IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 003376

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Arnold Polis
Date of birth:	31 March 1956
Date of death:	17 June 2024
Cause of death:	1a : Community acquired chest infection 1b : C6 quadriplegia secondary to remote diving accident (1972)
Place of death:	Box Hill Hospital 8 Arnold Street Box Hill Victoria
Keywords:	In care, disability, natural causes

INTRODUCTION

1. On 17 June 2024, Arnold Polis was 68 years old when he died in hospital. At the time, he lived at Victorian House in Burwood East which is supported accommodation operated by Yooralla.

2. Arnold is fondly remembered as a *'big bubbly character'* with a *'joyous personality'*. He loved the AFL, horse and car racing, and each year, dressed as Santa for Yooralla's Christmas party.

3. At 16 years of age, Arnold was involved in a diving accident and due to injuries to his spinal cord, developed C6 quadriplegia. He began living in supported accommodation and around 2004, moved to Victorian House.[1] Arnold used a wheelchair to move around and required assistance for hoist transfers, personal hygiene and meal preparation but was otherwise independent and could direct his supports.

4. Arnold's quadriplegia was complicated by autonomic dysreflexia,[2] atonic bladder and bowel[3] requiring long-term suprapubic catheterisation, recurrent catheter associated urinary tract infections, recurrent pneumonia, heart failure with preserved ejection fraction[4] and atrial fibrillation.[5]

THE CORONIAL INVESTIGATION

5. Arnolds' death fell within the definition of a reportable death in the Coroners Act 2008 (**the Act**) as he was a *'person placed in custody or care'* within the meaning of the Act, as a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling immediately prior to his death. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

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[1] In 2021, Yooralla became the operator of Victorian House.
[2] A condition commonly affecting individuals with spinal cord injuries above the T6 level which involves an overreaction of the autonomic nervous system and can cause a sudden increase in blood pressure.
[3] A condition in which the muscles affecting the bladder and/or bowel do not fully contract, leading to an inability to effectively empty these organs.
[4] Previously known as *'diastolic heart failure'* and occurs when the heart's main pumping chamber, the left ventricle, does not fill with a sufficient volume of blood.
[5] An irregular and often rapid heart rhythm.

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.

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 Arnold'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 Arnold Polis 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]

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

Circumstances in which the death occurred

10. On 8 May 2024, Yooralla staff noticed blood in Arnold's urine and organised an ambulance transfer to Box Hill Hospital (**BHH**). Clinicians diagnosed him with a catheter-associated urinary tract infection, prescribed antibiotics and Arnold was discharged to Victorian House on 10 May 2024.

11. On 25 May 2024, Arnold told staff that he felt unwell – he had developed a productive cough and experienced shortness of breath. He was transferred to BHH and diagnosed with Citrobacter[7] urinary tract infection and Bordatella pertussis[8] associated respiratory infection.

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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] A gram-negative bacterium.

[8] A gram-negative bacterium.

On 1 June 2024, Arnold was discharged with antibiotics to treat both the urinary and chest infection.

12. Over the ensuing days, Arnold's symptoms did not resolve and his productive cough remained. On 3 June 2024, nursing staff observed his oxygen saturation levels were low and he had shortness of breath, so organised an ambulance to transfer him to BHH.

13. Arnold was admitted under the General & Acute Care Medicine Unit and was diagnosed with right lower zone pneumonia treated with antibiotics, supplemental oxygen and chest physiotherapy, decompensated left ventricular heart failure requiring diuresis, low potassium requiring supplementation and an acute kidney injury.

14. Arnold did not respond to these interventions and on 14 June 2024, he requested that clinicians cease treatment and transition him to end-of-life care. The Palliative Care team commenced comfort care and Arnold died at 11.14am on 17 June 2024.

Identity of the deceased

15. On 17 June 2024, Arnold Polis, born 31 March 1956, was visually identified by his niece, Adelaide Polis.

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

Medical cause of death

17. Forensic Pathologist Dr Michael Burke of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 19 June 2024 and provided a written report of his findings dated 20 August 2024.

18. The post-mortem computed tomography (**CT**) scan demonstrated reasonably clear lungs, suprapubic catheterisation and old changes to the cervical spine. The external examination was otherwise unremarkable.

19. Dr Burke provided an opinion that the medical cause of death was '*1(a) Community acquired chest infection'* secondary to *'1(b) C6 Quadriplegia secondary to remote diving accident in 1972'.* Dr Burke noted the cause of death was due to natural causes.

20. I accept Dr Burke's opinion.

CORONERS PREVENTION UNIT

21. In the interests of canvassing all aspects of Arnold's care, I engaged the Coroners Prevention (**CPU**)[9] Unit in order to better understand the medical care provided to Arnold and his clinical pathway.

22. The CPU considered Arnold's medical history, the circumstances leading to his hospitalisation on 3 June 2024 and care received at BHH. The CPU commented that given his spinal cord injury and its sequelae of recurrent chest and urinary infections, it is reasonable that as he aged, his respiratory effort and immune response weakened such that antibiotics eventually became ineffective.

23. The CPU provided its opinion that the medical treatment provided by BHH was reasonable and appropriate.

24. I accept the advice of CPU regarding the provision of health care.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Arnold Polis, born 31 March 1956;

    b) the death occurred on 17 June 2024 at Box Hill Hospital 8 Arnold Street, Box Hill Victoria, from community acquired chest infection secondary to c6 quadriplegia secondary to remote diving accident (1972); and

    c) the death occurred in the circumstances described above.

[9] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

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:

Gaye Polis, Senior Next of Kin

Yooralla

Eastern Health

Senior Constable Samantha Peck, Coronial Investigator

Signature:

Coroner Sarah Gebert

Date: 20 August 2025

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.