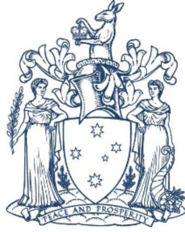

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2020 3566

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Deceased:	**David Charles Shaw**
Findings of:	**CORONER DARREN J. BRACKEN**
Date of Birth:	12 November 1963
Date of Death:	On or about 3 July 2020
Cause of Death:	Ischaemic and valvular heart disease
Place of Death:	Unit 1, 117 Vincent Road, Morwell, Victorian

CIRCUMSTANCES

1. At the time of his death Mr Shaw was 57 years old and lived alone.

2. Detective Senior Constable Myors was appointed as the coronial investigator and compiled and submitted the coronial brief evidencing the investigation into Mr Shaw's death.

Mr Shaw's Medical History

3. The Coronial brief included a 'statement' from Dr Paransothy from 'The Health Care Centre' medical practise where Mr Shaw was a patient. Dr Paransothy explained that Mr Shaw had a complex medical history which included schizophrenia, obesity, type 2 mellitus, chronic obstructive pulmonary disease as a result of smoking, ischaemic heart disease with previous myocardial infarction and had had an aortic valve replacement.[1]

Cause of Death

4. On 10 July 2020 Dr Heirich Bouwer, a specialist forensic pathologist performed an autopsy on Mr Shaw's body. In his report dated 28 January 2021 Dr Houwer described Mr Shaw as having a markedly enlarged heart with severe triple vessel coronary artery atherosclerosis and multiple old infarcts. Dr Bouwer commented that death was consistent with a sudden lethal cardiac arrhythmia and opined that the cause of Mr Shaw's death was ischaemic and valvular hear disease – natural causes.

MePACS Medical Alarm Service

5. On 16 July 2013 MePACS, a Medical Alarm Service through Peninsula Health, began monitoring Mr Shaw's condition.

6. The monitoring process required that Mr Shaw press the button on a portable electronic device which MePACS provided to him between 6.00am and 11.00am each day. Mr Shaw pressing the button registered with the MePACS Response Centre. If Mr Shaw did not press the button as required, staff at the MePACS Response Centre were required to

[1] See Letter dated 22 September 2020 from 'The Health Care Centre' Princess Drive Morwell.

telephone Mr Shaw and if he did not answer, telephone others whom Mr Shaw had nominated.

7. On Friday 3 July 2020 MePACS did not receive the electronic signal that Mr Shaw had pressed the button as required. Staff from the MePACS Response Centre called Mr Shaw's home and mobile telephone numbers; neither of which were answered. MePACS staff telephoned Mr Taylor, Mr Shaw's first nominated contact only to discover that Mr Taylor's telephone had been disconnected. Staff then called Mr Skermer but were unable to speak with him.

8. At 3.44pm MePACS staff checked that Mr Shaw had not been admitted to the LaTrobe Regional Hospital and at 4.14pm spoke to Mr Skermer for the first time. MePACS recorded Mr Skermer telling MePACS staff that he had seen Mr Shaw that morning and he was 'OK'.

9. On Saturday 4 July 2020 MePACS Response Centre received no notification of Mr Shaw having pushed the button on his electronic device by 11.00am.

10. MePACS notes record staff calling Mr Shaw's home at 1.19pm and the telephone 'ringing out'. Staff then called Mr Shaw's mobile telephone which was not answered and left a message. Despite having called Mr Taylor's telephone the previous day and discovering that it was disconnected, staff again called Mr Taylor; the telephone was not connected. At 1.35pm staff again telephoned Mr Skermer and MePACS notes record Mr Skermer telling the MePACS caller that:

    - He did not have a key to Mr Shaw's home.
    - He had knocked on Mr Shaw's door the day before [3 July] and there was no answer.
    - He would go and knock on Mr Shaw' door again.

