FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 1079/11

Inquest into the Death of JOHN THREADGOLD

Delivered On:	26th October, 2011
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne Victoria 3000
Hearing Dates:	26th October, 2011
Findings of:	CORONER KIM M W PARKINSON
Place of death/ Suspected death:	Bendigo
Police Coronial Support Unit (PCSU):	Leading Senior Constable King Taylor

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FINDING INTO DEATH WITH INQUEST

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

Court reference: 1079/11

In the Coroners Court of Victoria at Melbourne

I, KIM PARKINSON, Coroner

having investigated the death of:

Details of deceased:

Surname:	THREADGOLD
First name:	JOHN
Address:	6/122 Stradbroke Avenue, Swan Hill, Victoria 3585

AND having held an inquest in relation to this death on 26th October, 2011
at Melbourne

find that the identity of the deceased was JOHN THREADGOLD
and death occurred on or about

at Bendigo & Northern District Hospital, Lucan Street, Bendigo, Victoria 3552

from
1a. CARDIO PULMONARY ARREST
1b. RESPIRATORY FAILURE
1c. CHRONIC OBSTRUCTIVE AIRWAYS DISEASE
2. ALCOHOL ABUSE

In the following circumstances:

1. Mr Threadgold was born on 10 May, 1955 and was 55 years of age at the time of his death. He had an extensive psychiatric history and had been diagnosed with schizo-effective disorder and substance dependency. He had a medical history of chronic obstructive airways disease (COAD), aortic calcification, substance abuse acquired brain injury, anaemia and arthritis.

2. Mr Threadgold was a person in care as defined by s3(d) of the **Coroners Act 2008** ("the Act") and accordingly his death was reportable pursuant to s5(c) of that Act. An inquest into his death is mandatory pursuant to s52(2)(b) of the Act. Despite the mandatory requirement that this case be reported to the coroner, no report was made at the time of Mr Threadgold's death. On 18 March 2011, a report was made by the Executive Director of Psychiatric Services Bendigo Health. Dr Tune provided the coroner with a copy of a report made by the treating psychiatric registrar, Dr Uday Kolur, dated 27 August 2010. I have relied upon this report in the inquest proceedings.

3. As a consequence of the death not being reported, no examination was undertaken by a forensic pathologist.

4. Dr Kolur reported that Mr Threadgold had a significant psychiatric history; diagnosed with schizo-effective disorder with poly substance dependence and abuse issues. He had been an in-patient on three occasions before his last admission. (April 03, June 03 & May 09).

5. Mr Threadgold had been treated with numerous anti psychotic and anti depressive medications in the past as well as refusing to engage with drug and alcohol services. He also suffered from several chronic medical conditions including emphysema/chronic obstructive airway disease (COAD), arthritis, aortic calcification, substance abuse related acquired brain injury and anaemia.

6. On 9 July 2010, he was referred to local psychiatric services by a member from the Swan Hill Police Station and he was assessed at home on 13 July 2010. As a result of that assessment he was admitted to the Bendigo Hospital Psychiatric Service as an involuntary patient under the Mental Health Act.

7. He was noted to have an elevated mood, increased energy levels, he was demanding and abusive, uninhibited, had increased speech with racing thoughts, grandiose delusions, a decreased need for sleep and poor self care. It was noted that these symptoms had been present over the previous month and these behaviours were noted in a setting of poly substance abuse along with gambling problems.

8. Mr Threadgold was also assessed medically on 14 July 2010, regarding his physical health issues. He was treated with multivitamins, iron supplements, antibiotics, bronchodilators, antipsychotic and mood stabilising medication as well as alcohol detoxification and nicotine replacement therapy.

9. His mental state improved gradually over the course of the admission and on 2 August 2010 he was transferred to the Prevention and Recovery Care (PARC) Unit. PARC services are described as intermediary units sitting between adult acute psychiatric in patient units and

discharge to the patient's usual residents. They provide for clinical treatment and short term residential support.

10. On 3 August 2010, Mr Threadgold's status as an involuntary patient was upheld by the Mental Health Review Board.

11. Whilst in PARC Mr Threadgold smoked heavily, which exacerbated his breathlessness. On 5 August 2010, he was examined by the psychiatric registrar who directed further blood investigations, increased dose of bronchodilators and recommencement of antibiotics.

12. On 6 August 2010, Mr Threadgold was transferred from PARC back to the Bendigo Hospital Emergency Department as his symptoms of breathlessness increased. Mr Threadgold was diagnosed with possible acute myocardial infarction on a background of an exacerbation of his COAD. His prognosis was poor and his family were notified. In view of the poor prognosis he was recorded as not for resuscitation. Mr Threadgold died on 7 August 2010.

13. The cause of death recorded by the medical officer on the death certificate was cardio pulmonary arrest, respiratory failure and chronic obstructive airways disease in the setting of alcohol abuse. Despite there being no autopsy or examination by a pathologist for the coroner, there is no evidence to suggest that the cause of death as indicated is anything other than accurate.

14. Having considered the available evidence, I am satisfied that Mr Threadgold died from natural causes. I find that Mr John Threadgold died on 7 August 2010 and that the cause of his death was Cardio Pulmonary Arrest, Respiratory Failure and Chronic Obstructive Airways Disease in the setting of Alcohol Abuse.

Signature:

Kim M W Parkinson
Coroner

26th October, 2011