IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 004166

FINDING INTO DEATH WITHOUT INQUEST

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

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of STEVEN JOHN BROWN

without holding an inquest:

find that the identity of the deceased was STEVEN JOHN BROWN

born on 7 October 1959

and that the death occurred on 15 August 2014

at Maroondah Hospital, Davey Drive, Ringwood East, Victoria 3135
from:

I (a) ASPIRATION PNEUMONIA IN A MAN WITH CEREBRAL PALSY & EPILEPSY & RECENT PEG INSERTION

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

1. Mr Brown was a 54-year-old man who had a medical history that included cerebral palsy, epilepsy, intellectual disability, visual impairment and recurrent aspiration pneumonia secondary to his inability to swallow effectively. He was unable to speak or mobilise without a manual wheelchair. Mr Brown was cared for at home by his mother until 1997 when, due to the high level of care he required, he moved to Leena Court in Warranwood operated under the auspices of the Department of Human Services [DHS].

2. Mr Brown's medical needs were coordinated by his general practitioner, Dr Moraes, who developed a range of care plans administered by the Leena Court staff, to maximize his health and wellbeing. Mr Brown required the assistance of one or two disability support workers with many aspects of daily living, especially in the morning, during mealtimes and to administer medications.

3. Mr Brown was visited at least three times each week by his mother who remained involved in all aspects of his life. Mr Brown participated in some day programs or outings – he particularly enjoyed bowling and being outside – and helped out with domestic tasks at Leena Court.

4. Between April and August 2014, Mr Brown experienced respiratory infections and aspiration pneumonia and bronchopneumonia, on some occasions requiring hospitalization. He was reviewed by Dr Moraes and referred to a speech pathologist, but his condition continued to decline and he became malnourished.

5. On 1 August 2014, Mr Brown was admitted to Maroondah Hospital with a seven-day history of vomiting, drowsiness and symptoms suggestive of respiratory infection. Following diagnostic testing and review by a speech pathologist and dietician, he was diagnosed with severe oropharyngeal dysphagia, inflammation and malnutrition. He was commenced on intravenous antibiotics and fluids were commenced.

6. Following a discussion between Mr Brown's treatment team and his family, the assistance of the gastroenterology service was sought with a view to the insertion of a percutaneous endoscopic gastrostomy [PEG] tube as a palliative measure to alleviate hunger and provide a route through which to administer medications. On 14 August 2014, the PEG tube insertion surgery was performed and PEG feeding commenced. Mr Brown became agitated, most likely due to post-operative pain, and so subcutaneous analgesia was administered and a mitten restraint applied due to the high risk that he may pull out the PEG tube.

7. On 15 August 2014, a Code Blue medical emergency was called when Mr Brown was found to be hypotensive with an unrecordable blood pressure and in respiratory distress. After a discussion with his mother, Mr Brown was not transferred to the intensive care unit but continued to be managed in the general ward. When later the same day, Mr Brown developed cardiorespiratory arrest, pursuant to his mother's wishes, he was not resuscitated and died at 8.50am.

8. Given that Mr Brown's family was strongly opposed to an autopsy, Forensic Pathologist, Dr Joanna Glengarry of the Victorian Institute of Forensic Medicine [VIFM] conducted an external examination of the body, considered the circumstances of the death as reported by police to the coroner, reviewed available medical records and post-mortem computerised tomography [PMCT] scans and provided a written report of her findings.

9. Dr Glengarry observed a mild, patchy increase in lung markings consistent with aspiration pneumonia and wide-spread free air within the abdominal cavity (of unknown cause) on post-mortem CT scans. The PEG tube was not in situ during the external examination and so its contribution to Mr Brown's death, if any, could not be determined. In the absence of an autopsy, Dr Glengarry concluded that it was reasonable to attribute Mr Brown's death to aspiration pneumonia in a man with cerebral palsy and epilepsy and recent PEG insertion.

10. At the time of his death, Mr Brown was a "person placed in custody or care" as defined in section 3[1] of the *Coroners Act* 2008 [the Act] because he was in the care of the Department of Human Services immediately before his death.

11. Mr Brown's designation as a "person placed in custody or care" is significant. This is because the Act recognizes that people in the control, care or custody of the State are vulnerable and therefore, irrespective of the nature of the death, requires it to be reported to the Coroner and so subject to the independent scrutiny and accountability of a coronial investigation.

12. As an additional protection, until the insertion of section 52(3A) into the Act in November 2014, all deaths of people placed in custody or care required a mandatory inquest. Now, the Coroner is no longer required to hold an inquest if satisfied that the death was due to natural causes but must publish Findings made concerning natural causes deaths of people in custody or care.[2] Of course, the Act preserves a discretionary power to hold an inquest in relation to any death a coroner is investigating.[3]

13. I find that Mr Brown, late of 10 Leena Court in Warranwood, died at Maroondah Hospital in Ringwood East on 15 August 2014 of aspiration pneumonia secondary to cerebral palsy, epilepsy and recent PEG insertion. Relying on the advice provided by Dr Glengarry, I am satisfied that Mr Brown's death was due to natural causes. The available evidence does not support a finding either that there was any want of care on the part of DHS or the staff of Leena Court that caused or contributed to Mr Brown's death, or that any want of clinical management or care on the part of the staff of Maroondah Hospital, caused or contributed to his death.

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

Ms Brown

Eastern Health

Constable M Milovanovic (#38331), Ringwood Police Station

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: **16 September 2015**

Coroners Court of Victoria

[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 73(1B).
[3] Section 52(1) provides that a coroner may hold an inquest into any death that the coroner is investigating.