11. MePACS staff telephoned Mr Shaw thoughout the afternoon without success. At about 3.04pm staff again called Mr Skermer "*…to clarify information provided to MePACS on 3rd July,*" MePACS notes record Mr Skermer:

"…*confirming client did not answer the door on 3rd July, but his previous call stated he had seen Mr Shaw across the street on the morning of 3/7/2020 and he was ok.*"

12. Having not been able to contact Mr Shaw by 3.51 pm, MePACS staff confirmed that Mr Shaw was not at the LaTrobe Hospital and at 4.01pm contacted police and asked that they conduct a welfare check on Mr Shaw. MePACS notes record that shortly after MePACS calling the police Mr Skermer telephoned MePACS and told them that: "*He thought he saw client* [Mr Shaw]*across the road on 3rd July, but it was at a distance and could not be sure if it was actually Mr Shaw. He then advised that client has not answered the door* <u>*today*</u> [2]*(3rd July) and his lights were off all night and there was a note on Mr Shaw's door from 3rd July.*"[3]

13. Notes of Mr Skermer's conversation with MePACS shortly after 4.01pm on 4 July referring to "…*client has not answered the door today (3rd) July and his lights were off all night and there was a note on Mr Shaw's door from 3rd July*." is confusing given that the telephone call was said to have been made on 4 July.[4]

14. Shortly afterward police went to Mr Shaw's home and found him dead in bed.

Statement of William Skermer

15. In his statement to the coronial investigator Mr Skermer says that he thought that he had seen Mr Shaw early Friday morning [Friday was 3 July] but it was a little bit dark and he wasn't sure it was Mr Shaw. Mr Skermer refers to having told "…*the MePACS people*…" that he wasn't sure if it was Mr Shaw or not. The context of the statement does not make it clear when Mr Skermer told told "…*the MePACS people*..." of possibly having seen Mr Shaw – that is wether he told them this on 3 July or 4 July.

16. Mr Skermer then explicitly refers to "…*the MePACS people*..." telephoning him on Saturday [4 July] immediately after the Friday [3 July] and asked him if he had seen Mr Shaw. In his statement Mr Skermer told the MePACS caller that he thought that he had

[2] My emphasis.

[3] Statement Ms Nelson Peninsula Health Operations Manager signed 29 September 2020 [8].

[4] Statement Ms Nelson Peninsula Health Operations Manager signed 29 September 2020 [8].

seen Mr Shaw the day before, but he couldn't be sure it was Mr Shaw.[5] When asked if he had seen Mr Shaw that day, the day of the call – Saturday 4 July, Mr Skermer's statement refers to him telling the caller that he had not. Mr Skermer elaborates in his statement and says that he didn't see Mr Shaw at all on Saturday [4 July].

17. Mr Skermer's statement refers to 'the MePACS people' calling him, he thought on Sunday [5 July] asking if he had seen Mr Shaw. Mr Skermer's statement refers to him having told the MePACS caller then that he had not seen Mr Shaw on that day and that he had not seen him the day before either. Mr Skermer's statement refers to him going across to Mr Shaw's home and knocking on the front door and bedroom window and there being no response. He refers to having seen no house lights on. Mr Skermer's statement refers to MePACS staff calling him again on Sunday [5 July] at about 4.00pm and asking if he had seen Mr Shaw – Mr Skermer's statement refers to him telling the caller that he had not seen Mr Shaw all weekend. Mr Skermer's statement refers to police going to Mr Shaw's home after 5.00pm on Sunday (5 July) in the evening and finding him dead.[6]

ANALYSIS OF THE EVIDENCE

18. Other than Mr Skermer's statement all other material in the coronial brief refers to police finding Mr Shaw dead in his home in the evening of Saturday 4 July.

19. The Ambulance Victoria 'Verification of Death' form refers to ambulance staff declaring life to have been found to be extinct at 5.38pm on 4 July 2020.

20. In his statement Mr Michael Shaw (Mr Shaw's brother) refers to police contacting him on 4 July and telling him of his brother's death.

21. Ms Nelson's statement[7] in the coronial brief refers to records from MePACS provided to the court setting out telephone calls from the MePACS Response Centre to Mr Skermer on 3 and 4 July, to police on 4 July and to police having found Mr Shaw dead

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[5] The terms of [7] of his statement are equivocal about whether he says that MePACS staff telephoned him on 3 July – Friday. If it is taken to mean tat MePACS staff spoke to him on the 3 July – Friday it makes clear that he told them that he saw a person that he thought was Mr Shaw that morning albeit that he wasn't sure the person was in fact Mr Shaw

[6] Coronial Brief Statement of William Skermer p.2.

[7] Coronial Brief Statement of Sheryl Nelson, Operations Manager, Peninsula Health dated 29 September 2020 [8]. Ms Nelson refers to MePACS being a 'business unit' of Peninsula Health.

in his home on 4 July 2020. MePACS have no record of having called Mr Skermer on Sunday 5 July.

