IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 003307

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Antony John Howard
Date of birth:	27 September 1962
Date of death:	18 June 2022
Cause of death:	1(a) Aspiration pneumonia and non-ST elevation myocardial infarction in a man with intellectual disability 2 COVID-19
Place of death:	Austin Hospital 145 Studley Road, Heidelberg, Victoria, 3084
Keywords:	Austin Hospital, Palmyra Care Facility, National Disability Insurance Scheme, COVID-19, NSTEMI, aspiration pneumonia.

INTRODUCTION

1. On 18 June 2022, Antony John Howard was 59 years old when he died at the Austin Hospital (**Austin**) in Heidelberg. At the time of his death, Antony lived at 6 Palmyra Court, Greensborough, at the Palmyra Care Facility (**Palmyra**), a specialist residential service.

2. Antony's medical history included an intellectual disability, autism, and a visual impairment secondary to glaucoma.[1] Antony was supported in his daily activities by carers from "Life Without Barriers" through National Disability Insurance Scheme funding.[2]

3. As a child, Antony attended a special needs school in Ormond and was initially placed in Janefield care facility in Bundoora before moving to Palmyra following Janefield's closure in 1996. According to his father, Peter Howard, despite his disability, Antony led a "relatively healthy life" until his death.[3]

THE CORONIAL INVESTIGATION

4. Antony'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.

5. 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. Whilst a coroner must normally hold an inquest following the death of a person placed in custody or care,[4] an inquest is not mandatory if the coroner finds that the death was due to natural causes.[5]

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.

[1] Coronial brief, statement of Dr Stephen Cain and Dr Chris Leung dated 5 December 2022, page 1.
[2] Coronial brief, statement of Dr Stephen Cain and Dr Chris Leung dated 5 December 2022, page 1.
[3] Coronial brief, statement of Peter Howard dated 16 November 2022, page 1.
[4] *Coroners Act 2008*, section 2(b).
[5] Ibid, section 3A.

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 an officer to be the Coroner's Investigator for the investigation of Antony'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 Antony John Howard 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.[6]

10. In considering the issues associated with this finding, I have been mindful of Antony's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

11. On 15 June 2022, Antony tested positive to COVID-19 on a Rapid Antigen Test after suffering from a cough and a fever.[7]

12. On 16 June 2022 at 5.49pm, Antony was transported to the Austin Emergency Department (**ED**) where he was found to be febrile with a temperature of 38.8 degrees, a heart rate of 150, and low blood pressure. Antony was referred to the cardiology unit after further investigations noted the presence of high troponin[8] levels.[9] A chest X-ray was unremarkable.[10]

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[6] 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.

[7] Medical Deposition dated 18 June 2022, page 1.

[8] A protein released in response to damage to heart muscle (and other muscles).

[9] Coronial brief, statement of Dr Stephen Cain and Dr Chris Leung dated 5 December 2022, page 2.

[10] Medical Deposition dated 18 June 2022, page 1.

13. On 17 June 2022, Antony was reviewed and found to have a "mild COVID illness" with a plan for admission under cardiology and further tests to take place later that morning however, at approximately 7.35am a Medical Emergency Team (**MET**) alert was made after Antony was found to have an increased heart rate, decreased oxygen saturations, and drowsiness.[11] Scans showed signs that indicated aspiration pneumonitis, however there was no pulmonary embolus noted. Antony was then commenced on intravenous antibiotics.[12]

14. At 12.11pm, Antony's condition was reviewed by Dr Stephen Cain, general medical registrar, who noted Antony appeared to be suffering from aspiration pneumonitis, COVID-19, a non-ST elevation myocardial infarction (**NSTEMI**),[13] and thrombocytopaenia[14]. Dr Cain had extensive discussions with Antony's father regarding his Goals of Care (**GoC**) who expressed a preference for full measures to be undertaken in the event of an acute deterioration.[15]

15. On 18 June 2022 at approximately 5.15am, a second MET call was made after Antony was found to have significant worsening of his oxygen saturations and blood pressure. Despite intensive therapies, Antony's condition continued to deteriorate, with staff attempting to contact his family to discuss his condition and ongoing GoC.[16]

16. Following Antony's deterioration, a meeting was held between the General Medicine and Infectious Diseases/COVID teams who noted that Antony's condition was likely a result of aspiration pneumonitis, sepsis, or an NSTEMI.

17. Clinicians discussed Antony's condition with his parents, explaining that, despite intensive treatments, his death appeared imminent. Further invasive therapies, including intubation, were not recommended due to Antony's high risk of complications and prognosis. Dr Cain stated that Antony's family "understood the medical update and likely trajectory" and accepted the use of comfort-based management.[17]

18. Antony passed away at 12.55pm.

[11] Coronial brief, statement of Dr Stephen Cain and Dr Chris Leung dated 5 December 2022, page 2.
[12] Medical Deposition dated 18 June 2022, page 2.
[13] A type of heart attack.
[14] Low platelet count, which can result in issues with bleeding.
[15] Coronial brief, statement of Dr Stephen Cain and Dr Chris Leung dated 5 December 2022, page 3.
[16] Coronial brief, statement of Dr Stephen Cain and Dr Chris Leung dated 5 December 2022, pages 3-4.
[17] Coronial brief, statement of Dr Stephen Cain and Dr Chris Leung dated 5 December 2022, pages 4-5.

Identity of the deceased

19. On 19 June 2022, Antony John Howard, born 27 September 1962, was visually identified by his sister, Emma Howard.

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

Medical cause of death

21. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 20 June 2022 and provided a written report of his findings dated 22 June 2022.

22. The post-mortem computed tomography (**CT**) scan confirmed the presence of right lower lung lobe consolidation, and patchy infective changes throughout both lungs. There were also pleural effusions. Contrast was seen within the urinary bladder. No unexpected signs of trauma were noted during the examination.

23. A post-mortem nasopharyngeal swab was positive for COVID-19/SARS-CoV-2 on PCR testing.

24. Toxicological analysis of post-mortem samples was not indicated and was not performed.

25. Dr Young noted that aspiration pneumonia is infection of the lungs that occurs after inhaling (aspirating) foreign material, such as food or vomitus. In this case, the diagnosis was made clinically, and supported by imaging. In combination with myocardial infarction, this has resulted in a cardiorespiratory arrest.

26. Dr Young provided an opinion that the medical cause of death was from 1 (a) aspiration pneumonia and non-ST elevation myocardial infarction in a man with an intellectual disability.

27. I accept Dr Young's opinion.

28. On the basis of the available information, I find that this death was due to natural causes.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Antony John Howard, born 27 September 1962;

    b) the death occurred on 18 June 2022 at Austin Hospital 145 Studley Road, Heidelberg, Victoria, 3084, from *aspiration pneumonia and non-ST elevation myocardial infarction in a man with intellectual disability*; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Antony'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:

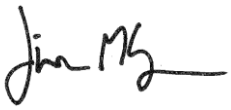
Peter And Jo Howard, Senior Next of Kin

Robyn Shea, Austin Health

Scott Shelly, Barry Nilsson Lawyers

Senior Constable Jessica Pappin, Victoria Police, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 23 February 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.