IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000138

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Mr H
Date of birth:	[redacted] 1947
Date of death:	07 January 2021
Cause of death:	*Infectious Exacerbation of Chronic Obstructive Airways Disease* with the *Contributory Factor* of *Lewy Body Dementia*
Place of death:	Latrobe Regional Hospital, 10 Village Avenue, Traralgon, Victoria, 3844
Keywords:	*Death in care; natural causes*

This finding has been de-identified by order of Coroner Sarah Gebert to replace the names of the deceased, and his family members with pseudonyms to protect their identity and redact identifying information.

INTRODUCTION

1. Mr H was 73 years of age at the time of his death. He is survived by his wife, Mrs H, with whom he lived at their home in [redacted].

2. The couple had three children together. Their youngest child tragically died in 2018.

3. Mr H had a long history of mental health issues, but was extremely resistant of medical assistance.

4. On 7 January 2021, Mr H passed away in Latrobe Regional Hospital a day after his initial admittance for health concerns.

THE CORONIAL INVESTIGATION

5. Mr H'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.

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 Mr H'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. As advice was received from the pathologist that Mr H's death was due to *natural causes*,[1] a mandatory inquest was not required.[2]

10. This finding draws on the totality of the coronial investigation into Mr H's death 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]

Background

11. Mr H grew up in [redacted] and was the oldest of four boys. In 1964, his mother died suddenly from cancer. The family was *fractured* as a result of this, with Mr H and one of his brothers suffering from post-traumatic stress disorder.

12. In May 1992, Mr H turned 45 and experienced a nervous breakdown. He was the same age as his mother when she died. Mr H became convinced that he would soon die as well.

13. From 2008, Mrs H noticed a decline in both Mr H's physical and mental health. He would repeat statements and questions, had difficulty following instructions and started to struggle with his hobby of making things in his shed. He had a *pathological fear of illness* and of hospital admission. However, Mr H refused to acknowledge this issue and avoided medical intervention.

14. In 2015, Mr H was diagnosed with vascular dementia by a geriatrician. Between 2016 and 2020, five people close to Mr H, including his youngest son, passed away. Mr H's beloved dogs also died in 2020. Mrs H stated that with each death, Mr H's health deteriorated further and that by mid-2020, he was *pretty much gone*. He would sleep for the majority of the day and in the final three months of his life, he refused medication.

15. In the last week of his life, Mrs H attempted to have Mr H taken to hospital as he was having difficulty breathing, but he refused to go.

[1] Paragraph 28.
[2] Section 52(3A) of the Act.
[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.

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

Circumstances in which the death occurred

16. On 5 January 2021, Mr H received a visit from a district nurse who discussed Mr H's health with Mrs H. The nurse also assessed Mr H and encouraged him to attend [redacted] Regional Health Urgent Health Care Department for treatment, but this was refused.

17. At approximately 2.25am on 6 January 2021, Victoria Police attended an address following a complaint about Mr H standing naked on the deck of a house close to his home in [redacted]. Mr H told the police that he had just got off a boat and that he had lost his wife. He also claimed that he had been *robbed and bashed,* although police noted that he exhibited no injuries.

18. Mr H became confused and police took him home at approximately 3.00am. Mrs H was not aware that Mr H had left the property. She put Mr H back to bed and padlocked the gates of the property so he could not leave again.

19. The district nurse returned to visit Mr H in the late morning of 6 January 2021 and subsequently had a discussion with [redacted] Regional Health. They organised for a doctor to attend Mr H and assess whether he should be an involuntary admitted to care under the *Mental Health Act 2014*.

20. The doctor determined that Mr H needed to be involuntarily admitted. Ambulance Victoria paramedics arrived at 2.58pm and, with the assistance of police, convinced Mr H to come with them to hospital. Mr H arrived at Bairnsdale Regional Health Service at 4.29pm and he was triaged at 4.49pm.

21. Blood tests found that Mr H had high levels of both white blood cells and C-reactive protein, which are both indicative of a *severe infection*. A chest x-ray and CT brain scan were performed, with the former showing pneumonia and the latter showing extensive white matter disease in his brain.

22. Mr H was transferred to Latrobe Regional Hospital for psychiatric assessment at 7.45pm and arrived at 9.56pm. Although Mr H had been placed on antibiotics before his transfer, his health deteriorated. Mrs H requested no escalation of his treatment, and that comfort care should be prioritised.

23. Mr H passed away at 9.35am on 7 January 2021.

Identity of the deceased

24. On 7 January 2021, Mr H, born [redacted] 1947, was visually identified by his wife, Mrs H.

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

Medical cause of death

26. Forensic Pathologist, Dr Melanie Archer from the Victorian Institute of Forensic Medicine, conducted an examination on 8 January 2021 and provided a written report of her findings dated 2 February 2021.

27. The post-mortem examination revealed no evidence of an injury of a type likely to have caused or contributed to death.

28. Dr Archer provided an opinion that the medical cause of death was *Infectious Exacerbation of Chronic Obstructive Airways Disease* with the *Contributory Factor* of *Lewy Body Dementia* and that on the basis of the material available to her, Mr H's *death was due to natural causes*.

29. I accept Dr Archer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr H, born [redacted] 1947;

    b) the death occurred on 07 January 2021 at Latrobe Regional Hospital, 10 Village Avenue, Traralgon, Victoria, 3844, from *Infectious Exacerbation of Chronic Obstructive Airways Disease* with the *Contributory Factor* of *Lewy Body Dementia*; and

    c) the death occurred in the circumstances described above.

31. I convey my sincere condolences to Mr H's family for their loss.

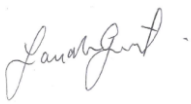
32. Pursuant to section 73(1B) of the Act, I order that a redacted copy of this finding be published on the Coroners Court of Victoria website in accordance with the rules.

33. I direct that a copy of this finding be provided to the following:

Mrs H, Senior Next of Kin

Sergeant Joanne Geddes, Coroner's Investigator

Signature:



Coroner Sarah Gebert

Date : 11 October 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.