IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 001227

FINDING INTO DEATH WITH INQUEST

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

Inquest into the death of PAUL KOLEMBUS

Delivered on:	11 July 2014
Delivered at:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne, Victoria
Hearing dates:	11 July 2014
Findings of:	Coroner Paresa Antoniadis SPANOS
Assisting the Coroner:	Ms Erica Capuzza, Coroner's Solicitor.

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of PAUL KOLEMBUS
and having held an inquest in relation to this death on 11 July 2014
in the Coroners Court of Victoria at Melbourne

find that the identity of the deceased was PAUL KOLEMBUS
born on 24 June 1981
and that the death occurred on 22 March 2013
at Wantirna Health, 251 Mountain Highway, Wantirna, Victoria 3152

from:

I (a) COMPLICATIONS OF ACUTE PANCREATITIS.

in the following circumstances:

1. Mr Kolembus was a 32-year-old man who was born to parents Marija Selymesi and Frank Kolembus. He had two older brothers, David and Bryan.
2. Mr Kolembus had a history of cerebral palsy, profound intellectual disability, spastic quadriplegia, visual impairment, scoliosis and epilepsy. He used a wheelchair and required staff support for all aspects of his life. He had resided at Polaris House, a Department of Human Services (DHS) residential care facility, from about age 10. His regular general practitioner (GP) was Dr Peter Elliott.
3. According to staff at Polaris House, Mr Kolembus seemed happy, and although he was unable to speak, he was able to communicate with staff by making sounds and facial expressions.
4. From August 2012, Mr Kolembus' health deteriorated due to recurrent gall stone pancreatitis. He was admitted to the Box Hill Hospital on 20 August 2012 with vomiting and lethargy. Tests revealed pancreatitis and Mr Kolembus was treated and discharged home on 24 August 2012, with his fluid and food intake being monitored.
5. On 20 September 2012, Mr Kolembus was admitted to the Box Hill Hospital with symptoms of pancreatitis. He had been experiencing abdominal pain and was having difficulty tolerating oral intake. It was determined that he should undergo a cholecystectomy or surgical removal of the gallbladder.
6. Surgery was planned for 11 October 2012, however a laparoscopic approach was unsuccessful due to multiple adhesions, and the surgeons considered that an open approach was not possible due to complications and risks related to Mr Kolembus' physical deformities and the location of the gall bladder.

7. Mr Kolembus remained in the intensive care unit (ICU), and a less invasive procedure was attempted, an endoscopic retrograde cholangiopancreatography (ERCP). This was also unsuccessful due to Mr Kolembus' distorted anatomy. He was returned to the ICU where he recovered well, before transfer to the ward where he was monitored and tolerated his usual oral intake. Mr Kolembus was discharged to Polaris House on 15 October 2012, a determination having been made that he was not for surgical intervention.

8. In consultation with hospital clinicians, Dr Elliott, Ms Selymesi and DHS staff, planning was commenced for longer-term palliative care in the event of further recurrences of pancreatitis. Mr Kolembus' family continued to visit him regularly, and consulted with Dr Elliott and the residential care facility staff. Dr Elliott visited Mr Kolembus weekly, as did an Eastern Health palliative care nurse.

9. Mr Kolembus' condition continued to deteriorate. On 19 March 2013, he was transferred to Wantirna Health, a palliative care facility, as planned. There he received medical care and rested comfortably, and Ms Selymesi stayed with him until his death on 22 March 2013 at 12.20am. As was appropriate, Mr Kolembus' death was reported to the Coroner.

10. Apart from a jurisdictional nexus with the State of Victoria, reportable deaths are, generally, deaths that appeared to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury. However, some deaths are reportable irrespective of the nature of the death, based on the status of the person immediately before their death. Mr Kolembus' death was reportable as he was a person under the control, care or custody of the Secretary to the DHS.[1] This is one of the ways in which the *Coroners Act 2008* recognises that people in the control, care or custody of the State are vulnerable, and affords them the protection of the independent scrutiny and accountability of a coronial investigation.

