IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2015 0296

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of MICHAEL ROBERT FAULKS without holding an inquest:

find that the identity of the deceased was MICHAEL ROBERT FAULKS

born on 12 May 1951

and the death occurred on 18 January 2015

at 8 Evelyn Court Wangaratta Victoria 3677

from:

1 (a) COMPLICATIONS OF HEPATIC CIRRHOSIS IN A MAN WITH MULTIPLE COMORBIDITIES

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

1. Mr Michael Faulks was 63 years of age at the time of his death. He lived in a residential care facility at 8 Evelyn Court Wangaratta.

2. Mr Faulks had a history of physical illnesses and intellectual disability, cirrhosis, hypertension, left nephrectomy[1], atrial fibrillation, ischaemic heart disease, hepatitis B, deep vein thrombosis and a previous intracranial haemorrhage due to a fall. He required regular medication and constant medical attention.

3. Between July 2014 and January 2015, Mr Faulks health had been deteriorating, to the point where he could no longer leave his bed. In December 2015, the Palliative Care Team at the

[1] Nephrectomy is removal of the kidney

Wangaratta Hospital became involved with his care. On 18 January 2015, Mr Faulks' breathing became shallow, he became unresponsive and his condition worsened. At 5.08pm, Mr Faulks died peacefully, in the presence of one of his carers Jacqueline Serong. Emergency services were called and Mr Faulk was declared deceased at 5.30pm.

INVESTIGATIONS

Forensic pathology investigation

4. Dr Joanna Glengarry, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination on the body of Mr Faulks, post mortem CT scan, referred to medical records and the Victoria Police Report of Death, Form 83.

5. Dr Glengarry noted that the CT scan showed ascites[2] and a small nodular liver. There were increased lung markings suggestive of bronchopneumonia. The external examination showed no evidence of an injury of a type likely to have caused death.

6. On the evidence available to her, Dr Glengarry reported to the Coroner that the cause of Mr Faulks' death was complications of hepatic cirrhosis in a man with multiple comorbities. She was of the opinion that the death was due to natural causes.

COMMENTS

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

1. Mr Faulks' death was reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) ('the Act') because he was immediately before death a person placed in care, as defined by section 3 of the Act. Section 52 of the Act mandates the holding of an Inquest, save for circumstances where the person is deemed to have died from natural causes, pursuant to section 52(3A). In these circumstances, I have exercised my discretion pursuant to section 52(3A) not to hold an inquest into Mr Faulk's death.

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[2] Ascites is the accumulation of fluid in the peritoneal cavity, causing abdominal swelling.

1. FINDINGS

On the evidence available to me, I find that Michael Robert Faulks died of natural causes.

I accept and adopt the medical cause of death as identified by Dr Joanna Glengarry and find that Michael Robert Faulks who had multiple comorbidities died of complications of hepatic cirrhosis.

And I further find that there is no relationship between the cause of Mr Faulks' death and the fact he was a person placed in care.

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:

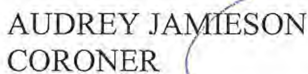
Mr Ronald Faulks

Dr Abm Hassanuzzaman

Ms Kym Peake, Department of Health and Human Services

First Constable Sarah Edwards

Signature:



AUDREY JAMIESON
CORONER

Date: **14 June 2016**