IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2014 4715

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 SIMON MARK EVERILL

without holding an inquest:
find that the identity of the deceased was SIMON MARK EVERILL
born 20 May 1959
and the death occurred on 14 September 2014
at Maroondah Hospital, Davey Drive, Ringwood East Victoria 3135
from:

1 (a) COMPLICATIONS OF RIGHT MIDDLE CEREBRAL ARTERY INFARCTION

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

1. Simon Mark Everill was 55 years of age at the time of his death. Mr Everill had five sisters and resided in Mount Evelyn at accommodation managed by Wesley Mission Victoria. He had been living in supported government accommodation since the age of 11 years. Mr Everill had a medical history including epilepsy, intellectual disability, hypertension and type 2 diabetes mellitus treated with insulin. His regular medications included *inter alia* simvastatin, olanzapine, sodium valproate, lamotrigine and metformin.

2. On 3 September 2014, Mr Everill fell twice while out on a field trip, and initially appeared to be fine. However, after Mr Everill's return home, his condition deteriorated; he appeared to be drowsy and a locum General Practitioner was called at 5.04pm. Following the consultation,

ambulance paramedics attended and subsequently transported Mr Everill to the Maroondah Hospital, arriving at 10.24pm.

3. Mr Everill was admitted to Maroondah Hospital with an altered conscious state. Upon examination on 4 September 2014, Mr Everill was persistently drowsy with a Glascow Coma Scale[1] score of nine. A computed tomography (CT) scan of Mr Everill's brain identified an evolving right middle cerebral artery infarction. Mr Everill had dense left hemiplegia[2] and his condition did not significantly improve during his admission. Following discussion with Mr Everill's family, he was transitioned to palliative care and was declared deceased at 9.20pm on 14 September 2014.

INVESTIGATIONS

Forensic pathology investigation

4. Dr Yeliena Baber, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination upon the body of Mr Everill, reviewed a post mortem CT scan and e-medical deposition form from Maroondah Hospital, and referred to the Victoria Police Report of Death, Form 83. Dr Baber noted that the external examination showed findings consistent with the clinical history, and the post mortem CT scan identified a large right middle cerebral artery infarction.

5. On the evidence available to her, Dr Baber ascribed the cause of Mr Everill's death to complications of right middle cerebral artery infarction. Dr Baber opined that Mr Everill's death resulted from natural causes.

Police investigation

6. The circumstances of Mr Everill's death have been the subject of investigation by Victoria Police on my behalf. Police obtained statements from Mr Everill's sister Caroline O'Neill, General Practitioner at Mount Evelyn Medical Surgery Dr Niraj Desai, Connecting Communities Eastern staff members Adam Craig, Melinda Gravenall, Tracy-Ann Williams, Fred Tsao, residential Disability Support Worker Linda Willoughby, Residential Co-ordinator for Wesley Mission Victoria, Eastern region Efthimia Tseres, Locum General Practitioner Dr

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[1] The Glascow Coma Scale is a quick, practical standardised system for assessing the degree of conscious impairment in the critically ill and for predicting the duration and ultimate outcome of coma, primarily in patients with head injuries. The scale is now measured out of 15, with 15/15 being the best possible score.

[2] Paralysis of the left side of the body.

Andre Mostert, Ambulance Victoria paramedic Chloe Bell and Maroondah Hospital physician Dr Ronak Moolchandani.

7. Ms O'Neill stated that her brother had lived at home until he was 11 years old, when their mother had been unable to cope with his challenging behavioural issues. Ms O'Neill stated that while her brother had been difficult to manage, he settled down considerably as an adult with his carers. She added that Mr Everill had been looked after by well-trained carers, who were completely professional in their care of him.

8. Mr Everill's regular General Practitioner Dr Desai stated that he was a very regular clinic patient and that his seizures and blood sugar levels were difficult to control. Mr Everill's last visit to the clinic had been on 1 September 2014, regarding a chest infection, a fall in his room with no head injury, and fluctuating blood sugar levels. Mr Everill had been away from day service activities for two weeks due to ill health and at this appointment, he was cleared to go back to day service activities.

9. On 3 September 2014, Mr Everill participated in activities provided Wesley Mission's Connecting Communities Eastern day service. Statements provided by the Connecting Communities eastern staff members identified that the group had stopped at a supermarket, to purchase food for a barbeque planned at the Upper Yarra Reservoir. Mr Everill tripped outside the supermarket and fell on to his knees, but did not hit his head. He stood up, expressed to staff that he was fine and completed the shopping. At morning tea, staff treated Mr Everill's grazed knees and rang the co-ordinator Adam Craig to tell them about his fall.

