IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 4581

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: GRANT WHITE

Finding Of:	AUDREY JAMIESON, CORONER
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank 3006
Distributed On:	14 October 2019
Hearing Date:	14 October 2019
Police Coronial Support Unit:	Leading Senior Constable Ross Treverton

CONTENTS

I, AUDREY JAMIESON, Coroner having investigated the death of GRANT WHITE

And having held an inquest in relation to this death on 14 October 2019

at MELBOURNE

find that the identity of the deceased was GRANT WHITE

born on 1 September 1952

and the death occurred on 11 September 2017

at 14 Hotham Street, Preston, Victoria 3072

from:

1 (a) CARDIOMEGALY

in the following summary of circumstances:

1. At the time of his death, Grant White was 65 years of age and resided in Preston House: Department of Health and Human Services (**DHHS**) supported accommodation. Mr White had a complex medical history which included heart disease, paranoid schizophrenia and an intellectual disability. His sister Kay and brother Lindsay lived interstate.

2. At approximately 7.15am on 11 September 2017, a Preston House staff member checked on Mr White in his bedroom; he was in bed and alive. About 30 minutes later, the staff member returned to Mr White's bedroom. Mr White was lying on top of his bed in a slumped position and was unresponsive.

3. The staff member contacted the on-duty Disability Development and Support Officer who attended Mr White and was unable to detect a pulse. Emergency services were notified, and staff moved Mr White to the floor to commence cardiopulmonary resuscitation (**CPR**), as instructed. Ambulance Victoria paramedics attended and declared Mr White deceased.

4. Victoria Police members attended Preston House to make initial enquiries and commence an investigation into Mr. White's death. Police Officers noted a small amount of blood in Mr White's mouth, which appeared to have come from a small cut to his bottom lip. There were no other visible signs of injury.

BACKGROUND CIRCUMSTANCES

5. Mr White had a significant medical history that included diastolic murmur, paranoid schizophrenia, epilepsy, chronic obstructive pulmonary disease, pulmonary hypertension, moderately severe mitral regurgitation, mitral valve prolapse (2001), atrial fibrillation, heart failure (2015), transient ischaemic attack (2016), dysphagia, recurrent falls, recurrent epistaxis and iron deficiency anaemia (March 2017).

6. Mr White also had an intellectual disability which was the result of contracting meningitis as a young boy. After contracting meningitis, he would often run away from home and be found sniffing petrol.

7. As Mr White grew older, he became increasingly violent, especially towards his mother, and he was ultimately unable to remain at home. He was placed at the Caloola Mental Health Facility in Sunbury, a facility for people with intellectual and/or physical disabilities.

8. In 1992, Mr White moved into DHHS supported accommodation, Preston House.

9. During the last 12 months of his life, Mr White was treated for a number of specific medical concerns, including heart conditions. Cardiologist Dr John Brennan reviewed Mr White biannually. Mr White's General Practitioner Dr Huyen Le also saw him on a regular basis.

10. On 25 January 2017, Dr Brennan diagnosed Mr White with moderately severe mitral valve regurgitation.

11. On 8 August 2017, Dr Brennan reviewed Mr White. On examination he was found to have '*scattered coarse wheezes in the chest with a loud apical pansystolic murmur*'.[1] Mr White said he did not suffer shortness of breath at that time. An ECG was conducted and showed atrial fibrillation with T-wave changes consistent with left ventricular strain.

12. Dr Brennan did not think Mr White was an ideal candidate for mitral valve replacement given his intellectual disability and other comorbidities. Dr Brennan also noted that Mr White smoked cigarettes which increased the operative risks. Dr Brennan wrote a letter to Dr Le, advising him of the outcome of the review. Dr Brennan indicated that Mr White's heart rate seemed to be well controlled with his current medication. He wrote that spironolactone[2] could be added to Mr White's prescribed medication, if he were to develop any fluid retention.

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[1] Coronial Brief, *Letter of Dr J. Brennan to Dr H. Le*, dated 8 August 2017 p 27.

[2] Spironolactone is known as a "water pill" or a potassium sparing diuretic. It is used to treat heart failure and liver disease by reducing excess fluid build-up (oedema) and improving certain symptoms, such as breathing issues.

13. On 31 August 2017, Dr Le reviewed Mr White for multiple medical issues at the request of DHHS staff. Dr Le noted that Mr White's chest was clear on auscultation. He was clinically stable with chronic low blood pressure readings and bilateral lower leg oedema. Dr Le prescribed Mr White spironolactone pursuant to Dr Brennan's suggestion.

