IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 002221

# FINDING INTO DEATH WITH INQUEST

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

## Inquest into the death of WILLIAM MORRISON NUNAN

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| Delivered on: | 14 October 2014 |
| Delivered at: | Coroners Court of Victoria<br>65 Kavanagh Street<br>Southbank Victoria 3006 |
| Hearing dates: | 14 October 2014 |
| Findings of: | Coroner Paresa Antoniadis SPANOS |
| Assisting the Coroner: | Leading Senior Constable Amanda Maybury, Police Coronial Support Unit. |

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of WILLIAM MORRISON NUNAN
and having held an inquest in relation to this death on 14 October 2014
in the Coroners Court of Victoria at Melbourne

find that the identity of the deceased was WILLIAM MORRISON NUNAN
born on 18 August 1935
and that the death occurred on 3 May 2014
at the Caritas Christi Hospice, 104 Studley Park Road, Kew, Victoria 3101

**from:**

I (a) URINARY TRACT INFECTION IN A MAN WITH DEMENTIA AND EPILEPSY

**in the following circumstances:**

1. Mr Nunan was a 78-year-old man who, at the time of his death, was a palliative care patient at Caritas Christi Hospice [the Hospice] at the above address. Mr Nunan had been admitted to the Hospice on I March 2014 for end of life care because his general health had deteriorated rapidly over the preceding four months, and to such an extent that he could no longer be appropriately cared for at the Disability Accommodation Services group home at which he ordinarily lived.
2. Mr Nunan had an intellectual disability and suffered from intractable epilepsy throughout his life. He was cared for by his family, at home, until he was 18 years old. Due to the nature of his disability, Mr Nunan had little formal education and limited communication skills.
3. Upon reaching adulthood, Mr Nunan's support needs could no longer be met by his family and so he became a registered client of the Department of Human Services, Disability Services [DHS].
4. Under the auspices of DHS Disability Accommodation Services, Mr Nunan was admitted to the Caloola Training Centre in Sunbury in 1953 where he resided until the facility closed in 1992. Mr Nunan lived at a group home in Glen Waverley between 1992 and 2012 and at another group home in Mount Waverley, from January 2012 until March 2014 when he was admitted to the Hospice.
5. With advancing age, Mr Nunan's health declined. He suffered from chronic urinary retention and urinary tract infections and so a long-term supra-pubic catheter was inserted in 2007 to manage these conditions. Mr Nunan's urinary tract issues exacerbated his epilepsy. In 2010, Mr Nunan was diagnosed with dementia and, following a fractured hip sustained in a fall in

2011 and the subsequent development of osteoarthritis, his mobility was restricted. He became reliant on a wheelchair for mobility within the group home and out in the community, and required the staff assistance and a hoist for transfers to and from his wheelchair.

6. Mr Nunan's medical care was monitored and co-ordinated by his general practitioner. Mr Nunan consulted his doctor at her clinic or at the group home depending on his health needs at particular times. In addition, Mr Nunan's overall health was reviewed annually, most recently on 13 February 2013.[1] Mr Nunan's medical team included a neurologist, dementia assessment and support, speech and occupational therapists, a urologist, district nurses, as well as other specialist staff (some providing training to group home staff) as required.

7. Throughout 2013, group home staff observed that Mr Nunan's physical health was deteriorating. In particular, Mr Nunan was becoming less able to assist during transfers to and from his wheelchair; was less talkative and responsive to others; was at greater risk of aspiration due to a reduction in his swallowing reflex; and the incidence of epileptic seizures requiring hospitalization, urinary tract infections and aspiration pneumonia were becoming more frequent.

8. In September 2013, Mr Nunan's surviving sisters, Patricia Nunan and Nola Curran, were appointed as his joint Medical Guardians.

9. In December 2013, a case conference occurred between Mr Nunan's general practitioner, his Medical Guardians and Disability Services Accommodation staff during which a plan to address Mr Nunan's current and future medical needs was developed. The plan addressed the management of chronic and emergent medical symptoms, and pain.

10. Mr Nunan's general health continued to deteriorate rapidly in early 2014 largely due to his decreasing ability to tolerate nourishment by mouth. His general practitioner's assessment on 28 February 2014 was that his needs could no longer be appropriately addressed at the group home, and arrangements were made for Mr Nunan to be admitted to the Hospice.

