IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 4554

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, PETER WHITE, Coroner having investigated the death of KELVIN STANLEY MARGETTS without holding an inquest:
find that the identity of the deceased was KELVIN STANLEY MARGETTS
born on 25 February 1952
and the death occurred on 7 September 2015
at the Dandenong Hospital, 135 David Street, Dandenong, Victoria
from:

1 (a) BOWEL OBSTRUCTION

Pursuant to section 67(1) of the *Coroners Act 2008* I make findings with respect to the following circumstances:

1. Kelvin Stanley Margetts was a 63 year old man who lived in a Department of Human Services run group home at 1196 Heatherton Road, Noble Park. He suffered from a severe intellectual disability and was non-communicative. He was a quadriplegic and suffered blindness in his right eye.
2. Mr Margetts is survived by his mother and two brothers however it appears that his family had not seen him for about seven years. He had been cared for by Disability Support Officer Carol Taylor since 1999.
3. Mr Margetts was treated by Dr Martin Hartnett of the Eastbrook Family Clinic. Dr Hartnett would attend the group home when required. He last saw Mr Margetts in July 2015 when he attended to perform Mr Margett's annual physical examination. No issues were identified.
4. On 5 September 2015, Ms Taylor noticed that Mr Margetts had a phlegmy cough and seemed to be experiencing difficulties eating his meal. The next morning, she observed that he was still having breathing difficulties and she contacted the locum doctor. The locum doctor attended and noted that Mr Margetts had low blood pressure, had breathing

difficulties and had a hard stomach. The doctor administered Microlax for constipation and advised Ms Taylor to call an ambulance if his breathing did not improve or he did not open his bowels. Ms Taylor called an ambulance after the doctor had left and he was conveyed to the Dandenong Hospital.

5. On admission, he was diagnosed with a blockage of the bowel. He was clinically hypoxic with tachycardia and marked respiratory distress. Blood investigations were consistent with advanced sepsis. A CT of his abdomen revealed markedly distended loops of bowel with impending perforation. Given his clinical condition, the decision was made not to escalate treatment. Mr Margetts passed away on 7 September 2015 at 2.45am.
6. As Mr Margetts was a resident of a Department of Health and Human Services run facility, his death was reportable under section 4(2)(c) of the *Coroners Act 2008* (the Act).
7. Senior Pathologist Dr Michael Burke of the Victorian Institute of Forensic Medicine performed a post mortem medical inspection. Dr Burke provided me with a report of his findings. The post mortem CT scan confirmed bowel obstruction and showed a hiatus hernia. Dr Burke concluded that the cause of Mr Margetts' death was 1(a) bowel obstruction. I adopt Dr Burke's findings in relation to the cause of death.
8. As part of my investigation, Constable Jessica Hill provided me with a coronial brief of evidence (the brief). The brief contains statements from Ms Taylor, Dr Hartnett and Constable Hill. I have relied on the totality of the material before me in setting out this finding.
9. As Mr Margett's death was due to natural causes, pursuant to section 52(3A) of the Act, I was not required to hold an inquest.
10. On the material before me, I am satisfied that Mr Margett was well cared for by Ms Taylor at the group home. There were no issues identified through the course of the investigation.

Pursuant to section 73(1B) of the *Coroners Act 2008* I order that this finding be published on the internet.

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

Mr Margett's family

Shane Beaumont, Department of Health and Human Services

Constable Jessica Hill

Signature:

PETER WHITE
CORONER
Date: **12 May 2016**