IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 4806

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***
*Amended pursuant to section 76 of the **Coroners Act 2008** on 26 April 2017*

I, JACQUI HAWKINS, Coroner having investigated the death of David John Maynard

without holding an inquest:
find that the identity of the deceased was David John Maynard
born on 17 December 1941
and the death occurred on 10 October 2016
at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3050
from:

1 (a) HOSPITAL ACQUIRED PNEUMONIA COMPLICATING CHRONIC LUNG DISEASE

1. David Maynard was 74 years old at the time of his death. His known past medical history included chronic lung disease, diabetes mellitus, gastro-oesophageal reflux disease (GORD) and delusional disorder.

2. Mr Maynard's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Coroners Act).

3. At the time of his death, Mr Maynard was 'in care' pursuant to section 3 of the Coroners Act. A coroner must hold an inquest if the deceased was, immediately before death, a person placed in care, in accordance with section 52(2)(b) of the Coroners Act. Pursuant to section 52(3A) of

the Coroners Act, I am not required to hold an inquest in these circumstances, if I consider that the death was due to 'natural causes'.

4. In accordance with section 52(3B) of the Coroners Act, a death may be considered to be due to 'natural causes' if the coroner has received a report from a medical investigator, in accordance with the rules, that includes an opinion that the death was due to 'natural causes'. I have received such a report in this case. Therefore, I make my findings with respect to the circumstances and exercise my discretion not to hold a public hearing through an inquest.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame, or determine criminal or civil liability[1].

6. Mr Maynard's daughter, Christa Maynard wrote to the Coroners Court of Victoria and expressed concerns regarding lung surgery her father underwent in the late 1980's. These concerns are outside the scope of the coronial jurisdiction as they are not sufficiently proximate or causally related to Mr Maynard's death.

7. In writing this Finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

Identity

8. David Maynard was visually identified by his daughter, Jane Maynard on 17 October 2016. Identity was not in issue and required no further investigation.

Medical cause of death

9. On 12 October 2016, Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed a medical examination on the body of Mr Maynard and reviewed the post mortem computed tomography (CT) scan and the Form 83 Victoria Police Report of Death.

[1] In the coronial jurisdiction facts must be established on the balance of probabilities 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.

10. Dr Lynch reported the external examination of the body and the findings were consistent with the history.

11. Toxicological analysis of post mortem detected the presence of olanzapine.

12. Dr Lynch provided an opinion that the medical cause of death was 1(a) HOSPITAL ACQUIRED PNEUMONIA COMPLICATING CHRONIC LUNG DISEASE.

13. On the basis of the information available at the time of completing his report, Dr Lynch provided an opinion that Mr Maynard's death was due to natural causes.

Background circumstances

14. On 23 July 2016, Mr Maynard was admitted to the Royal Melbourne Hospital with chest pain on a background of functional decline. On assessment, Mr Maynard was found to be delirious. Investigations attributed the chest pain to GORD and he was commenced on medication. The cause of delirium was attributed to hyponatraemia. Following discussions with Mr Maynard's family and treating team, the decision was made to discharge to residential care.

15. On 1 September 2016, Mr Maynard was discharged to a transitional care program at Royal Melbourne Hospital Royal Park campus. During his stay, Mr Maynard became increasingly paranoid, he was resistive to care and tried to abscond on a number of occasions. Due to the risk of absconding, Mr Maynard was transferred to the secure Geriatric Evaluation and Management (GEM) ward on 26 September 2016. On admission to the GEM ward, he was referred to the aged psychiatry team for review. Mr Maynard was assessed to have an untreated psychotic disorder with chronic psychosis and formal thought disorder. On 29 September 2016, he was transferred to the Aged Person's Mental Health Unit at the Bundoora Extended Care Centre and placed on an Inpatient Assessment Order under the *Mental Health Act 2014*. An Inpatient Temporary Treatment Order was made on 30 September 2016.

16. Mr Maynard's physical health deteriorated during his admission at the Bundoora Extended Care Centre. His presentation was discussed with clinicians at the Royal Melbourne Hospital and he was commenced on antibiotics, however his condition continued to deteriorate and on 3 October 2016, he was transferred back to the Royal Melbourne Hospital for ongoing investigations and treatment. Following chest x-rays, Mr Maynard was commenced on intravenous antibiotics. On 5 October 2016, a CT scan revealed lower lobe consolidation in the right lung consistent with pneumonia and findings in keeping with an infective process. A bronchoscopy was planned for 10 October 2016.

Circumstances in which the death occurred

17. On 10 October 2016 at approximately 8.14am, Mr Maynard was found on the floor next to his bed by nursing staff. He was unresponsive. Mr Maynard was last seen alive and well at approximately 7.30am. A Code Blue was called and staff commenced cardiopulmonary resuscitation (CPR). Mr Maynard could not be revived and he was declared deceased.

Findings

18. Having considered the evidence I am satisfied that no further investigation is required.

19. I am satisfied that the medical care and management of Mr Maynard was reasonable and appropriate in the circumstances.

20. Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

21. I find that:

    a. the identity of the deceased was David John Maynard born 17 December 1941; and

    b. David Maynard died on 10 October 2016 from 1(a) *hospital acquired pneumonia complicating chronic lung disease*;

    c. in the circumstances described above.

22. I wish to express my sincere condolences to Mr Maynard's family. I acknowledge the grief and devastation that you have endured as a result of your loss.

Pursuant to section 73(1B) of the Act I order that this finding be published on the internet in accordance with the rules.

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

The family of Mr Maynard; and

Information recipients.

Signature:

JACQUI HAWKINS
Coroner
Date: 27 March 2017