IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 000939

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Tom Owen Row
Date of birth:	15 December 1962
Date of death:	18 February 2022
Cause of death:	1(a) Choking asphyxia 2 Dementia, Chromosome 18 Deletion Syndrome, Fragile X Syndrome
Place of death:	35 McPhee Street, Hamilton, Victoria, 3300
Keywords:	Home@Scope, Fragile X Syndrome, Chromosome 18q Deletion Syndrome, dysphagia, choking.

INTRODUCTION

1. On 18 February 2022, Tom Owen Row was 59 years old when he died at home. At the time of his death, Tom lived at 35 McPhee Street, Hamilton, a residential care facility (**RCF**) operated by Home@Scope.

2. Tom's recorded medical conditions included an intellectual disability, dementia, Fragile X Syndrome, and Chromosome 18q Deletion Syndrome. At the time of his death, Tom was prescribed risperidone, melatonin, and temazepam.[1]

3. Tom had resided at the McPhee Street RCF with four other residents for over 30 years. A review of Tom's support needs was completed when the RCF was transferred from the Department of Families, Fairness, and Housing to Home@Scope. He received support from a multi-disciplinary team, including psychiatry, occupational therapy, speech pathology, and nursing reviews.[2]

4. Tom was not diagnosed with dysphagia (swallowing difficulties) however an isolated choking incident occurred on 25 February 2019 when he was admitted to the emergency department with a partial airway obstruction due to behavioural factors and his tendency to eat quickly.[3]

5. A speech pathology review did not identify any ongoing swallowing difficulties and he was discharged back to the RCF with several recommendations to avoid similar incidents in the future, including pre-cut meals, use of straws, simple prompts to discourage Tom from eating too fast or talking whilst eating, and continuing to monitor for signs of swallowing difficulties. A speech therapist review was completed in June 2021.[4]

6. A referral had been completed for Tom to have a full medical examination under general anaesthetic including a computed tomography (**CT**) scan. This was to investigate the progression of Tom's dementia which he had been diagnosed with in 2020, however the request was rejected.[5]

[1] Statement of Benjamin Maw dated 2 June 2022, page 1.
[2] Statement of Benjamin Maw dated 2 June 2022, page 1.
[3] Statement of Benjamin Maw dated 2 June 2022, page 2.
[4] Statement of Benjamin Maw dated 2 June 2022, page 2.
[5] Statement of Benjamin Maw dated 2 June 2022, page 5.

THE CORONIAL INVESTIGATION

7. Tom'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. 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.

8. 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.

9. 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.

10. This finding draws on the totality of the coronial investigation into the death of Tom Owen Row including statements and evidence obtained from the McPhee Street RCF. 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]

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

[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.

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

Circumstances in which the death occurred

12. On 18 February 2022, Tom ate his afternoon tea and returned to his bedroom at approximately 3.10pm to have his normal sleep/relax. Staff did not report any issues. At approximately 5.50pm, Tom's disability support worker attended Tom's bedroom to wake him but found Tom lying on his back in an unresponsive condition with evidence of emesis on the floor.[7]

13. Upon finding Tom, staff at the RCF immediately contacted 000 and commenced cardiopulmonary resuscitation. Ambulance Victoria paramedics attended the scene and continued resuscitation efforts however they were unsuccessful and verified that Tom was deceased at 5.35pm.[8]

14. Staff did not report Tom experiencing any respiratory distress or signs consistent with choking following his afternoon tea. He presented in his normal condition and did not appear to be breathing abnormally, was not coughing, gagging, and did not have an altered appearance.[9]

Identity of the deceased

15. On 18 February 2022, Tom Owen Row, born 15 December 1962, was visually identified by his disability support worker.

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

Medical cause of death

17. Forensic Pathologist Dr Hans De Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 21 February 2022 and provided a written report of his findings dated 22 February 2022.

18. Examination of the post-mortem CT scan revealed a large food bolus lodged in the larynx. There were no other relevant positive findings.

19. Toxicological analysis was not indicated and was not performed.

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[7] Statement of Benjamin Maw dated 2 June 2022, page 3; RCF Incident Report 67688 dated 18 February 2022, page 1.
[8] Statement of Benjamin Maw dated 2 June 2022, page 3; Ambulance Victoria Verification of Death form dated 18 February 2022.
[9] Statement of Benjamin Maw dated 2 June 2022, page 3.

20. Dr De Boer provided an opinion that the medical cause of death was due to 1 (a) choking asphyxia, with dementia, Chromosome 18 Deletion Syndrome, and Fragile X Syndrome as contributing factors.

21. I accept Dr De Boer's opinion.

REVIEW OF CARE

22. Tom's death was reviewed by the RCF's Incident Response Group (**IRG**) which confirmed that all plans, documented strategies, and policies had been followed on the date of Tom's death. The review, however, identified that Tom's Comprehensive Health Assessment Program (**CHAP**) and Specialised Health Management Plan (**SHMP**) were out of date, possibly due to the extra pressures imposed by the COVID-19 pandemic.[10]

23. The RCF IRG review made several recommendations in response to Tom's death, including:

    a) Implement systems and processes to ensure that customers have current CHAPs and SHMPs in place; and

    b) If a customer refuses or is unable to attend a medical review for a particular reason, then Home@Scope should collaborate with Behaviour Support Practitioners (if applicable) and Allied Health providers to ensure the required review is completed.[11]

24. I note that these recommendations were included in the Service Improvement Action Plan for the RCF facility and are to be actioned as a priority.

FINDINGS AND CONCLUSION

25. After having reviewed the conclusions of the RCF IRG review and taking note of the concessions and recommendations made following Tom's death, I am satisfied that appropriate remedial actions have occurred and that no further action is required by this court.

26. I note that regular telephone contact occurred between Tom's family and the McPhee Street RCF and that on 19 March 2022 his family provided thanks for the care provided to Tom by the RCF staff and stated that he had "the best twelve months of his life".

[10] Statement of Benjamin Maw dated 2 June 2022, page 5.
[11] Statement of Benjamin Maw dated 2 June 2022, page 5.

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

    a) the identity of the deceased was Tom Owen Row, born 15 December 1962;

    b) the death occurred on 18 February 2022 at 35 McPhee Street, Hamilton, Victoria, 3300, from *choking asphyxia*; and

    c) the death occurred in the circumstances described above.

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

Pursuant to section 73(1A) 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:

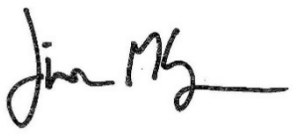
Gail Bloomfield, Senior Next of Kin

Treasure Jennings, Disability Services Commissioner

The Hon. Colin Brooks, MP, Minister for Disability, Ageing, and Carers

First Constable C Mead, Victoria Police, Reporting Member

Signature:



CORONER SIMON McGREGOR

CORONER

Date: 20 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.