IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000551

FINDING INTO DEATH WITH INQUEST

Form 37

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

Findings of:	Coroner Simon McGregor
Deceased:	Alan Joseph Wilson
Date of birth:	8 June 1965
Date of death:	29 January 2021
Cause of death:	Acute alcohol toxicity
Place of death:	Regis Macleod Aged Care Services, 118 Somers Avenue, Macleod, Victoria, 3085
Key words:	Regis MacLeod, Regis Aged Care, acute alcohol toxicity, COVID-19

INTRODUCTION

1. On 29 January 2021, Alan Joseph Wilson was 55 years of age when he died from Acute Alcohol Toxicity.[1] He was found deceased in his bed at the Regis Macleod Aged Care Facility where he lived. At the time of his death, Alan lived at the facility and had been a resident since 2016.

THE CORONIAL INVESTIGATION

2. Alan's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.[2] 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.[3]

3. 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.

4. 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.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Alan'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.

[1] Appendix 2, Dr Heinrich Bouwer, Forensic Pathologist, Victorian Institute of Forensic Medicine, Medical Examiner's Report, 43.
[2] Coroners Act, 2008, Section 4 (1)
[3] Coroners Act, 2008, Section 4 (2)(c)

6. This finding draws on the totality of the coronial investigation into the death of Alan Joseph Wilson 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.[4]

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

Identity of the deceased

7. On 29 January 2021, Alan Joseph Wilson, born 8 June 1965, was visually identified by Gagandeep Kaur, the general manager of Regis Macleod Aged Care.[5]

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

Medical cause of death

9. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the 4 February 2021, at 7.30 a.m. and provided a written report of his findings dated 13 July 2021.

10. The post-mortem examination revealed that the deceased a history of fragile X syndrome and psoriasis. There was no significant natural disease detected apart from small bilateral pleural effusions, thick tenacious mucus in the airways and plural anthracosis. There was moderate rectal faecal loading. The stomach content was watery and dark black/grey colour with a strong smell of alcohol (probably red wine). The small and large bowel contents were dark in colour was probably due to red wine staining.

11. Post-mortem toxicological analysis detected a blood and vitreous alcohol concentration at 0.33 per cent and 0.32 per cent respectively. Blood alcohol concentration in excess of 0.30 per cent can cause death in the absence of other contributing factors. High blood alcohol concentration causes significant central nervous system depression which may lead to aspiration of gastric contents.

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[4] 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.

[5] Exhibit 3. Statement of identification, 133.

12. There was no post- mortem evidence of violence or injury contributing to death.[6]

13. Toxicological analysis of post/ante-mortem samples identified the presence of citalopram at 0.08g/L, risperidone at ~ 7ng/mL and hydroxyrisperidone (prescribed) at ~ 14 ng/mL. No other common drugs or poisons were identified.[7]

14. Dr Heinrich Bouwer provided an opinion that the cause of death was from 1(a) Acute alcohol toxicity. [8]

15. I accept Dr Heinrich Bouwer's opinion.

Circumstances in which the death occurred

16. Alan Wilson, born 8 June 1965, was born with an intellectual disability and later diagnosed with schizophrenia.[9] He started drinking alcohol from a young age and suffered from an alcohol addiction. Before being admitted to the Regis Macleod Aged Care facility, he lived with his elderly mother Marie Wilson. Although Marie was Alan's primary carer, Alan was supported by his sisters, mainly Catherine Klidomitis.

17. After a severe fall in early 2016, Alan was referred to the Aged Care Assessment Service and was approved for a Transitional Care Program, high level residential respite, and residential care. He was admitted to the Regis Macleod Aged Care facility in November 2016.[10] [11]

18. Alan suffered from severe alcoholism and had very challenging behaviours. He was very defiant over authority and would refuse to take his medication.[12]

19. During COVID-19 lockdowns in 2020, Alan's health improved as he was no longer able to leave the facility to purchase alcohol, however once the lockdown restrictions were lifted in November 2020 and Alan was able to leave the facility to purchase alcohol, his alcohol consumption increased, and his mental health deteriorated significantly.

