IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006612

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Stephen John Lunson
Date of birth:	5 July 1953
Date of death:	9 December 2021
Cause of death:	1(a) Pneumonia 1(b) Interstitial lung disease
Place of death:	Sunshine Hospital, 176 Furlong Road, St Albans, Victoria, 3021

INTRODUCTION

1. On 9 December 2021, Stephen John Lunson was 68 years old when he died at Sunshine Hospital. At the time of his death, Stephen lived in a group home in Keilor Lodge.

2. Stephen liked going for walks, fishing, bus trips, listening to music and reading magazines. He like desserts, particularly ice cream and cake, but disliked vegetables.

3. When Stephen was nine months old, he became ill[1] and subsequently developed an intellectual disability and severe epilepsy. In 1962, when Stephen was nine years old, he was placed at Kew Cottages following medical advice. Kew Cottages was a government-run accommodation facility for intellectually disabled children.[2]

4. Stephen lived at Kew Cottages until 1994, when he moved to a group home on Stoke Street in Deer Park. In 2018, he moved into a group home on Verona Street in Keilor Lodge, run by Home@Scope, where he lived until his death. According to his cousin, Gwenyth, he thrived at the Verona Street home.[3]

5. Stephen was very close to his parents, who were devoted to him. He spent three out of four weekends at their home until 2005 when Stephen's father fell ill but continued to visit them weekly. After his father passed away in 2007, his mother visited him every Wednesday, until her death in 2014.[4]

6. Stephen had limited vocabulary and was quiet and soft-spoken. He used gestures and a personal communication dictionary to communicate and led his support workers to activities he wished to engage with. He could mobilise well independently. He required support for aspects of daily living including meal preparation, personal care, medication administration and attending medical appointments.[5]

Medical history[6]

7. In addition to his intellectual disability and epilepsy, Stephen's medical history included hypercholesterolaemia and vitamin D deficiency which were well managed.

[1] There is conflicting evidence as to Stephen's illness at the age of nine months. His cousin Gwenyth Rogers suggests that he had encephalitis and meningitis, whereas medical records suggest he had a salmonella infection.
[2] Coronial Brief (CB), Statement of Gwenyth Rogers, dated 6 June 2022.
[3] Ibid.
[4] Ibid.
[5] Medical records from Western Health; Statement of Anthony McCormick, dated 22 April 2024.
[6] Medical records from Western Health; Statement of Dr John He, dated 2 May 2022.

8. In October 2019, Stephen was referred to the Western Health Respiratory Outpatient Clinic with a history of cough. A computed tomography (**CT**) scan of his chest was suggestive of interstitial lung disease and showed evidence of subpleural pulmonary fibrosis and significant motion artefact.

9. Stephen had a repeat CT scan in May 2020 which was suggestive of possible chronic hypersensitivity pneumonitis as a diagnosis. He was again assessed in May 2021 and as he was asymptomatic with a mild dry cough and untroubled by his breathing, clinicians determined to monitor him instead of commencing treatment due to the difficulty in monitoring him for side effects.

10. In the latter half of 2021, Stephen's respiratory symptoms became exacerbated, with constant coughing, dyspnoea and low oxygen saturation. He was regularly seen by his general practitioner Dr John He who made referrals to the Western Health Respiratory Outpatient Clinic and prescribed oral antibiotics and short-term prednisolone as needed.

11. On 2 November 2021 he presented at the Sunshine Hospital with chest infection symptoms and hypoxia. Clinicians noted that his presentation was suggestive of Covid-19 but could have also be his interstitial lung disease. He did not tolerate a Covid-19 test swab and refused blood testing. Stephen was discharged with a diagnosis of pneumonia, with antibiotics and steroid medications.

12. On 1 December 2021, Stephen was reviewed via telehealth at the Western Health Respiratory Outpatient Clinic. His breathing had deteriorated since his last review, with constant coughing, dyspnoea and low oxygen saturation. The cause of his deterioration was unclear, and the decision was made for Stephen to be reviewed face-to-face on 15 December 2021 for further clinical examination.

THE CORONIAL INVESTIGATION

13. Stephen's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). In addition, I considered that Stephen's circumstances were analogous to a person 'in care'.

14. Since 2019, funding for disability services in Victoria has shifted from the Department of Families, Fairness and Housing to the National Disability Insurance Scheme. This shift meant that the definition of *person placed in custody or care* in section 3(1) of the *Coroners Act 2008* to include 'a person under the control, care or custody of the Secretary to the Department

of Human Services or the Secretary to the Department of Health' was no longer sufficient to capture the group of vulnerable people in receipt of disability services that the legislature had intended. The *Coroners Regulations 2019* were amended on 11 October 2022 to create a new category of person considered to be 'in care' under Regulation 7 of the Coroners Regulations 2019, being a 'person in Victoria who is an SDA resident residing in an SDA enrolled dwelling'.

