IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 007435

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Trevor James Bayldon
Date of birth:	11 April 1967
Date of death:	28 December 2022
Cause of death:	1(a) Bronchopneumonia in a man with functional decline and trisomy 21
Place of death:	St. Vincent's Public Hospital Melbourne, 41 Victoria Parade, Fitzroy, Victoria, 3065
Keywords:	In care, natural causes, bronchopneumonia

INTRODUCTION

1. On 28 December 2022, Trevor James Bayldon was 55 years old when he passed away at St Vincent's Hospital, Melbourne (**SVHM**). At the time of his death, Mr Bayldon resided at 1/10 Lisson Grove, Hawthorn, a staff supported disability service operated by Scope. He had been living at that address for 21 years.

2. Mr Bayldon was diagnosed with down syndrome at birth and was removed from the care of his mother and placed in the care of the state. He resided in state run care facilities throughout his life. However, service provision for the residence where he lived was transferred from the Department of Health and Human Services to Home@Scope on 21 July 2019. At the time of his death, Mr Bayldon's accommodation and care needs were funded by the National Disability Insurance Scheme (**NDIS**).

3. Mr Bayldon had multiple complex health issues. His medical history included dementia and epilepsy. In the 12 months prior to his passing, Mr Bayldon's physical condition deteriorated significantly, and he required the use of a wheelchair to mobilise. He had limited verbal skills and was only able to communicate via gestures, signs, pictures, and sounds.

4. Mr Bayldon reconnected with his sister Carleen Bayldon later in life. His sister noted that Mr Bayldon was well-cared for and loved at his residence in Lisson Grove, and he had many friends there. She believed that her brother "*had the best 'family' and care growing up*" and that he did not want for anything.

THE CORONIAL INVESTIGATION

5. Mr Bayldon's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).[1] Mr Bayldon's death was reportable because he was a "*person placed in custody or care*" by virtue of the definition of that phrase in s 3 of the Act. Pursuant to that definition, he was "*a prescribed person or a person belonging to a prescribed class of person*" due to his status as an "*SDA resident residing in an SDA enrolled dwelling*".[2] I have received information that the address Mr Bayldon resided at is an address where the residents meet these criteria.

[1] Section 4(1), (2)(c) of the Act.
[2] Pursuant to Reg 7(1)(d) of the *Coroners Regulations 2019*, a "*prescribed person or a prescribed class of person*" includes a person in Victoria who is an "*SDA resident residing in an SDA enrolled dwelling*", as defined in Reg 5.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The 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 an officer to be the Coroner's Investigator for the investigation of Mr Bayldon's death. The Coroner's Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Trevor James Bayldon 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.[3]

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

Circumstances in which the death occurred

10. On the morning of 27 December 2022, Mr Bayldon was observed by his carer with an altered conscious state, increased work of breathing and breathlessness. His carers called 000 and requested an ambulance. On arrival, paramedics noted that Mr Bayldon was struggling to breathe, was grey in colour and was diaphoretic.

11. Mr Bayldon was transported by ambulance to SVHM, where he was assessed in the emergency department (**ED**). ED staff found he was non-communicative, tachycardic, hypotensive and tachypnoeic. His breathing was shallow with audible upper respiratory tract secretions and scattered crackles.

[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.

12. Staff commenced Mr Bayldon on high flow nasal prong oxygen, intravenous fluid resuscitation and intravenous antibiotics. Blood tests revealed an elevated white cell count and c-reactive protein, hypernatremia, and a mild kidney injury.

13. Despite maximal active supports, Mr Bayldon's condition continued to deteriorate, and he required very high oxygen supports. Clinicians spoke with Mr Bayldon's carers, and it was agreed that due to his poor functional baseline and progressive frailty, that an admission to the intensive care unit (**ICU**) was not in his best interests. Mr Bayldon was assessed by the Palliative Care Team, and he was provided with end-of-life comfort care. He passed away at 1.08pm on 28 December 2022.

Identity of the deceased

14. On 28 December 2022, Trevor James Bayldon, born 11 April 1967, was visually identified by his carer, Alisha Buultjens.

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

Medical cause of death

16. Forensic Pathologist Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 30 December 2022 and provided a written report of his findings dated 11 January 2023.

17. The post-mortem examination revealed no significant findings of note.

18. Examination of the post-mortem CT scan showed bilateral lung consolidation with air bronchograms, a large, distended bladder, fatty liver, and cerebral atrophy.

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

20. Dr Bouwer provided an opinion that the medical cause of death was "*1 (a) Bronchopneumonia in a man with functional decline and trisomy 21*". Dr Bouwer also provided an opinion that the death was due to natural causes.

21. I accept Dr Bouwer's opinion.[4]

[4] Pursuant to s 52(3A) of the Act, a coroner is not required to hold an inquest where the deceased was, immediately before death, a person placed in custody or care, if the coroner considers that the death was due to natural causes.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Trevor James Bayldon, born 11 April 1967;

    b) the death occurred on 28 December 2022 at St. Vincent's Public Hospital Melbourne, 41 Victoria Parade, Fitzroy, Victoria, 3065, from bronchopneumonia in a man with functional decline and trisomy 21; and

    c) the death occurred in the circumstances described above.

I convey my condolences to Mr Bayldon'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:

Gloria Bayldon, Senior Next of Kin

St Vincent's Hospital Melbourne

First Constable Alex Kimberley (VP45975), Victoria Police, Coroner's Investigator

Signature:

Coroner Catherine Fitzgerald

Date : 02 October 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.