FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 3715/10

Inquest into the Death of DREW AARON BOALER

Delivered On:	17th June, 2011
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street MELBOURNE 3000
Hearing Dates:	6th June, 2011
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Sergeant David DIMSEY, Police Coronial Support Unit, to assist the Coroner

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Court reference: 3715/10

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner

having investigated the death of:

Details of deceased:

Surname:	BOALER
First name:	DREW
Address:	14 Hillston Road, Moorabbin, Victoria 3189

AND having held an inquest in relation to this death on 6th June, 2011

at Melbourne

find that the identity of the deceased was DREW AARON BOALER born on the 9th July, 1971

and death occurred on the 26th September, 2010

outside 67 Foam Street, Elwood, Victoria 3184

from: 1(a) COMPLICATIONS OF CHRONIC RENAL FAILURE

in the following circumstances:

1. Mr Boaler was a 39 year old resident of a community residential unit managed by the Department of Human Service (DHS) at 14 Hillston Road, Moorabbin, for some 20 years. Before that he had been cared for at home by his mother Mrs Maureen Boaler. Mr Boaler had a past medical history which included severe intellectual disability, epilepsy with complex partial seizures, goitre/hypothyroidism, bi-polar disorder and renal impairment thought to be related to the drug lithium (a mood stabiliser) administered to treat his psychiatric illness.

2. Mr Boaler could not communicate verbally but had some sign language and could communicate. Although never formally diagnosed with autism, he had some autistic traits and regularly attended a day program dedicated to people with autism as this seemed to his carers to be a good "fit" for him. He also had a number of behaviours which were a challenge for those caring for him. At times he would eat to excess, at other times he would refuse to eat. He had to be supervised to ensure he took all his prescription medications. During the last two years or so

preceding his death, he had a tendency to drink excessive amounts of water, sometimes in excess of 20 litres per day requiring drastic measures to be taken, such as the removal of tap handles from the bathroom and locking the kitchen.

3. Treating doctors were somewhat hampered in diagnosing and treating him by his tendency to be unco-operative with medical procedures. Although they could do blood tests, Mr Boaler would not submit to a renal biopsy or renal ultrasound which would have been helpful in diagnosing the nature of his renal impairment. In the absence of such investigations, Mr Boaler's renal impairment was presumed to have arisen from lithium toxicity. They reduced his dose of lithium but could not wean him off it entirely as he became very unsettled and aggressive without it.

4. On the morning of Sunday 26 September 2010, Mr Boaler appeared unusually tired but improved after he had been given his lunch. One of his carers, Mr Biram decided to take him out for a drive, an activity which Mr Boaler usually enjoyed. Prior to leaving, Mr Boaler had taken all his regular medications. He was helped into the back of the mini van by Mr Biram who drove the mini van. They left at about 1:45pm travelling in the direction of St Kilda.

5. While driving along Beach Road, Elwood, Mr Biram could hear Mr Boaler breathing heavily. He pulled over in Foam Street, Elwood, and called "000". While doing so he slid open the door and heard Mr Boaler breathing very heavily before seeing his head slump forward and hearing his breathing apparently stop. Mr Biram checked for vital signs and following the "000" operator's instructions, commenced cardiopulmonary resuscitation (CPR). Ambulance officers arrived shortly thereafter and continued CPR for 30 minutes but could not revive Mr Boaler.

6. Police also arrived a short time later and commenced their investigations of Mr Boaler's death. One of the attending police officers was Constable Lee Doherty from St Kilda Police who compiled the brief of evidence on which this finding is based. The brief includes statements from his general practitioner and a treating neurologist and treating renal physician. Constable Doherty concluded that there were no suspicious circumstances.

7. An autopsy was performed by Forensic Pathologist Dr Shelley Robertson from the Victorian Institute of Forensic Medicine (V.I.F.M.) who reviewed the circumstances as reported by the police. Dr Robertson attributed Mr Boaler's death to *complications of chronic renal failure* and noted *autism, epilepsy and intellectual disability* as contributing factors signifying, as I understand it, that they were significant conditions not directly related to the cause or mechanism of death. Dr Robertson commented in her autopsy report that *"The precise cause of the renal failure had not been ascertained according to his medical records however, it may have been related to the multi-drug therapy he was receiving for his underlying conditions."*

8. Toxicological analysis of postmortem samples revealed traces of chlorpromazine (a phenothiazine tranquilizer used to treat psychosis, marketed as "Largactil") and olanzapine (used for mood stabilization and as an anti-manic drug, marketed as "Zyprexa") and carbamazepine (an anti-convulsant used to treat epilepsy and some types of neuralgia, marked as "Tegretol", "Teril" and "Carbamazepine Sandoz") at a level consistent with normal therapeutic use.

9. Based on the totality of the material before me, including Mrs Maureen Boaler's indication during the inquest that her son was never formally diagnosed with autism, I make no finding as to autism. I find that Mr Boaler died from the *complications of chronic renal failure* but am unable to find to the required standard of proof, the antecedent cause or causes of his chronic renal failure. As to any indirectly contributing factors, I note the presumption made by treating doctors that the renal failure was caused by long term lithium administered to treat his psychiatric illness. Based on their statements, I find that long term lithium therapy was an indirect contributing factor which should be noted as such in the formulation of the cause of death.

9. As Mr Boaler was a person placed in care immediately before he died,[1] his death was reportable to the coroner irrespective of the cause of death, and an inquest is mandated as part of the coronial investigation of his death.[2] In this respect, the *Coroners Act 2008*, recognises the vulnerability of those in the care of the State by ensuring that there is always a level of coronial scrutiny of the care they received, at least insofar as it may have caused or contributed to the death. Based on the totality of the material before me, I find no evidence of any want of care on the part of the staff of DHS and no want of clinical management on the part of any treating medical practitioners, which may have caused or contributed to Mr Boaler's death.

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 17th June, 2011

1 See definition of "person placed in custody or care" in section 3 of the *Coroners Act 2008* which includes, relevantly, - *"a person who is under the control, care or custody of the Secretary to the Department of Human Services".*

2 Section 52(2)(b) of the Act.