14. On 4 September 2017, Mr. White presented at the Emergency Department (**ED**) of the Austin Hospital complaining of pain to the upper abdomen and chest. His chest x-ray, electrocardiogram and troponin[3] level was reported as normal. His haemoglobin was low (6.5g/decilitre).[4] Mr White was given an iron infusion and discharged home after the second troponin test was negative. This was Mr White's third iron infusion in 2017, the first being in May.

15. On 6 September 2017, Dr Le conducted a medical review of Mr White, who presented as clinically well with no specific complaints. Dr Le noted that Mr. White was still waiting for an appointment with the chest pain clinic as referred by the Austin ED in June 2017. He recommended another review of Mr White with repeat haemoglobin and iron studies within two weeks. Dr Le also reviewed the specific Health Management Plans for Mr White's fluid retention, heart condition, low iron and nose bleeds. Mr. White's heart condition and fluid retention plans indicated that he would need to be reviewed by Dr Le earlier than scheduled if he presented with the following symptoms:

    a. Increased lethargy, shortness of breath, fluid retention (and)

    b. Swelling particularly in the legs and head.

16. Dr Le noted:

    (If) *'Grant is experiencing facial swelling/lower legs (particularly in the morning) Grant should be reviewed by his GP', and to 'call an ambulance for serious health concerns.'*

17. On 9 September 2017, Preston House staff made a progress note which stated:

    'to-day Grant appears to have some fluid retention and has appeared with occasional laboured breathing - not alarming. Grant states he's ok. No pain. He's presently

[3] Troponins are a group of proteins found in skeletal and heart (cardiac) muscle fibres that regulate muscular contraction. Troponin tests measure the level of cardiac-specific troponin in the blood to help detect heart injury.

[4] Hemoglobin is a protein in your red blood cells that carries oxygen to your body's organs and tissues and transports carbon dioxide from your organs and tissues back to your lungs. A normal hemoglobin range for men is 13.5 to 17.5 grams per decilitre.

relaxing on the couch and dozing on and off. If staff is concerned about his well-being seek medical treatment.'

18. Dr Le was not informed of Mr White's symptoms and no medical review was sought from a GP in relation to the same.

JURISDICTION

19. Immediately before his death, Mr White was 'in care' pursuant to section 3 of the *Coroners Act 2008* (Vic) [the Act]. A death which occurs in these circumstances is reportable to the Coroner.[5]

20. Section 52(2)(b) of the Act mandates the holding of an inquest into a death if the death or cause of death occurred in Victoria and the deceased person was, immediately before death, a person placed in care. A Coroner is not required to hold an inquest into a death which occurred in the circumstances set out above if they consider that the death was due to natural causes.[6]

PURPOSE OF A CORONIAL INVESTIGATION

21. The Coroners Court of Victoria is an inquisitorial jurisdiction.[7] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[8] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[9]

22. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of

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[5] *Coroners Act 2008* (Vic) s 4.

[6] Ibid s 52(3A).

[7] Ibid s 89(4).

[8] Ibid s 67(1).

[9] This is the effect of the authorities – see for example Harmsworth v The State Coroner [1989] VR 989; Clancy v West (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

recommendations by Coroners, generally referred to as the 'prevention' role.[10] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[11] These are effectively the vehicles by which the prevention role may be advanced.[12] It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

STANDARD OF PROOF

23. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*.[13] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

- the nature and consequence of the facts to be proved;
- the seriousness of an allegation made;
- the inherent unlikelihood of the occurrence alleged;
- the gravity of the consequences flowing from an adverse finding; and
- if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

[10] The 'prevention' role is now explicitly articulated in the Preamble and Purposes of the Act, in contrast to the Coroners Act 1985 where this role was generally accepted as 'implicit'.

[11] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[12] See also sections 73(1) and 72(5) of the Act which requires publication of coronial findings, comments, recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[13] (1938) 60 CLR 336.

24. The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

INVESTIGATIONS PRECEDING THE INQUEST

Identification

25. On 11 September 2017, DHHS Disability Accommodation Services (**DAS**) Manager Ondine Stachnowki completed a Statement of Identification for Grant White, who was born on 9 September 1952.

