IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 003717

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Peter Stuart Jamieson
Date of birth:	5 January 1965
Date of death:	7 July 2022
Cause of death:	1(a) Small bowel obstruction 1(b) Mid small bowel volvulus
Place of death:	4/ 6 Younger Street, Wangaratta, Victoria, 3677
Keywords:	'in care'

INTRODUCTION

1. On 7 July 2022, Peter Stuart Jamieson was 57 years old when he passed away at 4/6 Younger Street, Wangaratta, Victoria, a disability in-care facility operated by Home@Scope where Mr Jamieson had resided since the 1990s with his brother Wayne.

2. Mr Jamieson's medical history included diagnoses of geroderma osteodysplastic, dysphagia and constipation in addition to severe mitral valve regurgitation diagnosed in approximately 2020.

3. Mr Jamieson had limited speech and required 24 hour supports for most daily living activities that included 1:1 support for personal hygiene, community support, and mealtime management. He was under the care of his long-term general practitioner Dr Ian Price for over 20 years.

4. Mr Jamieson's constipation was managed through a specific Health Care Plan endorsed by Mr Jamieson's general practitioner, which included eating a high fibre diet, information on his daily aperient, fluid intake, daily exercise and monitoring/recording requirements.

5. Due to Mr Jamieson's dysphagia, he also required a texture modified meals/fluids with staff following a Mealtime Management Plan developed by Mr Jamieson's speech pathologist.

6. Mr Jamieson's temperature was monitored daily, as his health management plan to identify early signs of deteriorating health.

7. In June 2022, Mr Jamieson underwent his comprehensive annual health care appointment with his general practitioner.

THE CORONIAL INVESTIGATION

8. Mr Jamieson'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.[1]

9. 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.

[1] Coroner McGregor formerly had carriage of the investigation into Mr Jamison's death.

10. 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.

11. Victoria Police assigned Leading Senior Constable (L/S/C) Andrew Green to be the Coroner's Investigator for the investigation of Peter's death. L/S/C Green conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

12. This finding draws on the totality of the coronial investigation into the death of Peter Stuart Jamieson including evidence contained in the coronial brief. 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

Circumstances in which the death occurred

13. Mr Jamieson would typically retire between 9:00-9:30pm with staff ensuring that Mr Jamieson used the toilet before bed. He would typically sleep through the night, but on occasion would experience disturbed sleep.

14. At approximately 4:00am on the morning of 6 July 2022, Mr Jamieson experienced diarrhoea and did not have a bowel motion for the remainder of the day. He declined to take his medication, refused food and drink and had developed a cough around 6.00am.

15. Staff arranged an appointment was Mr Jamison's general practitioner, Dr Price who attended the care facility around 1.00pm that afternoon. Prior to Dr Price's arrival a COVID-19 Rapid Antigen Test was undertaken, which returned a negative result.

16. Dr Price reported that on examination Mr Jamieson was "*more subdued than normal but in no pain or distress*". His chest was clear, and he showed no signs of fever or a cough. Dr Price noted that Mr Jamieson had a runny nose, which was swabbed and returned a result for

[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.

Rhinovirus.[3] Dr Price prescribed Mr Jamieson amoxycillin to treat the upper respiratory tract infection.

17. At approximately 1.05am on 7 July 2022, support staff attended Mr Jamieson's room to check on him and he was found to be non-responsive. Staff immediately contacted the call operations manager who advised staff to commence cardiopulmonary resuscitation and contact emergency services. An ambulance was requested, and resuscitation equipment was retrieved. Staff reported that Mr Jamieson was 'cold and stiff'. Upon the arrival of Ambulance Victoria paramedics, he was unable to revived and was formally declared deceased at 1.30pm on 7 July 2022.

Identity of the deceased

18. On 7 July 2022, Peter Stuart Jamieson, born 05 January 1965, was visually identified by disability support worker, Penelope Schirmer.

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

Medical cause of death

20. Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 8 July 2022 and provided a written report of her findings dated 11 July 2022.

21. Dr Zhou provided an opinion that the medical cause of death was

    1(a) Small bowel obstruction
    1(b) Mid small bowel volvus

22. The toxicological analysis of post-mortem samples did not identify the presence of alcohol or common drugs or poisons.

23. Dr Zhou reported that the post-mortem CT scan revealed markedly distended small bowel loops with air-fluid levels and collapsed terminal ileum and colon, which are features of a mechanical small bowel obstruction, caused by a mid-bowel volvulus. Dr Zhou advised that a small a small bowel volvulus occurs when the bowel twists about its mesentery, which can

[3] Viral infectious agent.

result in intestinal obstruction and affect vascular inflow and outflow, leading to bowel ischeamia and necrosis.[4]

24. The CT scan also identified fluid within the abdomen, cardiomegaly, a moderate pericardial effusion, emphysematous changes, bronchiectasis left lower lobe of the lungs and scoliosis as well as patchy bilateral increased lung markings posteriorly. Dr Zhou noted that this may be due to post-mortem hypostasis.

25. Dr Zhou's did not identify any significant injuries that may have caused or the death and was of the view that it was due to natural causes.

26. I accept Dr Zhou's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Peter Stuart Jamieson, born 05 January 1965;

    b) the death occurred on 07 July 2022 at 4/ 6 Younger Street, Wangaratta, Victoria, from

        1(a) Small bowel obstruction
        1(b) Mid small bowel volvus

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Mr Jamieson's family and loved ones 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:

Mr William Jamieson, Senior Next of Kin

Mr Darren Bain, National Disability Insurance Scheme Quality and Safeguards Commission

LSC Andrew Green, Coroner's Investigator

[4] Death of the bowel wall.

Signature:

Coroner Kate Despot

Date : 17 August 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.