22. It is at least possible that Mr Skermer was mistaken about when he received some telephone calls from MePACS and when he thought that police discovered Mr Shaw's body.[8] What is clear though is that all that MePACS knew of Mr Shaw on 3 or 4 July was from Mr Skermer telling MePACS staff:

- Probably on 3 July that he thought that he saw Mr Shaw that day and that he was OK.

- On Saturday [4 July] that thought that he had seen Mr Shaw the day before [ie. 3 July] but that he couln't be sure and that he had not seen him that day [4 July].

23. Mr Skermer's accounts of telephone conversations with MePACS staff on Sunday [5 July] is not supported by any other evidence and is contradicted by some evidence in particular the evidence of Ms Nelson, Police and Ambulance staff. Mr Skermer may be confused about the dates on which he spoke to MePACS staff and what he told them when. This uncertainty is not seminal. Mr Skermer's evidence is in some ways clear – he thinks he saw Mr Shaw on Friday morning but his not sure it was Mr Shaw and he didn't see him after that. There is some uncertainty about what he says he told MePACS and what MePACS notes record him saying. Neither is that discrepancy seminal.

CONCLUSION

24. That Mr Shaw died of natural causes is uncontroversial. Precisely when he died cannot now be determined even to the extent of whether he died on 3 or 4 July 2020. It is at least likely that he was either incapacitated or dead by 11.00am on 3 July 2020. I cannot determine whether provision of medical aid at any particular time on 3 or 4 July would have prevented his death as it occurred.

25. Mr Shaw did not trigger his device by 11.00am on Friday 3 July 2020. When Mr Shaw did not answer telephone calls to his home or mobile telephone MePACS staff telephoned the first person on his contact list, Mr Taylor, whose telephone number they discovered had been disconnected. The second person on Mr Shaw's list, Mr Skermer

[8] I note the Mr Skermer's statement was witnessed on 6 October 2020, some three months after Mr Shaw's death.

was not first contacted by MePACS staff until 4.14pm when, according to MePACS staff he told them that he seen Mr Shaw that morning and he was 'OK'.

26. Nobody from MePACS directly spoke to Mr Shaw on 3 July.

27. Mr Shaw did not trigger his device by 11.00am on Saturday 4 July 2020. Staff from MePACS called Mr Shaw's home and mobile telephone numbers and receiving no reply and despite discovering the day before that his number was not connected, again called Mr Taylor. At 1.35pm MePACS staff spoke to Mr Skermer who told them that he had knocked on Mr Shaw's door the pevious day and there was no answer and in a later telephone call Mr Skermer "*…confirmed*" that Mr Skermer had knocked on Mr Shaw's door the previous day [3 July] and seen him on that day.

28. Mr Skermer's account of calls from and to MePACS in his statement is his best recollection of events, nonetheless he may be mistaken about what he told MePACS staff and when.

29. The utility of the MePACS process is founded on a timely response to MePACS not having received a signal from a client's device within nominated time frames. Response to a device not being triggered as expected should incorporate some real sense of urgency which ought to only be sated by explicit clear knowledge of the client's safety perhaps contingent on MePACS Response Centre staff speaking directly to such clients.

MATTERS IN RELATION TO WHICH FINDINGS MUST, IF POSSIBLE, BE MADE PURSUANT TO SECTION 67 *CORONERS ACT* (2008)

30. Having investigated Mr Shaw's death and pursuant to 67(1) of the *Coroners Act* (2008), I find that:

- The identity of the deceased is David Charles Shaw born 12 November 1963.
- Ms Shaw's death occurred:
  - On or about 3 July 2020 at Unit 1, 117 Vincent Road, Morwell, Victoria,
  - as a result of ischaemic and valvular heart disease, and
  - in the circumstances set-out above.

RECOMMENDATION

31. Pursuant to section 72 of the Act I recommend that:

> The Chief Executive Officer of Peninsula Health consider reviewing and limiting the time-frame within which enquiries must be made and concluded into the condition of patients who have not triggered MePACS electronic devices as expected. This review should incorporate consideration of introducing a schedule of criteria setting-out the minimum bases of and concomitant supporting evidence by which MePACS staff may consider themselves satisfied that such patients are not in need of urgent medical attention.

PUBLICATION

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.

DISTRIBUTION

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

Mr Michael Shaw, senior next of kin

Mr William Skermer.

Ms Sheryl Nelson, Operations Manager, Peninsula Health.

Ms Amber Salter, Legal Counsel, Peninsula Health.

Detective Senior Constable Jordan Myors.

Signature:

DARREN J BRACKEN

CORONER

Date: 08 March 2022.