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[6] Appendix 2, Autopsy Report, Dr Heinrich Bouwer, Forensic Pathologist, Victorian Institute of Forensic Medicine, 40 - 49.

[7] Appendix 1, Toxicology Report, Dr Heinrich Bouwer, Forensic Pathologist, Victorian Institute of Forensic Medicine, 30 - 39.

[8] Appendix 2, Autopsy Report, Dr Heinrich Bouwer, Forensic Pathologist, Victorian Institute of Forensic Medicine, 43

[9] Appendix 3, Dr Katrina Philip, Medical Practitioner, 19 - 25

[10] Appendix 3. Comprehensive Medical Assessment, Dr Katrina Philip, 50 - 53.

[11] Appendix 5. My Aged Care Support Plan, Carrie Kennedy, ACAS Clinician, Bundoora Aged Care Assessment Service, 56 - 58.

[12] Catherine Klidomitis statement, 12 -13.

20. Alan became less able to be reasoned with, talked to himself, and suffered hallucinations and delusions, requiring his relevant medications to be increased.[13] [14]

21. Although Alan had an alcohol consumption plan and staff were supervising him and encouraging him to drink less, Alan was not compliant with this plan or staff suggestions and encouragement.[15] [16]

22. Leading up to his death, he had become very agitated. He was unhappy and often would go out and get drunk and sneak alcohol back into the nursing home. He was also refusing to see family.[17]

23. In the two to three weeks leading up to Alan's death, Alan was suffering from more frequent hallucinations and delusions, was talking to himself more and became increasingly hostile towards staff.[18]

24. On previous nights before Alan's death, staff of the facility noted that Alan was consuming a significant amount of alcohol and often already drunk and asking for more wine.[19]

25. During a nursing round, an attendant recorded entering Alan's room between 4.00 – 4.30 a.m. for a visual check and recorded Alan as 'sound asleep'.[20]

26. During police attendance, on the 29 January 2021, police located on the bedside table with Alan's room, 3 bottles of wine, two of which were empty and the third was one third full.

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 Alan Joseph Wilson, born 8 June 1965;

    b) the death occurred on 29 January 2021 at Regis Macleod Aged Care Services, 118 Somers Avenue, Macleod, Victoria, 3085, from 1(a) *acute alcohol toxicity*; and

[13] Gagandeep Kaur Clinical Care Manager. Statement of First Constable Mutschler 44300, 28 - 29
[14] Dr Katrina Philip, statement, 19 - 25.
[15] Mohini Thapa, Nurse, statement, 17.
[16] Rohit Pant, Nurse, statement, 14.
[17] Catherine Klidomitis statement, 12-13.
[18] Mohini Thapa, nurse, statement, 17.
[19] Criselda Whelan, nurse, statement, 15-16.
[20] Rohit Pant, statement, 14.

c) the death occurred in the circumstances described above.

28. Having considered all of the circumstances, I am satisfied that his death was the unintended consequence of the deliberate ingestion of alcohol.

I convey my sincere condolences to Alan's family for their loss.

Pursuant to section 73(1) 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:

Marie Wilson, Senior Next of Kin

Catherine Klidomitis, nominated representative of the Senior Next of Kin

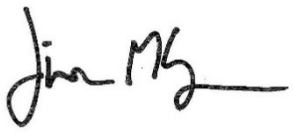
Dr Katrina Philip, general practitioner

Peter Lamborne, Regis McLeod Aged Care Facility

National Disability Insurance Scheme Quality and Safeguards Commission

First Constable Mutschler, Victoria Police, Coroner's Investigator

Signature:



CORONER SIMON McGREGOR

CORONER

Date: 2 September 2022

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.