IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 4681

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: BRIAN LENCH

Delivered On:	18 September 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne
Hearing Dates:	18 September 2012
Findings of:	HEATHER SPOONER, CORONER
Police Coronial Support Unit	Leading Senior Constable Nadine Harrison

I, HEATHER SPOONER, Coroner having investigated the death of BRIAN LENCH

AND having held an inquest in relation to this death on 18 September 2012

at Melbourne

find that the identity of the deceased was BRIAN JOSEPH LENCH

born on 2 April 1953

and the death occurred on 14 December 2011

at Wantirna Palliative Care Unit, 251 Mountain Highway Wantirna 3152

from:

1a. ASPIRATION PNEUMONIA IN A MAN WITH A LEFT MIDDLE ARTERY STROKE (PALLIATED)

in the following circumstances:

1. Mr Lench was aged 58 when he died. He lived in a residential care unit situate at 1/28 Pratt Street, Ringwood. This unit was managed by the Department of Human Services (DHS). Mr Lench had a past medical history that included congenital intellectual disability, congenital left eye blindness, a shizophreniform disorder and type 2 diabetes mellitus.

2. A police investigation was conducted into the circumstances surrounding the death. As Mr Lench was 'a person placed in care' of DHS as defined in S.3 *Coroners Act 2008* a mandatory inquest was convened pursuant to S.52(2)(b) of the Act.

3. A summary of the investigation was produced and read to the Court:

   "Mr Lench suffered from an intellectual disability and spent most of his life in care. He was left at Kew Cottages in 1955 when he was two years old and has been in care since. The circumstances of him being left are not known.

   On 6 October 2011, at approximately 6.55am Mr Lench was found in his room at 1/28 Pratt Street Ringwood by his carer John Curry. Mr Lench was lying on the floor and was on his side. It was suspected that Mr Lench had suffered a stroke. An ambulance was called and Mr Lench was transported to Box Hill hospital. Prior to this, Mr Lench had been in good health.

   On 6 October 2011 at the Box Hill hospital Mr Lench was seen by Dr Qaiser Niazi. Records indicated that Mr Lench had a background history of hypertension, left eye

blindness, intellectual disability, schizophrenia and type 2 diabetes mellitus. Dr Niazi ordered an urgent brain CT. It indicated that Mr Lench had a Left MCA stroke.

On 9 October 2011, Mr Lench developed respiratory distress. Doctors commenced intravenous antibiotics for aspiration pneumonia. On 11 October 2011 the ICU team were consulted for an opinion on Mr Lench. It was suggested that he may have developed Acute Respiratory Distress Syndrome. He was managed for this on the ward and over the following three to four days showed significant improvement, so much so that he was taken off intravenous antibiotics and put on oral antibiotics.

On 18 October 2011, Mr Lench was assessed by a Rehabilitation physician and was accepted for stroke rehabilitation. High sugar levels were also being treated using Metformin.

On 21 October 2011, Mr Lench was discharged from the Box Hill hospital to the Peter James Centre. On assessment at the Peter James Centre Mr Lench was found to have severe aphasia with little or no verbal output. He had a persistent cough and crackling in both lungs, was incontinent, could only walk approximately 10 metres while aided, required food to be pureed and had tachycardia.

Initially Mr Lench made progress in relation to his rehabilitation. On 30 October 2011, Mr Lench was noted to have deteriorated with a pulse rate of 120 and a respiration rate of 25. He was subsequently transported back to Box Hill hospital on 4 November 2011.

Mr Lench improved over the following days and on 11 November 2011, was transferred back to the Peter James Centre where there was to be further follow up to occur with the Congestive Heart Failure Clinic.

During this visit it was noted that functionally Mr Lench had deteriorated. On 15 November 2011 Mr Lench was obviously more breathless and drowsy. Over the following week Mr Lench continued to deteriorate. On 22 November 2011, it was noted that he had developed Cheyne-Strokes pattern of breathing, continued to have tachycardia and remained hypertensive. Mr Lench's medications were reviewed and altered but he continued to deteriorate.

On 25 November 2011 he was assessed for a second opinion. He was unresponsive to verbal stimuli initially but subsequently opened his eyes. His medication was further rationalised and some medications were ceased. On 30 November 2011, Mr Lench was transferred to Wantirna Health Palliative Care unit.

On 14 December 2011, Mr Lench died at this facility. He was discovered deceased by Nurse Annie Wang. His carer John Curry was with him at the time of his death."

4. An external examination and inspection was performed by Dr Bouwer, Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr Bouwer formulated the cause of death and commented in part in his report:

   The deceased, Brian Lench was a 58 year old man with intellectual disability under the care of DHS. He suffered a left middle cerebral artery stroke which was complicated by aspiration pneumonia, deep vein thrombosis and heart failure. He was initially admitted to Box Hill Hospital, but was transferred to Wantirna Hospital on 30th November for palliative management where he subsequently died on 14th December 2011.

   The external examination was consistent with the clinical findings as reported. There was no evidence of major trauma or injury.

   Post mortem CT scan revealed an enlarged heart, with increased lung markings. There was mild brain atrophy and enlarged dilated lateral ventricles. A left middle cerebral artery territory acute cerebral infarction is present. The left lower lobe is consolidated, consistent with pneumonia.

5. It is apparent that Mr Lench unfortunately died from aspiration pneumonia in the setting of a recent stroke. There was nothing in the investigation to indicate that he received anything other than appropriate medical management in the period leading up to his demise.

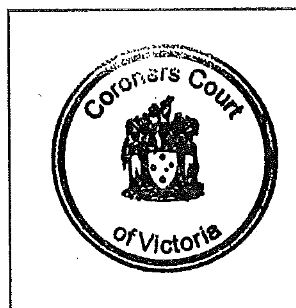
I direct that a copy of this finding be provided to the following:

The family of Mr Lench;

Investigating Member, Victoria Police;

Interested parties.

Signature:



HEATHER SPOONER
CORONER
Date: 18 September 2012