11. Another protection is the statutory requirement for mandatory inquests. While there is a discretionary power to hold an inquest in relation to any death a coroner is investigating,[2] this was a mandatory or statutorily prescribed inquest as Mr Kolembus was, immediately before death, a person placed in custody or care.[3]

12. This finding draws on the totality of the material the product of the coronial investigation of Mr Kolembus' death, contained in the inquest brief compiled by Senior Constable Rodney Church. All this material, together with the inquest transcript, will remain on the coronial file.

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[1] See section 3 for the definition of a "person placed in custody or care" and section 4(2)(c) of the definition of "reportable death".

[2] Section 52(1) provides that a coroner may hold an inquest into any death that the coroner is investigating.

[3] Section 52(2) and the definition of "person placed in custody or care" in section 3, in particular paragraph (d) thereof – "a person under the control, care or custody of the Secretary to the Department of Human Services.

In writing this finding, I do not purport to summarise all evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

13. Mr Kolembus' identity, the date, place and medical cause of death were never at issue. I find, as a matter of formality, that Paul Kolembus born on 24 June 1981, aged 32, late of 8 Polaris Drive, Doncaster East Victoria 3109, died at Wantirna Health, 251 Mountain Highway, Wantirna, Victoria 3152 on 22 March 2013.

14. Nor was the medical cause of death contentious. No autopsy was performed, as Senior Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (VIFM), conducted an external examination of Mr Kolembus' body in the mortuary, reviewed his medical records and the police report of death to the coroner, and provided a written report of his findings. Dr Burke concluded that it would be reasonable to attribute Mr Kolembus' death to *complications of acute pancreatitis*, without the need for autopsy. Dr Burke commented that the post mortem CT scan showed a small right haemothorax, and that there was no apparent free gas within the abdomen. He noted that the external examination was consistent with the clinical history of severe cerebral palsy.

15. The focus of the coronial investigation of Mr Kolembus' death was on the adequacy of clinical management and care provided to him in relation to the last months of his life. No concerns about clinical management and care were stated in the initial police report of Mr Kolembus' death to the Coroner.[4]

16. In her statement to police on 12 August 2013, Ms Selymesi expressed concerns that the second surgery at the Box Hill Hospital might have contributed to Mr Kolembus' death, and that treating clinicians should have taken more care.

17. I sought an additional statement from DHS regarding Mr Kolembus' overall care plan, including details of the first and second attempted procedures to deal with his acute pancreatitis.

18. An additional statement was obtained by Mr David Keating, Disability Accommodation Services Operations Manager, Inner Eastern Division of DHS. Mr Keating's statement verified the supports in place for Mr Kolembus, and explained that in about August 2012, it became apparent that Mr Kolembus' health was deteriorating significantly. Hence the decision to begin end of life planning, in anticipation that palliative care was envisaged in the near future.

19. I find that Mr Kolembus died from complications of acute pancreatitis.

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[4] Victoria Police Form 83 dated 22 March 2013.

20. The evidence before me reflects a high level of care provided to Mr Kolembus while resident at Polaris House, with timely and appropriate access to medical treatment for his terminal illness, and appropriate involvement of Mr Kolembus' mother in decision-making and palliative care.
21. The available evidence does not support a finding that there was any want of clinical management and care on the part of the staff of the residential facility or the medical and nursing staff of the Box Hill Hospital or Wantirna Health, or that any such want of clinical management or care caused or contributed to his death.

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

Ms Marija Selymesi

Dr Yvette Kozielski, Medico-Legal Officer, Eastern Health

Mr David Keating, Disability Accommodation Services Operations Manager, Inner Eastern Division, Department of Human Services

Ms Katie Haire, Deputy Secretary, Community and Executive Services Group, Department of Human Services

Senior Constable Rodney Church, Croydon Police Station.

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 11 July 2014