IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 3814

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: GEORG BRAUMULLER

Delivered On:	5 May 2014
Delivered At:	Coroners Court of Victoria
	Level 11, 222 Exhibition Street
	Melbourne 3000
Hearing Date:	5 May 2014
Finding Of:	AUDREY JAMIESON, CORONER
Police Coronial Support Unit	Sergeant Sharon Wade

I, AUDREY JAMIESON, Coroner having investigated the death of **GEORG MANFRED BRAUMULLER**

AND having held an inquest in relation to this death on 5 May 2014

at MELBOURNE

find that the identity of the deceased was **GEORG MANFRED BRAUMULLER**

born on 12 September 1970

and the death occurred on 9 September 2012

at The Alfred Hospital, 55 Commercial Road, Prahran 3181

from:

1 (a) PNEUMONIA

1 (b) LENNOX GASTAUT SYNDROME

in the following circumstances:

1. On 5 May 2014, a mandatory inquest under section 52(2)(b) of the *Coroners Act 2008* (Vic) (the Act) was held into the death of Mr Georg Manfred Braumuller, because immediately before his death, Mr Braumuller was "a person placed in....care" as it is defined in the Act. Mr Braumuller had an intellectual disability and had been a client of the Department of Human Services Disability Services for most of his life.

BACKGROUND AND CIRCUMSTANCES

2. Mr Braumuller was 41 years of age at the time of his death. He lived at a residential care facility operated by the Department of Human Services (DHS) for people with intellectual disabilities located at 11 Gordon Street, Bentleigh (the residence). Mr Braumuller had lived at the residence for over ten years and in other residential care facilities since a young age.

3. Ms Braumuller had a past medical history that included Lennox Gastaut Syndrome (childhood onset epilepsy), had significant physical disabilities and was confined to a wheelchair. His health had fluctuated over the two years prior to his death, and he had experienced a number of chest infections.

4. On 7 September 2012, Mr Braumuller attended the East Bentleigh Medical Centre (EBMC) with a carer and was seen by General Practitioner Dr Hla Hla Wai, who observed a

temperature of 39.3 degrees Celsius and a "chesty" cough. Dr Wai diagnosed a respiratory tract infection and prescribed antibiotic medication. A plan was made for Dr Wai to review Mr Braumuller in one week.

5. On 8 September 2012, Mr Braumuller's condition worsened to the extent that a transfer to the Alfred Hospital via ambulance was necessary. Admitting doctors diagnosed Mr Braumuller with pneumonia and informed family members that his condition was considered critical. After consultation with Mr Braumuller's family, a decision was made to provide him with palliative care.

6. Mr Braumuller died at the Alfred Hospital on 9 September 2012. His death was reported to the Coroners Court of Victoria by the residence on 11 September 2012.

FORENSIC PATHOLOGIST EXAMINATION AND EVIDENCE

7. Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination, reviewed a post mortem CT scan and reviewed the Victorian Police Report of Death, Form 83. Anatomical findings included increased lung markings consistent with pneumonia. Dr Burke ascribed the cause of Mr Braumuller's death to pneumonia in the setting of Lennox Gastaut Syndrome.

POLICE INVESTIGATION

8. The circumstances of Mr Braumuller's death have been the subject of investigation by Victoria Police. Police obtained statements from Mr Braumuller's brother-in-law, Mr Andrew Ayers, Dr Wai and a staff member of the residence.

FACTORS CAUSING OR CONTRIBUTING TO DEATH

9. The evidence supports a conclusion that Mr Braumuller died on 9 September 2012 and that the cause of his death was pneumonia in the setting of Lennox Gastaut Syndrome in a severely disabled man with a history of chest infections. The circumstances under which Mr Braumuller died were, according to the pathologist, consistent with Mr Braumuller's relevant past medical history. There was no evidence to suggest any other cause or contribution to his death. Mr Braumuller died from natural causes related to his underlying physical disabilities and the development of pneumonia.

COMMENTS

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

1. In all the circumstances, I am satisfied that there would be no benefit from conducting a full inquest into Mr Braumuller'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 Mr Braumuller's death which resulted from natural causes in the context of his underlying physical disability and development of pneumonia.

2. I note that the Alfred Hospital failed to report Mr Braumuller's death to the Court. This matter is a reminder to all health care facilities of the importance of medical personnel being informed of their obligations to report "reportable" deaths[1] (including deaths of "a person placed in....care" at the time of their death) to the Coroners Court of Victoria. Failure to report a reportable death has direct and at times irreparable consequences on coronial investigations, including the possible loss of opportunity to examine the body in order to inform the Coroner of a medical cause of death.

FINDING

I accept and adopt the medical cause of death as ascribed by Dr Michael Burke and I find that Georg Manfred Braumuller died from natural causes being pneumonia in the setting of Lennox Gastaut Syndrome.

AND I further find that there is no relationship between the cause of Mr Braumuller's death and the fact that he 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:

Mr Andrew Ayres

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[1] A death is a "reportable death" if the body is in Victoria, or the death occurred in Victoria, or the cause of death occurred in Victoria or the person ordinarily resided in Victoria at the time of death and the death appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury, or a death that occurs during a medical procedure o or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death, or a person who was immediately placed in custody or care immediately before death (see section 4 of the *Coroners Act 2008* (Vic) for the full definition).

Dr Hla Hla Wai

Mr Shane Beaumont, Department of Human Services – Disability Service

The Alfred Hospital

Senior Constable J O'Hara

Signature:

AUDREY JAMIESON
CORONER
Date: **5 May 2014**