15. While Stephen was not formally 'in care' at the time of his death on 9 December 2021, he was an SDA resident residing in an SDA-enrolled dwelling at the time. If reported today, his death would be considered to be an 'in care' death that requires additional steps be taken in the coronial process, including that an inquest (public hearing) be held unless the Coroner considers the death was due to natural causes, and that the present Findings be published on the Internet. It is of significance that the Coroners Regulations have now been updated to capture the passings of potentially vulnerable persons such as Stephen, with these enhanced investigative processes, to ensure that any issues associated with their care are appropriately and independently canvassed by the coroners of this state.

16. 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.

17. 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.

18. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Stephen'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.

19. This finding draws on the totality of the coronial investigation into the death of Stephen John Lunson 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.[7]

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

Circumstances in which the death occurred

20. On 6 December 2021, Stephen attended a telehealth consult with his general practitioner, Dr He. His support worker advised Dr He that he had not been eating and had a more pronounced cough over recent days. Dr He resolved to attend at Verona Lodge in the coming two days with medication.[8]

21. On 7 December 2021, Stephen continued coughing profusely and presented as lethargic, with minimal food intake.[9]

22. On the evening of 8 December 2021, care staff called an ambulance due to Stephen becoming extremely short of breath while showering. When paramedics arrived, they were unable to assess him as he was agitated, and so they administered olanzapine to sedate him such that he could be safely conveyed to hospital.[10]

23. Stephen and a support worker were conveyed by ambulance to the Sunshine Hospital Emergency Department, arriving at around 8:20pm. Stephen's oxygen saturation levels were low, but he refused oxygen and was agitated and resistant to care.[11]

24. On the morning of 9 December 2021, clinicians spoke to Gwenyth and advised that given Stephen was so hypoxic but resistant to care, the next step would be to sedate him so that he could be intubated. Gwenyth informed clinicians that it was her wish, and that of Stephen's late parents, that he was not to be intubated or resuscitated.[12]

25. Clinicians noted that Stephen's case was extremely difficult in that he had a potentially reversible condition but was resistant to receiving the necessary treatment. They determined

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[7] 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.

[8] Statement of Anthony McCormich, dated 22 April 2024.

[9] Ibid.

[10] Medical records from Western Health.

[11] Ibid.

[12] Ibid.

to given Stephen a chance to respond to steroids, but to transition him to comfort care if he deteriorated further. He was given subcutaneous morphine and midazolam for distress.[13]

26. At around 3pm, Stephen was transitioned to comfort care. His condition continued to deteriorate, and he was sadly declared deceased at 5:30pm.[14]

Identity of the deceased

27. On 9 December 2021, Stephen John Lunson, born 05 July 1953, was visually identified by his cousin, Jennifer Dymott, who completed a Statement of Identification.

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

Medical cause of death

29. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on the body of Stephen Lunson on 13 December 2021. Dr de Boer considered the Victoria Police Report of Death (Form 83), VIFM contact log, post mortem computed tomography (**CT**) scan and E-Medical Deposition Form from Sunshine Hospital and provided a written report of his findings dated 15 December 2021.

30. The findings at external examination were consistent with the known history. Examination of the post mortem CT scan showed bilateral lung consolidations with fibrosis, and cholecystolithiasis.

31. Dr Beer provided an opinion that Stephen died from natural causes and his medical cause of death was 1 (a) PNEUMONIA; 1 (b) INTERSTITIAL LUNG DISEASE.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Stephen John Lunson, born 05 July 1953;

    b) the death occurred on 09 December 2021 at Sunshine Hospital, 176 Furlong Road, St Albans, Victoria, 3021;

[13] Ibid.
[14] Ibid.

c) I accept and adopt the medical cause of death as ascribed by Dr Hans de Boer and I find that Stephen John Lunson died from natural causes being pneumonia on a background of interstitial lung disease.

2. AND having previously determined that Stephen John Lunson was equivalent to "a person in care", I find that there is no relationship between the cause of his death and the care he received.

I convey my sincere condolences to Stephen'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.

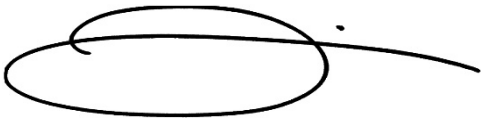
I direct that a copy of this finding be provided to the following:

Gwenyth Rogers, Senior Next of Kin

Western Health

Senior Constable Daniel Talbot, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 4 June 2024

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.