IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 4969

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**WILLIAM IAN DAVENPORT**
Date of birth:	28 June 1969
Date of death:	28 September 2017
Cause of death:	1(a) PULMONARY FIBROSIS ASSOCIATED WITH SCOLIOSIS
Place of death:	240 Beechworth Road, Wodonga, Victoria

HER HONOUR:

Background

1. William Ian Davenport was born on 28 June 1969. He was 48 years old when he died on 28 September 2017 from natural causes.

2. Mr Davenport lived in Wodonga in shared accommodation managed by the Department of Health and Human Services (**DHHS**). He saw his mother regularly and looked forward to spending time with her. Mr Davenport enjoyed repairing stereo speakers as well as all things Star Wars related.

3. Mr Davenport was born with a rare chromosomal abnormality, Trisomy 4p. He experienced symptoms associated with this disorder including moderate intellectual disability, scoliosis, and behavioural problems. He had multiple health issues including anxiety and heart problems. He was diagnosed with anxiety, hypothyroidism, urinary incontinence, cellulitis, and lipodermatosclerosis in his legs. A family history of heart disease and diabetes was noted. Mr Davenport also experienced dysphasia, balance issues, hay fever, obesity, short-sightedness, spasticity, hypertonia, hand tremors, and telangiectasia.

4. Mr Davenport received regular medical care from General Practitioners at the Albury-Wodonga Family Medical Centre.

5. On 15 September 2017, Mr Davenport was reviewed by Dr Haresh Kumar, as he had had a moist productive cough for two or three days. He was prescribed antibiotics and scheduled for review in a few days' time.

6. On 18 September 2017, Mr Davenport returned with the same carer, who thought he seemed slightly better. Dr Kumar agreed that clinically he appeared somewhat better, but Mr Davenport still had persistent crepitations in the chest.

7. On 21 September 2018, Mr Davenport attended his doctor to review blood test results. Dr Kumar described the results as not especially concerning. They showed his C-reactive protein was very slightly raised, which was considered consistent with his recurrent illness. His platelets were stable but low, which was thought to be a side effect of the prescribed medication, sodium valproate. His white blood cell count and thyroid function were normal and sodium valproate levels were within therapeutic range. Mr Davenport still had course

crepitations in the chest, so was prescribed alternative antibiotics and a chest x-ray was arranged.

8. On 26 September 2017, Mr Davenport attended the medical centre in relation to urinary and loose stool incontinence and saw Dr Angela Bruce. She believed that his chest was better and noted on examination there was no respiratory distress, no crepitation, no recession and he wasn't using accessory muscles. He had normal air entry and no rhonchi. Dr Bruce planned to review Mr Davenport the following week.

9. On the morning of 27 September 2017, Mr Davenport was seen at the Albury-Wodonga Health Emergency Department in relation to an unwitnessed fall he had had overnight. The attending doctor found no injuries and his carers did not notice behavioural changes following the fall.

The coronial investigation

10. Mr Davenport's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

11. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[1]

12. Mr Davenport's death was reportable not only because it was unexpected but also because he was in the care of the State at the time of his death. Deaths of persons in the care of the State are reportable to ensure independent scrutiny of the circumstances surrounding their deaths. If such deaths occur as a result of natural causes a coronial investigation must take place but the holding of an inquest is not mandatory.

13. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

14. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

15. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Davenport's death. The Coroner's Investigator investigated the matter on my behalf and submitted a coronial brief of evidence.

16. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation (including by the holding of an inquest) was not required.

17. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Identity of the deceased

18. Mr Davenport was visually identified by his carer, Adele Chung, on 28 September 2017. Identity was not in issue and required no further investigation.

Medical cause of death

19. On 5 October 2017, Dr Michael Burke, Senior Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy upon of Mr Davenport's body and reviewed a post mortem computed tomography (CT) scan.

20. No acute pneumonia was seen at autopsy. The autopsy revealed pulmonary fibrosis and fat embolism and chronic inflammation. There was myocardial interstitial fibrosis and a florid acute prostatitis.

21. Mr Davenport had significant pulmonary fibrosis. Toxicological examination showed markedly raised C-reactive protein (inflammatory marker) of 186.7 (normal less than 5mg/L). Mr Davenport also had acute prostatic inflammation which may have resulted in systemic sepsis given the raised C-reactive protein. The microscopy and culture of the swab showed the presence of Enterobacter aerogenes. Dr Burke commented that these three

factors may well have culminated in Mr Davenport suffering a sudden cardiac arrhythmia causing his death.

22. Toxicological analysis of post mortem specimens taken from Mr Davenport identified valproic acid,[2] paroxetine,[3] chlorpromazine,[4] and quetiapine.[5]

23. Dr Burke concluded that there was no evidence to suggest Mr Davenport's death was due to anything other than natural causes.

24. After reviewing toxicology results, Dr Burke completed a report, dated 23 November 2017, in which he formulated the cause of death as "*1(a) Pulmonary fibrosis associated with scoliosis*". I accept Dr Burke's opinion as to the medical cause of death.

Circumstances in which the death occurred

25. At about 1:00pm on 28 September 2017, Mr Davenport's mother arrived to collect her son in accordance with their typical weekly routine., Mr Davenport was heavily asleep in a chair but *'sprung to life'* when his mother woke him.

26. Mr Davenport and his mother went about their usual activities for the afternoon. She thought he appeared well and did not notice anything unusual.

27. At about 6:00pm, Mr Davenport was collected by a carer and taken back to his home.

28. At approximately 7:50pm, two carers assisted Mr Davenport from the kitchen table to the bathroom. After, as they were readying him for bed, they noticed that his breathing was faltering.

29. At 8:08pm, they telephoned emergency services. On the instruction of the call operator, they placed Mr Davenport on the ground and performed cardiopulmonary resuscitation until paramedics arrived.

30. At 8:20pm, Ambulance Victoria Paramedics arrived. Sadly, Mr Davenport could not be revived, and his death was confirmed at 8:55pm.

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[2] Valproic acid (as sodium valproate) is a carboxylic acid used therapeutically as an anti-convulsant, treatment for manic depression or in some instances for neurogenic pain.
[3] Paroxetine is used clinically as an anti-depressant.
[4] Chlorpromazine is used in the treatment of psychotic disorders.
[5] Quetiapine is an antipsychotic drug used in the treatment of schizophrenia.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was William Ian Davenport, born 28 June 1969;

(b) Mr Davenport died on 28 September 2017 at 240 Beechworth Road, Wodonga, Victoria, from pulmonary fibrosis associated with scoliosis;

(c) his death was the consequences of natural causes; and

(d) the death occurred in the circumstances described above.

I convey my sincere condolences to Mr Davenport's mother and extended family.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet in accordance with the rules.

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

Cheryl Bartold, Senior Next of Kin

Senior Constable Matthew Higgs, Coroner's Investigator, Victoria Police

Signature:

ROSEMARY CARLIN
CORONER
Date: 2 July 2019