26. Identity is not in dispute and required no further investigation.

Medical Cause of Death

27. Dr Paul Bedford, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), performed an autopsy upon the body of Grant White, reviewed a post mortem computed tomography (**CT**) scan, and referred to the Victoria Police Report of Death, Form 83.

28. Dr Bedford reported that post mortem examination confirmed Mr White had an enlarged heart (cardiomegaly) and heart disease. There was no evidence of coronary artery disease. Dr Bedford commented that an enlarged heart predisposes an individual to abnormal and potentially fatal heart rhythms. He stated that Mr White had a diseased liver with multiple benign fibrovascular tumour nodules. These did not cause any haemorrhage or necrosis and were not associated with cirrhosis. Toxicological analysis of Mr White's post mortem blood detected haloperidol (~0.008 mg/L).[14]

29. Dr Bedford ascribed the medical cause of Mr White's death to cardiomegaly.

Conduct of my Investigation

30. The investigation and the preparation of the Coronial Brief was undertaken by Leading Senior Constable (LSC) Ross Treverton from the Police Coronial Support Unit (**PCSU**) on my behalf.

[14] Haloperidol is a butyrophenone derivative used therapeutically as an anti-psychotic agent.

Further Investigation

31. Upon review of the available evidence, I instructed LSC Treverton to obtain further statements from Mr White's General Practitioner Dr Huyen Le and Cardiologist Dr John Brennan. I requested that the medical practitioners address Mr White's presentation and symptoms on 9 September 2017.

32. Dr Brennan stated that Mr White had very severe mitral regurgitation but the addition of spironolactone to his prescribed medications may have resulted in some improvement of his condition on 9 September 2017; '*and he may have survived a little longer*'.[15]

33. Dr Le responded to my request, detailing his most recent consultations with Mr White. He stated that spironolactone had, in fact, already been prescribed to Mr White, pursuant to Dr Brennan's suggestion in a letter dated 8 August 2017.

34. Dr Le stated that he believed regular, permanent DHHS staff at Preston House were well informed of Mr White's cardiac and respiratory conditions. Dr Le said that he expected Preston House staff to request a medical review as soon as possible if certain symptoms arose, as they had done in the past. Dr Le stated that, had he been contacted in relation to Mr White's symptoms on 9 September 2017, he would have advised taking Mr White to a hospital emergency department for assessment, as it was the weekend. Dr Le said that Mr White likely required higher level management given his near maximum combination of diuretics and cardiac medications.

Directions Hearing

35. On 18 April 2019, interested parties were formally notified of my intention to hold a Directions Hearing in this matter. I informed the interested parties that, after reviewing the available evidence, I had identified that Mr White was a person placed 'in care' at Preston House at the time of his death, pursuant to section 3 of the Act. I also indicated that my Investigation had identified a failure to escalate Mr White's care when he presented with specific symptoms on 9 September 2017. The interested parties were provided with a copy of the coronial brief.

36. On 14 May 2019, a Directions Hearing was held and LSC Treverton appeared to assist me. LSC Treverton read a summary of Mr White's relevant background information, medical history and the circumstances of his death. My assistant submitted that the Investigation into

[15] Coronial Brief, *Statement of Dr John Brennan*, dated 29 August 2018, p 24.

the death of Grant White may need to progress to a formal Inquest, unless appropriate concessions were made by interested parties.

37. I reiterated my concerns about the failure of Preston House staff to appropriately escalate Mr White's care when he presented with specific symptoms on 9 September 2017. My concerns related to systemic issues that may be apparent in the circumstances of Mr White's death, including:

    a. the training provided to DAS staff to enable them to recognise deterioration in a resident's physical health and follow the recommendations of a resident's treating medical professionals, and

    b. the management of residents' medical needs, including the way in which such needs are documented and monitored by DAS staff.

38. I invited DHHS to address me in relation to concessions on these points, as well as any preventative or restorative measures implemented since Mr White's death.

39. I noted that the National Insurance Disability Scheme (**NDIS**) marked changes in the provision of disability services to Victorians with disabilities. Specifically, the majority of DAS houses were soon to be managed by organisations other than DHHS and funded by the NDIS. The legal representative for DHHS Ms M. Wilson informed me that Preston House was transitioning out of the Department's management. Ms Wilson helpfully supplied that the shifting landscape may have an effect on future coronial recommendations and offered to request further information from her client in order to assist the Court.

40. The Department requested, and was granted, leave for further time to review the coronial brief and to provide a statement to the Court, addressing my concerns. I indicated that this matter may proceed to a Summary Inquest, without the need to call witnesses, if DHHS made appropriate concessions.