11. Mr Nunan was assessed by the admitting medical officer at the Hospice as presenting with a reduced consciousness state, poor respiratory effort and noisy upper respiratory sounds. The medical officer formed the view that Mr Nunan required end of life care in the context of advanced dementia, refractory seizures, and recently reduced consciousness state, verbal responses and oral intake. Mr Nunan's end of life care plan was for the administration of medications to manage seizures, pain and other symptoms as required, along with regular mouth care and ongoing supportive care. The palliative care medical team and a multi-

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[1] Mr Nunan's 2014 annual review was scheduled in March but did not occur because, by that time, he had been admitted to the Hospice.

disciplinary health care team, which incorporated social and pastoral care workers, regularly reviewed Mr Nunan's condition.

12. Throughout March and April 2014, Mr Nunan became increasingly drowsy and had only minimal oral intake; however, the Clonazepam administered to him was effective in eliminating seizure activity and he appeared to be comfortable.

13. On or about 28 April 2014, Mr Nunan appeared to be experiencing some abdominal discomfort. After a medical review, it was determined that Mr Nunan had developed a urinary tract infection, and so antibiotics were commenced and his suprapubic catheter was changed. In the following days, Mr Nunan appeared comfortable although he had minimal oral intake and minimal urine output.

14. On 3 May 2014, Mr Nunan's condition deteriorated rapidly during lunchtime and he died peacefully at about 1pm with nursing staff at his bedside. The medical officer on-call at the Hospice confirmed his death shortly thereafter.

15. 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 death. Mr Nunan's death was reportable as he was a *person placed in custody or care*[2] of the Secretary to the DHS. 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.

16. Another protection is the requirement for mandatory inquests. While there is a discretionary power to hold an inquest in relation to any death a coroner is investigating,[3] this was a mandatory or statutorily prescribed inquest as Mr Nunan was, immediately before death, a person placed in custody or care.[4]

17. This finding draws on the totality of the material the product of the coronial investigation of Mr Nunan's death, contained in the inquest brief compiled by Senior Constable Keith Grimley of the Camberwell Police Station. All this material, together with the inquest transcript, will remain on the coronial file. 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.

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[2] 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".

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

[4] Section 52(2) and the definition of "person placed in custody or care" in section 3.

18. Mr Nunan's identity, the date and place of death were never at issue. I find, as a matter of formality, that William Morrison Nunan born on 18 August 1935, aged 78, late of XXX GROUP HOME ADDRESS PLS, died at Caritas Christi Hospice, 104 Studley Park Road, Kew, Victoria 3101 on 3 May 2014.

19. Nor was the medical cause of death contentious. No autopsy was performed, as Forensic Pathologist Dr Lee of the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination of Mr Nunan's body in the mortuary, reviewed his medical records and the police report of death to the coroner, and provided a written report of her findings. Dr Lee concluded that it would be reasonable to attribute Mr Nunan's death to *urinary tract infection in a man with dementia and epilepsy*, without the need for autopsy. Dr Lee noted no suspicious circumstances and that Mr Nunan's death was due to natural causes.

20. Post mortem toxicology testing of blood revealed the presence of 7-aminoclonazepam at ~0.3mg/L and Clonazepam at ~0.04mg/L, consistent with therapeutic administration.

21. The focus of the coronial investigation of Mr Nunan's death was on the adequacy of clinical management and care provided to him to the last months of his life. No concerns about clinical management and care were stated in the initial police report of Mr Nunan's death to the Coroner.[5] Nonetheless, I requested that statements be provided by Mr Nunan's treating doctors and the manager of his usual residence prior to his admission to the Hospice.

22. Based on the evidence before me, I am satisfied that the health care provided to Mr Nunan during his residence at the group home and later at the Hospice, was appropriate and consistent with the care delivered in the Victorian public health care system. The evidence does not support a finding that there was any want of case or clinical management and care on the part of residential, medical and nursing staff at either Mr Nunan's group home or the Hospice, or that any such want of clinical management or care caused or contributed to his death.

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[5] Victoria Police Form 83 dated 4 August 2013.

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

Ms Patricia Nunan

Ms Nola Curran

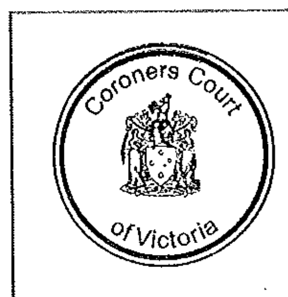
Corporate Counsel, Caritas Christi Hospice

Mr Kevin Lowe, Disability Accommodation Services, Department of Human Services

Dr Judith Riseley, Waverley General Practice

Senior Constable Keith Grimley, Camberwell Police Station

Signature:




**PARESA ANTONIADIS SPANOS**
CORONER
Date: 16 October 2014