IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 1935

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Gary Edward Holmes
Date of birth:	7 September 1954
Date of death:	17 April 2019
Cause of death:	1(a) Hypostatic bronchopneumonia complicating end stage Parkinson's disease
Place of death:	Colac Area Health, 2-28 Connor Street, Colac, Victoria

INTRODUCTION

1. On 17 April 2019, Gary Edward Holmes was 64 years old when he died from natural causes. At the time of his death, Mr Holmes lived at the Murray Street Group Home in Colac.

THE CORONIAL INVESTIGATION

2. Mr Holmes'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. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. 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.

5. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Holmes's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into Mr Holmes's death, including evidence contained in the coronial brief. 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[1] 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.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

7. On 17 April 2019, Gary Edward Holmes, born 7 September 1954, was visually identified by Jacqueline Phillips, manager of the residential service at which he resided.

8. Identity is not in dispute and requires no further investigation.

Medical cause of death

9. Forensic Pathologist, Dr Matthew Lynch, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 19 April 2019 and provided a written report of his findings dated 23 April 2019.

10. Toxicological analysis of post-mortem samples identified the presence of acetone,[2] morphine,[3] and midazolam.[4]

11. Dr Lynch provided an opinion that the medical cause of death was *"1(a) Hypostatic bronchopneumonia complicating end stage Parkinson's disease"*. He concluded Mr Holmes's death was due to natural causes.

12. I accept Dr Lynch's opinion.

Circumstances in which the death occurred

13. Mr Holmes was born deaf and blind. An operation undertaken when he was a young child failed to assist his disabilities and led to mental health issues. According to his sister, Anne-Marie Konigson, her brother was mobile but needed a high level of care. He was thereafter cared for at a group home.

14. Ms Konigson noted that their mother had four small children at the time (she was born later) and received little support. She stated, *"I don't think it was mum's decision to send Gary to the home as much as the hospital's at the time. Mum wouldn't have given him up for the world given the chance and I think it would have been very difficult for her."*

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[2] Concentrations of acetone elevate during fasting.
[3] Morphine is a narcotic analgesic used for the treatment of moderate to severe pain.
[4] Midazolam is used to treat epilepsy. It is also used as a preoperative medication, antiepileptic, sedative-hypnotic, and anaesthetic induction agent.

15. At the time of his death, Mr Holmes was under the care of a Victorian government department then known as the Department of Health and Human Services (**DHHS**). Mr Holmes had been cared for in group homes for most of his life, including Kew Cottages and Colanda Residential Services. At the beginning of April 2019, he moved to Murray Street Group Home, a disability accommodation service in Colac, due to Colanda undergoing redevelopment.

16. In mid-2016, Mr Holmes was diagnosed with Parkinson's disease and his health began to deteriorate.

17. By April 2019, Mr Holmes's health was declining rapidly. While he had previously been able to hold a cup to his mouth and drink thin fluids, his carers now struggled to feed him and maintain his hydration. His general practitioner, Dr Mohammad Gadi from Otway Medical Clinic, noted that Mr Holmes's posture and minimal oral intake put him at risk of dehydration or aspiration if oral intake was pushed. He asked Mr Holmes's carers to monitor him closely.

18. On 5 April 2019, another general practitioner admitted Mr Holmes to Colac Hospital due to dehydration; Mr Holmes was unable to swallow and take his usual medications. Hospital notes indicate that his carers did not identify any specific event leading to his deterioration.

19. Mr Holmes was subsequently transitioned to palliative care. During his admission, Mr Holmes's swallowing difficulties continued, and he removed his feeding tubes on two occasions.

20. Mr Konigson recalled that her brother appeared to be very sick at this time and was slowly fading away with his illness; he was chairbound and clearly deteriorating.

21. Mr Holmes passed away on 17 April 2019 with his Ms Konigson at his bedside.

DISABILITY SERVICES COMMISSIONER

22. After Mr Holmes's death, the Disability Services Commissioner (**DSC**) commenced an investigation into the disability services provided by DHHS. I note that management of the Murray Group Home transferred to Home@Scope in October 2019.

23. The DSC is an independent body that has the power to inquire and investigate any matter relating to the provision of disability services or regulated disability services to a person who was receiving these services at the time of their death. The jurisdiction of the DSC is an important oversight of a particularly vulnerable group of persons in our community. Whereas the coronial jurisdiction is limited to the surrounding circumstances of death, which are in turn

limited to events which are sufficiently proximate and causally related to the death, the jurisdiction of the DSC expands to services provided to the deceased during their lifetime, whether or not those services are connected with the death.

24. I note that section 7(a) of the Act requires me to avoid necessary duplication of inquiries and investigations. I have therefore determined that there has been no need to mirror the DSC's investigations.

25. As a result of its investigation, the DSC made a number of findings relating to the care provided by the DHHS, now taken over by Home@Scope. In summary, these were:

    (a) a speech pathologist's recommendations were not followed, potentially impacting on Mr Holmes's complex communication needs;

    (b) Mr Holmes had longstanding swallowing issues, yet a Specific Health Management Plan was not created for him when these first became apparent; and

    (c) record-keeping practices were deficient.

26. Home@Scope advised the DSC about their current policies and practices as follows:

    (a) each resident of the Murray Street Group Home has had an individual health assessment in the past 12 months and each resident has Specific Health Management Plans (**SHMPs**). The SHMPs are reviewed every three months;

    (b) each resident has had an occupational therapy assessment and as a result has a manual handling and transfer risk plan;

    (c) the Scope Communication and Inclusion Resource Centre (**CIRC**) has provided communication resources as appropriate to the residents' communication needs. Staff have viewed webinars related to use and the CIRC team is providing education and use sessions across the entity as required;

    (d) staff in this home have also had formal training in epilepsy, administering midazolam, dysphagia, bowel management, PAC, and PBS; and

    (e) Home@Scope has been implementing a digital service delivery system in which case notes are recorded. Also included are external assessments and customer profile information such as information regarding transfer risks, night monitoring

requirements, manual handling requirements etc., the aim of which is to ensure documentation is consistent and up to date.

27. Given these improvements, the DSC determined that no further action was required with regard to Mr Holmes's case.

28. I am satisfied that the issues identified by the DSC did not directly impact on Mr Holmes's cause of death. I note that he was reviewed by a general practitioner and his carers could not identify a trigger for his deterioration, which was noted to have occurred over many months. I am satisfied that his deterioration was a natural progression of his Parkinson's disease rather than due to a lack of care.

FINDINGS AND CONCLUSION

29. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was Gary Edward Holmes, born 7 September 1954;

    (b) the death occurred on 17 April 2019 at Colac Area Health, 2-28 Connor Street, Colac, Victoria, from hypostatic bronchopneumonia complicating end stage Parkinson's disease; and

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

30. I am satisfied that his death was due to natural causes.

I convey my sincere condolences to Mr Holmes's family for their loss.

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

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

James Holmes, senior next of kin

Disability Services Commissioner

Constable Sharon Convey, Victoria Police, Coroner's Investigator

Signature:

CAITLIN ENGLISH

DEPUTY STATE CORONER

Date: 28 April 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** (the Act), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within six months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.