41. In the event that this matter progressed to an Inquest, LSC Treverton submitted that the following issues were to be discussed and determined:

    a. The nature of Mr White's symptoms on 9 September 2017 (including shortness of breath and fluid retention), pursuant to the Preston House notes on that date;

    b. Whether Preston House staff failed to appropriately inform Dr Le of Mr White's symptoms on that date, as requested subsequent to his review of Mr White on 3 September 2017, and

c. Whether the failure to escalate Mr White's care represented a missed opportunity to intervene in the clinical course leading to his death.

Statement of Acting Assistant Director, DAS, North Division, DHHS, Brett Eastwood

42. On 9 July 2019, the Court received a statement from Acting Assistant Director of Disability Accommodation Services, North Division, DHHS Brett Eastwood.

Mr White's Care at Preston House on 9 September 2017

43. Mr Eastwood stated that Mr White had "Specific Health Management Plans" for several medical conditions. He informed me that a Specific Health Management Plan is a template document that DAS staff must complete and follow when a person has a medical condition. It requires staff to do particular things to care for a resident's health. The template, and all relevant procedures, are set out in the department's Residential Services Practice Manual. The Residential Services Practice Manual is published by the Department for use by departmental staff working with DAS residents, and its use is mandatory. It is publicly available on the internet and it is available to all departmental staff on the department's intranet. A hard copy is maintained in every DAS house.

44. Mr White had a Specific Health Management Plan for fluid retention, which was reviewed and signed by Dr Le on 6 September 2017. This plan instructed staff to be '*mindful*' of Mr White's *'swelling and weight gain'*. It noted *'swelling particularly in legs and head'* as a sign that Mr White's health would need to be reviewed by a medical practitioner *'earlier than planned'*.

45. Mr White also had a specific health management plan for his heart condition (mitral valve prolapse with atrial fibrillation). This plan was also reviewed and signed by Dr Le on 6 September 2017. It instructed staff to '*seek GP review in the first instance*' '*at times of increased fluid retention (facial legs swelling).*' It also noted that if Mr White '*is experiencing facial swelling/lower legs (particularly in the morning)*' his health '*should be reviewed by his GP*'.

46. Mr Eastwood conceded that, although DAS staff observed that Mr White had fluid retention on 9 September 2017, they did not follow his specific health management plan. This would have involved arranging for him to be seen by Dr Le or another registered medical practitioner. Mr Eastwood also noted that staff did not consult with nurse-on-call, as required by the Residential Services Practice Manual.

47. Mr Eastwood reviewed other progress notes made about Mr White on the date of his death. He commented that Mr White had excellent verbal skills and that he had been quite active during that day. Mr Eastwood stated that staff had evidently relied on Mr White telling them that he was "OK" instead of following his Specific Health Management Plan.

48. On behalf of DHHS, Mr Eastwood acknowledged that Preston House staff ought to have arranged for Mr White to be examined by Dr Le or another registered medical practitioner, or ought to have consulted with nurse-on-call, on 9 September 2017.

Staff Training

49. Mr Eastwood stated that DAS staff are employed as Disability Development Support Officers on either an ongoing or casual basis. At the time of writing his statement, 94% of staff employed by the Department held a Certificate IV in Disability Services or equivalent. He stated that the Department also supported employees to gain this qualification. Mr Eastwood stated that all staff must maintain a current First Aid Level 2 Certificate.

50. Mr Eastwood informed that staff are required to complete three days of pre-service induction training and are rostered for two shadow shifts with an experienced worker in a DAS home before completing their final day of induction. When staff are rostered for their first shift at a DAS home, they are required to complete an orientation checklist specific to that facility and its residents. This checklist alerts and directs staff to general and specific information relating to the home and residents, including the house manual and specific health alerts.

51. As specified in the Residential Services Practice Manual, staff working with a resident with a specific health condition are also required to be trained in the management of that condition.

Implementing the National Disability Insurance Scheme

52. As part of implementing the NDIS in Victoria, DHHS is transferring management of DAS homes to Community Service Organisations (**CSOs**). As of 13 October 2019, only 10 homes remain under the auspices of DHHS management. Mr Eastwood informed me that the management of Preston House was transferred to the CSO "Scope" on 21 July 2019.