10. Staff took Mr Everill's blood sugar levels a number of times throughout the day, including at morning tea and again at lunch. Disability Support Worker Tracy-Ann Williams noted that his blood sugar levels before lunch had been lower than usual (around 5mmol/L).

11. During lunch, at approximately 12.15pm, Mr Everill had a second fall, where he slipped off a picnic bench seat. Staff member Melinda Gravenall observed the fall and stated that Mr Everill did not hit his head. Staff checked if Mr Everill was feeling alright and he replied 'yes, yes'. Ms Williams reported that they thought the problem was Mr Everill's diabetes at this point and tried to get him to eat and increase his blood sugar levels.

12. On the bus trip back to the day service's Croydon offices, Ms Gravenall noticed that Mr Everill was quieter than usual, and asked a colleague sitting nearer to him to check he was okay. The colleague replied that Mr Everill was fine. As everyone alighted from the bus, Ms Gravenall noted that Mr Everill was still sitting at the back of the bus. She observed that he was unable to

hold his drink bottle properly, and sought the assistance of a colleague. Mr Everill said he was 'good' and 'okay', but Ms Gravenall noted that his face was changing colour and his words were becoming more difficult to understand.

13. Mr Craig stated that Mr Everill presented that afternoon as if he had experienced a small seizure; his eyes were glazed over and his mouth was drooping on the left hand side. Mr Craig added that this was how Mr Everill would usually look when he came out of a seizure. Mr Everill was assisted indoors and Mr Craig explained the situation to Linda Willoughby, a disability support worker from his residential facility who had come to pick him up. Ms Willoughby stated that Mr Everill had looked very tired, as if he had experienced an epileptic seizure. Mr Everill was quite cheery, smiling and talking, but appeared weak, so it was decided he would be taken home and monitored.

14. Ms Willoughby drove Mr Everill home and they arrived at 3.45pm. Mr Everill indicated he wanted to lay down, and was assisted into bed. Approximately 10 minutes later, Ms Willoughby noticed that Mr Everill was sitting up in his room, and she brought him a cup of tea. She noticed he was initially unable to use his left hand, but then moved it. Ms Willoughby contacted the residential co-ordinator Efthimia Tseres, who advised her to call a locum doctor. The call was made at 5.04pm and locum Dr Andre Mostert arrived at approximately 8.10pm. Dr Mostert stated that he believed Mr Everill's condition was possibly due to an epileptic seizure but this was not clear. He did not suspect a stroke at this time. Dr Mostert stated that he recommended calling an urgent ambulance immediately, to transport Mr Everill to the nearest hospital. However, Ms Willoughby stated that Dr Mostert advised her to call an ambulance within an hour, and there was no urgency.

15. Ms Willougby informed Ms Tseres that an ambulance would be required, and Ms Tseres decided to meet Mr Everill at Maroondah Hospital. Aware that Mr Everill became agitated in hospital environments, Ms Willoughby waited approximately half an hour to call the ambulance, so that Ms Tseres would have time to get to the hospital.

16. Ambulance paramedics arrived at 9.24pm and checked Mr Everill's blood sugar levels, which were low at 2.7mmol/L. Mr Everill became very agitated and required sedation. Ambulance paramedics transported Mr Everill to Maroondah Hospital, arriving at 10.24pm. At this time, Mr Everill's speech was slurred.

COMMENTS

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

1. Mr Everill's 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 Mr Everill's circumstances, it is therefore appropriate to conclude the investigation by an in-chambers Finding.

FINDINGS

The evidence available to me suggests that Mr Everill was diligently, professionally and appropriately cared for by Wesley Mission Victoria staff on 3 September 2014. I note the time delay between Mr Everill's possible stroke, contacting the General Practitioner, and the arrival of the locum. I also note the delay between the locum's assessment and the calling of an ambulance, possibly due to a breakdown of communication between staff in regards to urgency. However, on the balance of probabilities I find that these delays are unlikely to have altered the outcome of the natural stroke event. Having regard to Mr Everill's history of falls and epileptic seizures with similar symptoms, I find it is explicable that staff did not identify his condition as urgent.

I accept and adopt the medical cause of death as identified by Dr Yeliena Baber and find that Simon Mark Everill died from complications of right middle cerebral artery infarction.

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:

Ms Caroline O'Neill

Dr Yvette Kozielski, Medico-Legal Officer, Eastern Health

Ms Kym Peake, Secretary of the Department of Health and Human Services

Mr Victor Harcourt, Russell Kennedy Lawyers on behalf of Wesley Mission Victoria

Senior Constable Peter Keane

Signature:

AUDREY JAMIESON
CORONER

Date: **7 June 2016**