, commonly food or vomitus. People with large bowel volvulus (twisting of the large bowel leading to bowel obstruction) are at increased risk of aspiration due to pressure on the thoracic organs from abdominal distension. Chronic dysphagia (difficulty swallowing) and cerebral palsy may also carry an added risk of aspiration.

16. Dr Young provided an opinion that the medical cause of Mr Martin's death was from natural causes, namely *"1(a) Aspiration pneumonia complicating large bowel volvulus in a man with chronic dysphagia and cerebral palsy"*.

17. I accept Dr Young's opinion.

Circumstances in which the death occurred

18. On 15 March 2022, Mr Martin was admitted to Box Hill Hospital with vomiting, reduced oral intake, and a change in behaviour. Abdominal x-rays demonstrated large, dilated loops of colon and a diagnosis of volvulus (an obstruction due to twisting or knotting of the gastrointestinal tract) was made. A subsequent CT scan confirmed a large bowel volvulus.

19. It was determined that Mr Martin was not an appropriate surgical candidate given his premorbid baseline. With Mrs Martin's agreement, a conservative management plan of treatment was initiated with nasogastric tube insertion and fleet enemas, consistent with Mr Martin's Advance Care Directives.

20. On the 17 March 2022, Mr Martin opened his bowels and had reduced distension of the abdomen, which were signs that the volvulus had resolved. The surgical team sought the support of the hospital palliative care services in transitioning Mr Martin back to his care facility. As it was considered that Mr Martin would be at high risk of the volvulus recurring, it was determined that if the volvulus was to recur, Mr Martin was not for transfer back to the hospital and was to receive end of life care at home.

21. However, Mr Martin's carers at the disability support service raised concerns that he was still not tolerating his oral intake and as such they were not willing to accept him back to the facility.

22. On 18 March 2022, a speech pathology review was undertaken. Mr Martin was noted to have premorbid chronic dysphagia requiring a modified food and fluids diet. However, his swallow had been further impaired as a result of his current illness. It was agreed that Mr Martin would be admitted to Wantirna Hospital for a period of observation before returning home.

23. Staff discussed the role of comfort feeding (at risk feeding) for quality of life (versus nil by mouth) with Mr Martin's mother. It was considered that if Mr Martin deteriorated at Wantirna Health, the focus of the management would be on symptom control only. Mrs Martin indicated her wishes that Mr Martin to be kept comfortable if he deteriorated any further.

24. Mr Martin was transferred to the Palliative Care Unit at Wantirna Health that day.

25. On 20 March 2022, Mr Martin's condition deteriorated with symptoms and signs consistent with a respiratory illness. He was diagnosed with an aspiration pneumonia. In line with previous discussions, Mr Martin was not started on antibiotics and was provided with symptom based care only.

26. Mrs Martin visited her son on 21 March 2022. When she returned home from her visit, hospital staff telephoned her to say that Mr Martin did not have long to live. By the time she returned, her son had passed away.

FINDINGS AND CONCLUSION

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

(a) the identity of the deceased was Andrew John Martin, born 25 February 1965;

(b) the death occurred on 21 March 2022 at Wantirna Health Palliative Care Unit, 251 Mountain Highway, Wantirna, Victoria;

(c) the cause of Mr Martin's death was aspiration pneumonia complicating large bowel volvulus in a man with chronic dysphagia and cerebral palsy;

(d) the death occurred in the circumstances described above; and

(e) the available evidence does not support a finding that there was any want of clinical management or care on the part of the staff of Wantirna Health or Life Without Barriers that caused or contributed to Mr Martin's death.

I convey my sincere condolences to Mr Martin'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:

Patricia Martin, senior next of kin
Life Without Barriers
Eastern Health
Senior Constable Sean Rickard, Victoria Police, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date: 09 January 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.