IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 5237

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: BEVERLY DAVIDGE

Delivered On:	16 July 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Date:	16 July 2014
Finding Of:	AUDREY JAMIESON, CORONER
Police Coronial Support Unit	Senior Constable Paul Collins

I, AUDREY JAMIESON, Coroner having investigated the death of **BEVERLY DAVIDGE**

AND having held an inquest in relation to this death on 16 July 2014

at MELBOURNE

find that the identity of the deceased was **BEVERLY DAVIDGE**

born on 16 March 1935

and the death occurred on 16 November 2013

at the Royal Melbourne Hospital, 300 Grattan Street, Parkville 3050

from:

1 (a) ACUTE GASTROINTESTINAL HAEMORRHAGE

in the following circumstances:

1. On 16 July 2014, a mandatory inquest under section 52(2)(b) of the *Coroners Act 2008* (Vic) (the Act) was held into the death of Ms Beverly Davidge, because immediately before her death, Ms Davidge was "a person placed in....care" as it is defined in the Act. Ms Davidge had an intellectual disability and had been a client of the Department of Human Services Disability Services.

BACKGROUND AND CIRCUMSTANCES

2. Ms Davidge was 78 years of age at the time of her death. She lived at a residential care facility operated by the Department of Human Services for people with intellectual disabilities located at 131 Primrose Street, Essendon ("Primrose House"). Ms Davidge had lived at this residence since July 2012.

3. Ms Davidge had a past medical history that included an intellectual disability, dementia, probable left ischaemic middle cerebral artery infarct, lumbar and cervical canal stenosis severely limiting functional mobility, gout, iron deficiency, hip dysplasia and right hip replacement. Prior attempts at colonoscopy investigations proved unsuccessful, as Ms Davidge did not tolerate the preparation.

4. On 11 November 2013, Ms Davidge was admitted to the Royal Melbourne Hospital (RMH) with a history of haematemesis[1] and malaena[2] and a suspected upper gastrointestinal bleed.

---

[1] The vomiting of blood.

She was not considered a suitable surgical candidate and was treated conservatively. She was discharge to Primrose House on 12 November 2013.

5. On the morning of 13 November 2013, Ms Davidge was observed by Primrose House staff to be unusually subdued and experiencing swallowing difficulties. Primrose House staff spoke with the Nurse on Call service, who advised that Ms Davidge should return to the RMH. An ambulance arrived at 4.45pm and transported Ms Davidge to the RMH, where she was admitted.

6. Ms Davidge had ongoing blood loss despite treatment, including red blood cell transfusions. On 15 November 2013, she deteriorated suddenly. In light of her co-morbidities, a decision was made that further aggressive treatment was no longer appropriate and she was to be provided with palliative care. Ms Davidge died on 16 November 2013.

FORENSIC PATHOLOGIST EXAMINATION AND EVIDENCE

7. Dr Linda Iles, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination upon the body of Ms Davidge, reviewed a post mortem CT scan and reviewed the Victorian Police Report of Death, Form 83. Anatomical findings included enlarged cerebral ventricles, calcified aortic valve and coronary arteries and fluids/blood in the small bowel. No obvious large old stroke or free sub-diaphragmatic gas was identified. Dr Iles ascribed the cause of Ms Davidge's death to acute gastrointestinal haemorrhage. Dr Iles however noted that without a full post mortem examination, the precise cause of the gastrointestinal bleeding would not be identifiable.

POLICE INVESTIGATION

8. The circumstances of Mr Davidge's death have been the subject of investigation by Victoria Police. Police obtained statements from Mr Davidge's General Practitioner Dr Karin Halla, a Primrose House staff member and Dr Eric Au (RMH).

FACTORS CAUSING OR CONTRIBUTING TO DEATH

9. The evidence supports a conclusion that Ms Davidge died on 16 November 2013 and that the cause of her death was acute gastrointestinal haemorrhage in a disabled woman with a history of malaena. The circumstances under which Ms Davidge died were, according to the forensic pathologist, consistent with Ms Davidge's relevant past medical history. There was

---

[2] The presence of blood in stools.

no evidence to suggest any other cause or contribution to her death. Ms Davidge died from natural causes.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

In all the circumstances, I am satisfied that there would be no benefit from conducting a full inquest into Ms Davidge's death or obtaining any further medical or other evidence, as neither would assist me to further understand the medical issues before me or the cause of Ms Davidge's death which resulted from natural causes.

FINDINGS

I accept and adopt the medical cause of death as ascribed by Dr Linda Iles and I find that Beverly Davidge died from acute gastrointestinal haemorrhage.

AND I further find that there is no relationship between the cause of Ms Davidge's death and the fact that she was "a person placed in care".

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that the following be published on the internet.

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

Ms Heather Kelly, State Trustees

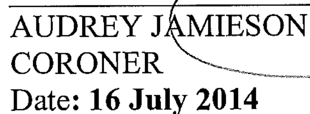
Mr Shane Beaumont, Department of Human Services – Disability Service

Melbourne Health

Dr Karin Halla, Fawkner Street Clinic, Essendon

Senior Constable R Goodrich

Signature:



AUDREY JAMIESON
CORONER
Date: **16 July 2014**