IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003964

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Kate Despot
Deceased:	Peter John Weatherly
Date of birth:	28 February 1958
Date of death:	27 July 2021
Cause of death:	1(a) Aspiration pneumonia in the setting of functional decline in a man with an intellectual disability
Place of death:	Austin Hospital 145 Studley Road, Heidelberg, Victoria, 3084
Keywords:	Death in custody or care; Custodial Supervision Order; Natural Causes.

INTRODUCTION

1. On 27 July 2021, Peter John Weatherly was 63 years old when he died at the Austin Hospital in Heidelberg following an admission on 24 May 2021.

2. At the time of his death, Mr Weatherly lived in a residential treatment facility at 7 Henderson Court, Bundoora, where he had resided subject to a Custodial Supervision Order since 2000.

THE CORONIAL INVESTIGATION

3. Mr Weatherly'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.

4. 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.

5. Victoria Police assigned First Constable Daniel Carr to be the Coroner's Investigator for the investigation of Mr Weatherly's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Peter John Weatherly 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.

BACKGROUND

7. Mr Weatherly was the youngest of three siblings and for the majority of his life lived in various support institutions. According to a 2020 Department of Health and Human Services (DHHS)[2] Person Centred Plan, Mr Weatherly enjoyed movies, listening to the radio, community outings, playing the drums and spending time with his family.

8. At the time of his death, Mr Weatherly was treated by General Practitioner Dr David Liu of the Viewbank Centre since February 2021. Prior to Dr Liu's care, Mr Weatherly was a patient of the now retired General Practitioner Dr Bryan Smith, who ceased to treat Mr Weatherly in November 2020.

9. Mr Weatherly's medical history included an Intellectual Disability, Chronic Obstructive Pulmonary Disease, Epilepsy, Cerebral Palsy, Dysphagia, Asthma, and Bipolar Affective Disorder.

10. The evidence suggests Mr Weatherly's health began to deteriorate in February 2021 with a reduction in his physical mobility and appetite. On 11 February 2021, following a stabilisation in his behaviour, Mr Weatherly ceased taking Risperidone, an anti-psychotic medication. Staff at Mr Weatherly's residential treatment facility noted that after he ceased Risperidone, Mr Weatherly began to experience a reduction in his fine motor skills, hand tremors and involuntary facial movements. According to a report prepared by the Disability Services Commissioner, it is believed that Mr Weatherly's uncontrollable movements (dyskinesia) were related to his cessation of Risperidone.[3]

11. On 13 April 2021, Mr Weatherly attended upon Dr Liu with the assistance of a carer presenting with shortness of breath experienced over two months and unsteadiness on his feet. Following his assessment, Dr Liu considered Mr Weatherly had aspiration pneumonia and ordered a chest x-ray which revealed left lower lobe consolidation. Mr Weatherly was commenced on a course of antibiotics on 29 April 2021 and was again reviewed by Dr Liu on 6 May 2021. Following the course of antibiotics, Dr Liu stated Mr Weatherly's shortness of breath had improved, however, the uncontrollable movements in his hands remained.[4]

[2] In February 2021, the Department of Health and Human Services was separated into two new departments: the Department of Health (DH) and the Department of Families, Fairness and Housing (DFFH).
[3] Treasure Jennings, Disability Services Commissioner, letter dated 21 December 2021.
[4] Statement of Dr Liu dated 23 February 2022.

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

Circumstances in which the death occurred

12. On 24 May 2021, Mr Weatherly presented to the Austin Hospital Emergency Department (ED) via ambulance following a further deterioration in his health, abdominal pain, and significant functional decline. The evidence suggests Mr Weatherly had a recent history of falls prior to this admission.

13. Professor Louise Burrell, General Physician and Head of General Medical Unit 4, from Austin Health provided a statement to my Coroner's Investigator in relation to Mr Weatherly's admission to the Austin Hospital. At the time of his admission, Mr Weatherly's prescribed medications were:

    i. Lithium;
    ii. Valproate;
    iii. Benzatropine
    iv. Spiriva;
    v. Seretide;
    vi. Cholecalciferol; and
    vii. Calcium carbonate.

14. Professor Burrell stated that on admission, Mr Weatherly presented as afebrile with a heart rate of 92 and blood pressure of 150/80. A chest examination revealed basal lung crepitation with normal heart sounds. An abdominal x-ray was performed which showed a normal gas pattern and a chest x-ray did not show any evidence of consolidation. A computerised tomography (CT) brain scan did not show any evidence of acute intracranial abnormality.

15. Throughout his admission, Professor Burrell stated Mr Weatherly experienced multiple clinical issues. Mr Weatherly was noted to have hypernatremia (high blood sodium) which was treated with thiazide diuretics and desmopressin, both of which were ineffective. Professor Burrell also stated his mobility continued to decrease.

