IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 1400

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: WALTER LEONARD COLYER

Delivered On:	28 June 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000 Victoria
Hearing Date:	14 June 2013
Findings of:	AUDREY JAMIESON, CORONER
Police Coronial Support Unit	Leading Senior Constable John Kennedy, assisting the Coroner

I, AUDREY JAMIESON, Coroner having investigated the death of **WALTER LEONARD COLYER**

AND having held an inquest in relation to this death on 14 June 2013

AT MELBOURNE

find that the identity of the deceased was **WALTER LEONARD COLYER**

born on 2 June 1948

and that the death occurred on 19 April 2012

at 25 Kirby Street, Reservoir 3073

from:

1 (a) ISCHAEMIC HEART DISEASE AND AORTIC STENOSIS

in the following circumstances:

1. On 14 June 2013, a mandatory inquest under section 52(2)(b) *Coroners Act 2008* (the Act) was held into the death of Mr Walter Colyer, because immediately before his death, Mr Colyer was "a person placed in ... care" as it is defined in the Act. Mr Colyer had an intellectual disability and had been a client of the Department of Human Services Disability Services for most of his life. Leading Senior Constable J. Kennedy assisting the Coroner read the summary prepared for the coronial brief and confirmed that no issues had been identified by the investigating member in respect of the cause of death of Mr Colyer or his care arrangements. No witnesses were called to give evidence.

BACKGROUND AND CIRCUMSTANCES

2. Mr Colyer was 63 years of age at the time of his death. He lived in Plenty Residential Services, Bundoora after the closure of the Janefield Training Centre. He had good verbal communication skills, was a smoker despite repeated unsuccessful efforts to give up, and had

a number of medical conditions including aortic stenosis, osteoporosis and epilepsy which were well-managed with medication. Mr Colyer's health was regularly overseen by his general practitioner, Dr L Kabat. He last saw her for a medication review on 20 March 2012. He also saw cardiologist Dr R Chan for review of his heart condition on 21 March 2012, who intended a further review in six months "following echocardiogram to quantitate severity of his valvular disease".

3. On 19 April 2012, Mr Colyer visited his sister Glennis Bertram. He was fine during the morning and walking to Northland shopping centre for lunch with her and his nephew. On return to Ms Bertram's home at approximately 3.00 pm, Mr Colyer sat on the couch to have a cigarette. He suddenly slumped in his seat. Ms Bertram went to her brother's aid, laid him on the floor of the lounge room and contacted Emergency Services requesting an ambulance. Whilst on the phone, Ms Bertram was advised to perform cardiopulmonary resuscitation (CPR). Ambulance paramedics and Mobile Intensive Care Ambulance (MICA) paramedics arrived soon after and continued with resuscitation attempts. They were however unable to revive Mr Colyer and he was declared deceased at Ms Bertram's home.

FORENSIC PATHOLOGIST EXAMINATION AND EVIDENCE

4. Dr Michael Burke, Forensic Pathologist at Victorian Institute of Forensic Medicine, performed an autopsy on the body of Mr Colyer. Dr Burke reported that the post mortem examination showed significant underlying heart disease. The heart was moderately enlarged and the coronary arteries had at least 80-90% stenosis. The valve cusps were thickened and there was fusion of the valves resulting in a significant degree of stenosis. Histology of heart sections showed hypertrophied myocardial fibres and myocardial fibrosis, and histology of the coronary artery confirmed stenosis by atheromatous plaques. Microscopic examination of the remaining tissue selected post-mortem confirmed the gross findings and did not demonstrate any further significant pathological change.

5. In certifying the cause of death as ischaemic heart disease and aortic stenosis, Dr Burke commented that there were no prior symptoms before Mr Colyer's collapse while visiting his sister and no evidence of any injury that would have contributed to the death. He went on to explain:

"The post mortem examination showed significant underlying heart disease. The heart was enlarged and there were areas of fibrosis and associated coronary artery atherosclerosis. There was significant aortic stenosis.

Individuals with an enlarged heart, myocardial fibrosis and aortic stenosis are at risk of sudden death from a cardiac arrhythmia (heart attack)....

Sudden death is well recognised in individuals with significant aortic stenosis with cardiomegaly."

6. Toxicology analysis found no evidence of alcohol and the two prescription medications identified were within or below the accepted therapeutic ranges.

FACTORS CAUSING AND CONTRIBUTING TO DEATH

7. The evidence supports a conclusion that Mr Colyer died on 19 March 2012 and that the cause of his death was ischaemic heart disease and aortic stenosis. Mr Colyer had a history of aortic stenosis, which was being treated by his cardiologist Dr Chan. The circumstances under which Mr Colyer suddenly died were, according to the pathologist, well recognised in individuals such as Mr Colyer, given his history of heart disease. There was no evidence to suggest any other cause or contribution to his death. His sister Ms Bertram, did all she could to assist him, and the attendance of ambulance and MICA paramedics was prompt, but they were unable to revive Mr Colyer despite their best efforts. Mr Colyer died from natural causes related to his underlying heart conditions.

COMMENTS

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

1. In all the circumstances, I am satisfied that there would be no benefit derived from conducting a full inquest into Mr Colyer's death or obtaining any further medical or other evidence, as neither would assist me to further understand the medical issues before me or the cause of Mr Colyer's death which resulted from natural causes in the context of his underlying heart issues.

FINDING

I accept and adopt the medical cause of death as ascribed by Dr Burke and I find that Walter Leonard Colyer died from natural causes being ischaemic heart disease and aortic stenosis.

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

Pursuant to section 73(1) 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:

Mrs Carol Bradbury

Ms Glennis Bertram

Department of Human Services - Disability Services

Ms Anne-Marie Halewood, Department of Human Services, Disability Accommodation Services Manager – Outer North

Constable D Paisley, Reservoir Police, Investigating member

Signature:

AUDREY JAMIESON
Coroner
Date: 28 June 2013