IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 5412

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	Gregory John BENNETT
Date of birth:	12 April 1966
Date of death:	26 October 2018
Cause of death:	*Aspiration Pneumonia*
Place of death:	Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria
Other matters	*Person placed in custody or care, natural causes*

INTRODUCTION

1. Gregory John Bennett[1] was a First Nations man who was born on 12 April 1966. He was 52 years of age at the time of his passing. Greg was survived by his brother, Alfred Bennett. His sister, Barbara Mudie, sadly passed away in April 2019.

2. Greg had lived in Department of Health and Human Services (**DHHS**) managed accommodation for 39 years. At the time of his passing he was living at a group home in Costello Street in Mont Albert North. The home was transferred to *Life Without Barriers* on 26 May 2019. There were four other residents.

3. Greg's many likes and interests included listening to Gold FM on the radio, going for walks, the movies, sitting outside in the garden and massages. He also enjoyed the support of his family who visited him regularly throughout the year. Greg was described by one of his carers as *sweet and lovely.*

4. Greg's General Practitioner (**GP**), Dr Geoff Gidley said that Greg was *profoundly disabled as a result of congenital rubella syndrome.* His health conditions included epilepsy, sleep apnoea, dysphagia, spastic quadriparesis with severe flexural contractures of all four limbs and at least one previous episode of aspiration pneumonia. Greg had visual and hearing impairments, and communicated through "facial expression, natural gestures, body language and vocalisation". Greg had difficulty swallowing food and drink and required a modified diet and support at mealtimes to minimise the risk of aspiration or choking. He was wheelchair bound for all mobility and was dependent on carers for all activities of daily life.

5. Dr Gidley said that despite the extent and severity of his physical disabilities he *generally was in good health and rarely required medical treatment* during the period of his care (since 2008). He last saw Greg on 10 October 2018 and said that he *appeared his usual self, with no sign of any new medical issues.* His sister, Barbara visited him a week before his passing and said that he *seemed fine.*

6. Late in the evening of 26 October 2018, Greg passed away at the Box Hill Hospital having been admitted earlier that day.

[1] Referred to in my Finding as 'Greg' unless more formality is required. I note that the Deceased's niece Rhiannan (who was the daughter of Barbara and Kenneth Mudie) referred to him as 'Uncle Greg,'

THE CORONIAL INVESTIGATION

7. Greg's death was reported to the coroner as he was considered to be *a person placed in custody or care* under section 3(1) of the *Coroners Act 2008* **(the Act)** and so fell within the definition of a reportable death under the Act.

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. Victoria Police assigned Senior Constable Stuart Sharp (**SC Sharp**) to be the Coroner's Investigator for the investigation into Greg's death. SC Sharp conducted inquiries on my behalf[2], including taking statements from witnesses and submitting a coronial brief of evidence. The brief includes statements from Greg's sister, his GP, a number of his carers, ambulance paramedics, a treating doctor from the Box Hill Hospital, the forensic pathologist who examined him and the Coroner's Investigator.

11. Greg's records were also obtained from DHHS as well as his medical records from the Box Hill Hospital.

12. As advice was received from a pathologist that Greg's death was due to natural causes[3], a mandatory inquest was not required.[4]

<u>Disability Services Commissioner</u>

13. I also considered the advice regarding the *Investigation into disability services provided by Department of Health and Human Services to Mr Gregory Bennett* prepared by the

[2] The carriage of the investigation was transferred from Deputy State Coroner English.
[3] Paragraph 28.
[4] S52(3A) of the Act.

Disability Services Commissioner (**DSC**) which was provided to the Court. The DSC investigation was conducted under the auspices of the *Disability Act 2006* with a different scope to that of a coronial investigation (although it can overlap). Consistent with the Act, a coroner should liaise with other investigative bodies to avoid unnecessary duplication and expedite investigations.[5]

14. This finding draws on the totality of the coronial investigation into Greg'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.[6]

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

Circumstances in which the death occurred

15. On 26 October 2018, Greg appeared well and went to his day program, Yooralla's Surrey Hills Hub, following his usual routine.

16. Staff at the day program noted that Greg appeared unwell in the morning and was subsequently monitored throughout the day for signs of deterioration. They contacted his residence but they were unable to pick him up earlier than scheduled. Greg ate and drank well at lunch after which he appeared *quite relaxed*. He then engaged in his usual activities over the rest of the afternoon.

17. Greg was picked up by his carers and returned home by 3.00pm. There were no signs of illness or difficultly observed at this time. Greg spent time in the lounge area alone after being given his afternoon tea with no issues noted at approximately 3.30pm.

18. He was checked at about 5.00pm, by a staff member commencing duty who did not notice any irregularity with his breathing but did notice redness on his cheek.

19. Shortly after 5.00pm, staff went to assist Greg with his dinner (and medication) and noticed that he was pale and his lips were blue and he was not responding.

[5] S.7 of the Act.

[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.

20. Staff commenced cardiopulmonary resuscitation (**CPR**) and emergency services were called. Staff continued CPR until emergency service personnel arrived at 5.25pm, including a Mobile Intensive Care Ambulance (**MICA**) paramedic and the Metropolitan Fire Brigade (**MFB**). They spoke to Greg's sister, Barbara about a potential treatment plan and were advised not to perform any invasive resuscitation.

21. Greg was transported to Box Hill Hospital arriving at 6.00pm (his carers accompanied him). Greg was unable to be assisted and a decision was made in consultation with Greg's family for comfort care measures and he was subsequently palliated.

22. Greg was declared deceased at 11.12pm on 26 October 2018.

Identity of the Deceased

23. On 26 October 2018, Barbara Mudie visually identified her brother Gregory John Bennett born 12 April 1966.

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

Medical cause of death

25. Specialist Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 28 October 2018 and provided a written report of his findings dated 29 October 2018.

26. A Toxicological analysis of post mortem samples identified the presence of nordiazepam[7] and carbamazepine[8] in quantities which are consistent with therapeutic use.

27. Dr Young provided an opinion that the medical cause of death was *Aspiration Pneumonia in a man with cerebral palsy*. In a later discussion with Dr Young he noted that the information provided to him at the time of the examination included that Greg suffered cerebral palsy which was later found to be inaccurate[9] and on the basis of this, he was content for the cause of death to be determined as *Aspiration Pneumonia*.

28. Dr Young stated that on the information available to him, he was of the opinion that Greg's death was due to *natural causes*.

[7] A metabolite of diazepam which is a sedative/hypnotic drug of the benzodiazepines class.
[8] Carbamazepine is an antiepileptic drug.
[9] The GP notes documenting congenital rubella syndrome.

29. I accept Dr Young's opinion.

FINDINGS AND CONCLUSIONS

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

    (a) the identity of the Deceased was Gregory John Bennett, born 12 April 1966;

    (b) the death occurred on 26 October 2018 at Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria from *Aspiration Pneumonia*; and

    (c) the death occurred in the circumstances described above.

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

32. Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet.

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

    Mr Alfred Lesley Bennett, senior next of kin

    K & L Gates on behalf of Yooralla

    Eastern Health

    Senior Constable Stuart Sharp, Victoria Police, Coroner's Investigator

Signature:

SARAH GEBERT

Date: 26 July 2021

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.