16. Mr Weatherly was noted to have poor oral intake during his admission and was choking on thin fluids. Professor Burrell stated that Mr Weatherly had recurrent desaturation and aspiration pneumonia. On 25 June 2021, an attempt was made to insert a nasogastric tube to address Mr Weatherly's poor oral intake, however, he actively resisted and medical staff were unable to insert the tube. Mr Weatherly's oral intake was instead managed intravenously.

17. On 13 July 2021, a CT scan was performed on Mr Weatherly's chest, abdomen, and pelvis. The results of the scan showed "*innumerable nodular opacities throughout both lungs with some showing cavitation*" consistent with an aspiration event.[5]

18. On 20 July 2021, a medical emergency team (MET) call was made as Mr Weatherly showed a decreased conscious state. Following this MET call Mr Weatherly showed minimal signs of improvement in the days that followed with continued reduced responsiveness and poor oral intake. On 23 July 2021, following discussions with his family, Mr Weatherly's treating team transitioned Mr Weatherly to palliative care.

19. At 2.43am on 27 July 2021, Mr Weatherly was formally pronounced deceased.

Identity of the deceased

20. On 27 July 2021, Peter John Weatherly, born 28 February 1958, was visually identified by his sister, Janice Islip, who signed a formal Statement of Identification.

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

Medical cause of death

22. Forensic Pathology Registrar Dr Joanne Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination upon the body of Mr Weatherly on 28 July 2021 and provided a written report of her findings dated 2 September 2021.

23. The post-mortem examination was consistent with the described circumstances with signs of medical intervention.

24. Examination of the post-mortem CT scan showed increased basal lung markings, prostatomegaly, coronary calcifications and liver cysts. The post-mortem CT scan did not show any evidence of intracranial haemorrhage.

25. Dr Ho provided an opinion that the medical cause of death was 1 (a) Aspiration pneumonia in the setting of functional decline in a man with an intellectual disability.

26. Dr Ho considered that Mr Weatherly's death was due to natural causes.

27. I accept Dr Ho's opinion.

[5] Statement of Professor Louise Burrell dated 26 May 2022.

DISABILITY SERVICES REVIEW

28. Following Mr Weatherly's death, an independent review was conducted by the Disability Services Commissioner in relation to the disability services provided to Mr Weatherly. In the course of their investigation, the Disability Services Commissioner requested that the Department of Families, Fairness and Housing (DFFH) conduct their own review of the disability services provided to Mr Weatherly.

29. The DFFH identified several issues in relation to Mr Weatherly's disability services. In summary, these issues related to:

    i. Overall inadequate record keeping, in particular in relation to Mr Weatherly's weight loss and falls history;

    ii. Mr Weatherly's Specific Health Management Plan had not been properly updated;

    iii. A lack of clarity concerning who was Mr Weatherly's medical treatment decision maker; and

    iv. Delay in considering alternative accommodation options in light of Mr Weatherly's deteriorating health.

30. The DFFH provided the Disability Services Commissioner with a plan of action to address the identified issues. These actions included conducting a series of file audits on all resident files, reviewing methods of communication with external stakeholders, and providing record keeping training to the residential treatment facility staff.

31. In a report provided to the Court, the Disability Services Commissioner stated that on 16 December 2021, the DFFH provided confirmation that the plan of action had been successfully implemented.[6] Based on the improvements that had been made, the Disability Services Commissioner concluded that no further action is required.[7]

32. I am satisfied that the identified issues have been adequately addressed by the DFFH and the Disability Services Commissioner. Further, I have not identified any evidence to suggest these issues caused or contributed to Mr Weatherly's death.

[6] Treasure Jennings, Disability Services Commissioner, letter dated 21 December 2021.
[7] As above.

FINDINGS AND CONCLUSION

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

    i. the identity of the deceased was Peter John Weatherly, born 28 February 1958;

    ii. the death occurred on 27 July 2021 at the Austin Hospital 145 Studley Road, Heidelberg, Victoria, 3084

    iii. I accept and adopt the cause of death as formulated by Dr Ho and find that Mr Weatherly died from aspiration pneumonia in the setting of functional decline in a man with an intellectual disability; and

    iv. the death occurred in the circumstances described above.

34. As noted above, Mr Weatherly's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before his death, he was placed in care subject to a Custodial Supervision Order. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Mr Weatherly died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an inquest into Mr Weatherly's death.

I convey my sincere condolences to Mr Weatherly'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:

Janice Islip, Senior Next of Kin

Austin Health

Disability Services Commissioner

Department of Families, Fairness and Housing

First Constable Daniel Carr, Coroner's Investigator

Signature:

Coroner Kate Despot

Date : 25 June 2023

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 6 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.