53. Pursuant to the contracts transferring management of the DAS homes from DHHS, CSOs are required to have policies and practices equivalent to those set out in Residential Services Practice Manuals. Mr Eastwood stated that these procedures/policies relate, *inter alia*, to residents' medical plans and the management of a residents' medical issues, including: health

support needs summaries, health plan development, Specific Health Management Plans and deteriorating health management plans.

SUMMARY INQUEST

54. Upon review of Mr Eastwood's statement, I determined that DHHS had made appropriate concessions, obviating any need to hear witness evidence.

55. I determined that this matter would be appropriately finalised by way of a Form 37 Finding into Death with Inquest and to hand-down my Findings at the conclusion of a Summary Inquest.

56. On 21 August 2019, interested parties were informed of my determination by way of a formal notice for a Summary Inquest to be held 14 October 2019. I indicated my intention to hand down my formal Findings on this date.

COMMENTS

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

1. The investigation into Mr White's death highlights the importance of reporting the deaths of similarly vulnerable members of our population.

2. Mr White's death was due to natural causes (cardiomegaly). A natural causes death is reportable in restricted circumstances.[16] In this case, Mr White's death was mandatorily reportable as it occurred '*in care*'.[17] A coronial investigation ensued and identified that Mr White's care was not escalated after he presented with specific symptoms two days prior to his death. A fact that has been appropriately conceded by those responsible for the provision of his care: The Department of Health and Human Services.

3. Mr White was '*in care*' pursuant to section 3 of the Act; *he was a person in the care of the Secretary to the Department of Health and Human Services.* Mr White's care arrangements fell comfortably within this definition because he resided in a Department of Health and Human Services Disability Accommodation Services house. Presently, all but ten of these houses have been transferred to the management of community service organisations; the residents who reside in these facilities are no longer in the *care of the Secretary to the*

[16] Above n 5.

[17] Ibid s 3.

Department of Health and Human Services. Therefore, deaths of these residents are no longer mandatorily reportable to the Coroners Court of Victoria.

4. Mr White's death would not have been mandatorily reportable had it occurred after the management of Preston House was transferred to the community service organisation Scope. In these circumstances, the dereliction in his care would not have come under the scrutiny of this Court.

5. There are many Victorians, like Mr White, who are rendered vulnerable by their dependence on others to provide care or assistance with their daily living activities. In my view, the provisions of the Act which mandate reporting the deaths of those 'in care' intends to capture this vulnerability – rather than any commercial classification, such as funding or management arrangements.

6. Following the transition from the responsibility of the Victorian DHHS to the NDIS, Victoria has not yet amended the *Coroners Act 2008* (Vic) to ensure that this vulnerable cohort has been encapsulated within the purview of the coronial jurisdiction. However, it is my hope that anticipated amendments to the Act will reflect changes already made in the New South Wales and Queensland coronial jurisdictions.

FINDINGS

Having investigated the death of Grant White and having held an Inquest into his death, I make the following Findings pursuant to section 67(1) of the *Coroners Act 2008* (Vic):

1. I find that the identity of the deceased is Grant White, who was born on 1 September 1952 and who died on 11 September 2017 at 14 Hotham Street, Preston, Victoria 3072.

2. I further find that Grant White resided in Department of Health and Human Services Disability Accommodation Services "Preston House". As such, I find that he was 'in care' immediately before his death pursuant to the definition contained in section 3 of the *Coroners Act 2008* (Vic).

3. AND I further find that Grant White presented with symptoms that included intermittent laboured breathing and fluid retention on 9 September 2017.

4. AND I further find that, on 9 September 2017, Preston House staff ought to have arranged for Grant White to be reviewed by his General Practitioner, or the nurse-on-call, pursuant to relevant Department of Health and Human Services policies and procedures.

5. AND I further find that Preston House staff's failure to appropriately escalate his care was a missed opportunity to intervene in the clinical course leading to his death.

6. I am, however, unable to definitively find that Grant White's death would have been prevented had his care been appropriately escalated, due to the nature of his pre-existing heart conditions.

7. I acknowledge and accept the concessions made by the Department of Health and Human Services in relation to Grant White's death.

8. I accept and adopt the medical cause of death formulated by Dr Paul Bedford and I find that Grant White died from cardiomegaly.

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:

Lindsay White

The Department of Health and Human Services

The Disability Services Commissioner

Leading Senior Constable Ross Treverton

Signature:

AUDREY JAMIESON
CORONER
Date: **14 October 2019**