IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000601

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	Mr H
Date of death:	29 January 2023
Cause of death:	1(a) aspiration pneumonia complicating sigmoid volvulus, in a man with multiple sclerosis
Place of death:	Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria, 3128

INTRODUCTION

1. On 29 January 2023, Mr H[1] was 58 years old when he died at Box Hill Hospital. At the time of his death, Mr H resided at Yooralla Neurological Support Services in Burwood East. [2]

THE CORONIAL INVESTIGATION

2. 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.

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 First Constable Jason Lin 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.

6. This finding draws on the totality of the coronial investigation into the death of Mr H 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]

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[1] This is a pseudonym.
[2] To ensure Mr H's anonymity, his date of birth has been removed from this document.
[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

7. Mr H was a resident at a Yooralla Supported Accommodation Home (**Yooralla**) in Burwood East, where he received assistance with all his daily care. His medical history included end stage multiple sclerosis and recurrent sigmoid volvulus.

8. On 25 January 2023 at approximately 5:21pm, emergency services were called to Yooralla in relation to pain that Mr H was experiencing.

9. The paramedics arrived at Yooralla at approximately 5:53pm and their assessment of Mr H revealed that he had abdominal pain, significant abdominal distension, and no bowel sounds. The primary diagnosis was noted as being bowel obstruction.

10. The paramedics transported Mr H to Box Hill Hospital, where he arrived at approximately 6:39pm and was triaged by 6:55pm. The hospital's initial impression was that Mr H was likely experiencing recurrent volvulus, as he was recently seen by the same surgical team on 21 January 2023 in similar circumstances. Mr H was noted to be agitated upon examination. He was administered morphine, ondansetron and paracetamol for his pain, and underwent a surgical review shortly after.[4]

11. Later that evening, an abdominal x-ray was performed. The results noted that Mr H had an obvious dilatation of the bowel, likely attributed to recurrent volvulus.[5]

12. On 26 January 2023, Mr H was very agitated (possibly due to his pain), and self-removed his inferior vena cava (**IVC**) filter. After administration of morphine, he became more settled. However, he was still refusing to eat and drink, was attempting to hit nursing staff and was not tolerating his oxygen mask well.[6]

13. In the early hours of 26 January 2023, Mr H was noted as being stable but his abdomen was still significantly distended. He was 'very combatant with care' and accordingly he was sedated ahead of the rectal tube insertion procedure which took place at around 4:00am via sigmoidoscopy.[7]

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[4] Medical Records of Eastern Health, 217-218.
[5] Medical Records of Eastern Health, 98.
[6] Medical Records of Eastern Health, 212-3.
[7] Medical Records of Eastern Health, 203-4, 213.

14. Once the rigid sigmoidoscopy was conducted, a large gush of faecal matter and gas was released, but the drainage was noted to have been going well and his abdomen was softer after the insertion. The plan post-insertion was for the rectal tube to be kept in.

15. At 7:27pm, another abdominal x-ray was performed, the results of which showed 'no appreciable small bowel dilatation'.[8] A chest x-ray was also performed, with noted that Mr H's lungs were underinflated, and his colon was dilated.[9]

16. On the morning of 27 January 2023, Mr H's condition was deteriorating, and he was refusing bloods and his cannula. [10] He also had laboured and rattly breathing and was administered antibiotics for aspiration pneumonia.[11] Accordingly, his family was notified.[12]

17. At around 3:00pm, the hospital staff met with Mr H's family and discussed palliative care. The family, including Mr H's wife and power of attorney, agreed that the hospital's care was to be redirected towards comfort for Mr H, as opposed to life-prolonging measures, in accordance with what he had previously expressed.[13]

18. Mr H's wife further explained that he had been refusing medications whilst in the nursing home as well, and expressed he 'had enough', particularly given his very frequent hospital admissions.[14]

19. It was noted that over the night of 28 January 2023 to the early morning of 29 January 2023, Mr H's breathing had changed. Accordingly, hospital staff contacted Mr H's wife who advised she would arrive at the hospital shortly. Tragically, Mr H had died overnight.[15]

Identity of the deceased

20. On 31 January 2023, Mr H, born on a date known to me, was visually identified by a nurse at Box Hill Hospital.

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

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[8] Medical Records of Eastern Health, 97.
[9] Medical Records of Eastern Health, 105.
[10] Medical Records of Eastern Health, 244.
[11] Medical Records of Eastern Health, 119, 252.
[12] Medical Records of Eastern Health, 244.
[13] Medical Records of Eastern Health, 242-3.
[14] Medical Records of Eastern Health, 243.
[15] Medical Records of Eastern Health, 251-2.

Medical cause of death

22. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 1 February 2023 and provided a written report of his findings dated 2 February 2023.

23. The post-mortem external examination revealed no unexpected signs of trauma.

24. Dr Young provided an opinion that the medical cause of death was 1 (a) aspiration pneumonia complicating sigmoid volvulus, in a man with multiple sclerosis.

25. I accept Dr Young's opinion.

FINDINGS AND CONCLUSION

26. 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 on a date known to me;

    b) the death occurred on 29 January 2023 at Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria, 3128, from aspiration pneumonia complicating sigmoid volvulus, in a man with multiple sclerosis; and

    c) the death occurred in the circumstances described above.

27. Having considered all of the circumstances, I am satisfied that the medical practitioners at Box Hill Hospital acted reasonably and provided appropriate care to Mr H.

I convey my sincere condolences to Mr H'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:

Ms H, Senior Next of Kin

Signature:

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Coroner John Olle

Date : 11 August 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.