IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 4133

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Sarah Gebert, Coroner
Deceased:	Laurence Joseph KERMOND
Date of birth:	14 April 1954
Date of death:	5 August 2019
Cause of death:	*Complications of end stage renal failure in a man with multiple co-morbidities*
Place of death:	Warrnambool Base Hospital, 40 Ryot St, Warrnambool, Victoria
Other matters	*Person placed in custody or care*, natural causes, Department of Health and Human Services, Disability Services Commissioner

INTRODUCTION

1. Laurence Joseph Kermond[1], born 14 April 1954, was 65 years of age at the time of his death. He had lived in a Department of Health and Human Services **(DHHS)** managed group home in Carramar Crescent in Warrnambool since 2007[2]. On 25 July 2019, Mr Kermond was admitted to the Lyndoch Living – Lake Lodge (**Lyndon Living**) in Warrnambool, which was better suited to his increasing medical needs. His sister, Elizabeth Latta said, *Laurie's quality of life had deteriorated and he needed the extra care.*

2. Mr Kermond had a history of Stage IV kidney disease, total colectomy, ileostomy for recurrent volvulus and bowel obstruction, glaucoma, previous basal cell carcinoma, anaemia, and depression. Mr Kermond also had a mild intellectual disability, visual impairment, and hearing impairment. He was non-verbal and used cards to communicate with family and staff. He also had difficulty walking and used a walking frame for mobility.

3. On Sunday 4 August 2019, Mr Kermond was admitted to the Warrnambool Base Hospital with reduced consciousness and hypothermia in a setting of end stage renal failure. A decision was made that he receive palliative care and Mr Kermond passed away the following day.

THE CORONIAL INVESTIGATION

4. Mr Kermond's death was reported to the coroner as he was considered to be *a person placed in custody or care* under section 3(1) of the *Coroners Act 2008* **(the Act)** and so fell within the definition of a reportable death under the Act.

5. 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.

6. 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.

---

[1] Referred to by his sister as 'Laurie'.
[2] The home was transferred to Home@Scope on 13 October 2019.

7. Victoria Police assigned Senior Constable Lewis Martin to be the Coroner's Investigator for the investigation into Mr Kermond's death. Senior Constable Martin conducted inquiries on my behalf, including taking statements from witnesses and submitting a coronial brief of evidence. The brief includes statements from Mr Kermond's sister Elizabeth Latta, the forensic pathologist who examined Mr Kermond, his carers from Lyndon Living and treating clinicians.

8. Mr Kermond's medical records were also obtained from South West Healthcare and the Warrnambool Medical Clinic, where he had been a patient.

Disability Services Commissioner

9. I also considered the advice regarding the *Investigation into disability services provided by Department of Health and Human Services to Mr Laurence Kermond* prepared by the Disability Services Commissioner (**DSC**) which was provided to the Court. The DSC investigation was conducted under the auspices of the *Disability Act 2006* with a different scope to that of a coronial investigation (although it can overlap). Consistent with the Act, a coroner should liaise with other investigative bodies to avoid unnecessary duplication and expedite investigations.[3]

10. I note that following the notification of the death, the DSC requested that DHHS undertake a review of their service provision to Mr Kermond, following which DSC assessed the review and received evidence regarding the implementation of the service improvements.[4] Given the improvements made, DSC determined that no further action was required.[5]

11. As advice was received from a pathologist that Mr Kermond's death was due to natural causes[6], a mandatory inquest was not required.[7]

12. This finding draws on the totality of the coronial investigation into Mr Kermond'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.[8]

---

[3] S.7 of the Act.
[4] No details of the review are included in the finding as they are not sufficiently relevant to the cause or circumstances of Mr Kermond's death.
[5] The DSC permitted me to include their advice regarding their investigation in my Finding.
[6] Paragraph 22.
[7] S52(3A) of the Act.
[8] 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

Background

13. Mr Kermond was the youngest of five siblings and grew up in south west Victoria. His interests included football, going to the greyhound races and train trips to Colac or Melbourne. His siblings maintained contact with him and facilitated his interests. It was noted that he particularly enjoyed holidays with his brother, Geoff.

14. Mr Kermond was a patient at the Warrnambool Medical Clinic. General Practitioner, Dr Corsini Aragon said that on 24 July 2019 he was discharged from the Warrnambool Base Hospital due to gastroenteritis and deteriorating renal function, at which time he was diagnosed with End Stage Kidney Disease which was not for dialysis. Following discharge, Mr Kermond was admitted to Lyndoch Living for respite care on 25 July 2019.

15. Dr Aragon last saw Mr Kermond on 27 July 2019 at Lyndoch Living where he said, *he was feeling ok and the staff did not have any concerns.*

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

Circumstances in which the death occurred

16. At approximately 3.30pm, Sunday 4 August 2019, Mr Kermond's carers observed signs of deterioration whilst administering medication, including that his left eye had rolled back and his left arm was slumped and heavy. Advice was sought from an on call general practitioner as well as his family.

17. At approximately 5.20pm, Mr Kermond was transported by ambulance to the Warrnambool Base Hospital. Following consultation with his sister, Elizabeth Latta, who acted as his financial administrator and medical treatment decision maker, it was decided that Mr Kermond be made comfortable with no interventions. He was transferred to the Comfort Care wing for that purpose.

18. At approximately 4.44pm on 5 August 2019, Dr Lightowler pronounced Mr Kermond deceased.

---

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

Identity of the Deceased

19. On 5 August 2019, Elizabeth Latta visually identified her brother Laurence Joseph Kermond born 14 April 1954.

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

Medical cause of death

21. Senior Forensic Pathologist Dr Baber from the Victorian Institute of Forensic Medicine (VIFM), conducted an examination on 7 August 2019 and provided a written report of her findings dated 8 August 2019.

22. Dr Baber stated that there was no evidence available to suggest that Mr Kermond's death was due to anything other than *natural causes*.

23. Dr Baber provided an opinion that the medical cause of death was '1(a) *Complications of end stage renal failure in a man with multiple co-morbidities*'.

24. I accept Dr Baber's opinion.

FINDINGS AND CONCLUSIONS

25. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    (a) the identity of the Deceased was Laurence Joseph Kermond, born 14 April 1954;

    (b) the death occurred on 5 August 2019 at the Warrnambool Base Hospital, 40 Ryot St, Warrnambool, Victoria from *Complications of end stage renal failure in a man with multiple co-morbidities*; and

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

26. I convey my sincere condolences to Mr Kermond's family for their loss. Elizabeth Latta said of her brother,

    I feel overall, Laurie had a great childhood and excellent care at Carramar Crescent and Lake Lodge.

27. Pursuant to section 73(1B) of the Act. I order that this finding be published on the internet.

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

Mrs Elizabeth Latta, senior next of kin

Disability Services Commissioner

South West Healthcare

Senior Constable Lewis Martin, Victoria Police, Coroner's Investigator

Signature:

SARAH GEBERT

CORONER

Date: 25 February 2021