IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 001736

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Alexander Cameron
Date of birth:	14 August 1982
Date of death:	25 March 2023
Cause of death:	1(a) Aspiration pneumonia <u>Contributing factor(s)</u> 2 Neuroleptic malignant syndrome
Place of death:	Werribee Mercy Hospital, 300-310 Princes Highway, Werribee, Victoria, 3030
Keywords:	In care death; natural causes; aspiration pneumonia; neuroleptic malignant syndrome

INTRODUCTION

1. On 25 March 2023, Alexander Cameron was 40 years old when he passed away at the Werribee Mercy Hospital (**WMH**). At the time of his death, Mr Cameron lived at 46 Dianchi Drive, Wyndham Vale, Victoria, 3024, in specialist disability accommodation (**SDA**). He was a participant in the National Disability Insurance Scheme.

2. Mr Cameron had a very complex medical history, commencing from early childhood. His medical history included asthma, attention deficit hyperactivity disorder (**ADHD**), autistic traits, class III obesity, epilepsy, hypertension, hypothyroidism, neuroleptic malignant syndrome (**NMS**), obsessive compulsive disorder (**OCD**), recurrent lower limb cellulitis and sepsis, recurrent pneumonia, Tourette syndrome, type 2 diabetes, urinary retention, varicose veins, venous insufficiency, and venous ulcer. At the time of his death he was described as presenting with "*a complex community of neurodevelopmental, neurological and neuropsychiatric disorders*" and he had complex care needs as a result. He was engaged with numerous support services including supports and accommodation funded through the NDIS.

3. A report reviewing Mr Cameron's mental health history was completed by consultant psychiatrist, Dr Jennifer Torr, dated 7 March 2023. She noted that Mr Cameron experienced a childhood onset of mental illness which was initially diagnosed as schizophrenia, however she opined it was more likely to have been bipolar I disorder with psychotic symptoms. She also provided a differential diagnosis of schizoaffective disorder bipolar type. Dr Torr further noted Mr Cameron's full scale IQ scores had progressively declined over time, however, was unable to determine the precise cause for same.

4. Mr Cameron lived with his parents, and later his mother, for most of his life and grew up in Canberra. In about 2017 he experienced a significant decline in his physical and mental health, requiring long-term inpatient admissions in Canberra where he was residing. These admissions spanned about four and a half years, following which he was supported by InLife Independent Living (**'InLife'**) to relocate to Victoria in July 2022. In Victoria, he initially lived in a private rental in Winchelsea, before moving into respite accommodation in South Morang, followed by SDA respite accommodation in Wyndam Vale.

THE CORONIAL INVESTIGATION

5. Mr Cameron's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).[1] Mr Cameron was a "*person placed in custody or care*" pursuant to the definition in section 4 of the Act, as he was "*a prescribed person or a person belonging to a prescribed class of person"* due to his status as an "*SDA resident residing in an SDA enrolled dwelling*".[2]

6. Mr Cameron's death was not reported at the time of his passing by the hospital where he died as it appears they were not aware of the required report to the Coroner due to his status as an SDA resident residing in an SDA enrolled dwelling. The case was instead reported to the Coroner by Births, Deaths and Marriages Victoria (**BDM**).

7. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The 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.

8. 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.

9. I requested that a Victoria Police officer be appointed as the Coroner's Investigator for the investigation of Mr Cameron's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Alexander Cameron 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

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[1] Section 4(1), (2)(c) of the Act.

[2] Pursuant to Reg 7(1)(d) of the *Coroners Regulations 2019*, a "*prescribed person or a prescribed class of person*" includes a person in Victoria who is an "*SDA resident residing in an SDA enrolled dwelling*", as defined in Reg 5. I have received confirmation from the NDIA that Mr Cameron resided at an address where the residents meet these criteria.

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

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

Circumstances in which the death occurred

11. Mr Cameron moved into SDA in Wyndham Vale in November 2022. His mother, Helen Culliver, located a local general practitioner (**GP**), Dr Nadeem Arif at MyClinic Werribee Village, to assist with the management of Mr Cameron's medical conditions. He first consulted with Dr Arif on 16 November 2022, however, Ms Culliver noted that Dr Arif was not able to immediately "*work through the long list*" of Mr Cameron's conditions.

12. Dr Arif provided referrals for blood tests and an electrocardiogram (**ECG**), a vascular surgeon, a podiatrist, and completed questionnaires for Mr Cameron to be considered for Medicare-subsidised home-based sleep studies. This occurred from November 2022 to January 2023, and appointments were made for a vascular surgeon and sleep studies in 2023.

13. In December 2022, Mr Cameron was accepted as a patient by the Saltwater Clinic, part of Mercy Mental Health (**MMH**) and was reviewed in mid-December 2022. The reviewing psychiatrist noted Mr Cameron was pleasant and cooperative and that his mental health was "*overall stable*".

14. On 19 December 2022, Mr Cameron presented to a hospital emergency department reporting chest pain. He underwent testing which did not reveal any significant abnormality.

15. On 5 January 2023, Mr Cameron presented to GP Dr Rewa Ahmadi, another doctor at MyClinic Werribee Village. His carers reported that he had been experiencing frequent loss of consciousness episodes, lasting about five seconds, with no vomiting. The carers also noted that Mr Cameron intermittently did not take his medication as required, which appeared to be an ongoing issue for him. Unfortunately, Dr Ahmadi was unable to gain Mr Cameron's cooperation and was therefore unable to complete a comprehensive examination. Dr Ahmadi requested that the carers arrange a full check-up and referred Mr Cameron for blood tests to check his valproate levels. A further referral to test Mr Cameron's clozapine drug serum levels

[3] 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.

was also provided on 11 January 2023 and, at Ms Culliver's request, a referral was provided to the Alfred Hospital's epilepsy clinic.

16. Ms Culliver spoke with Dr Ahmadi by telephone on 17 January 2023 and expressed dissatisfaction with the management of her son. She requested the clozapine serum test results; however, they had not yet arrived.

17. On 25 January 2023, Mr Cameron presented to Dr Arif in the company of his carers, reporting a two-week history of an urgency to vomit with associated abdominal pain, which had become worse over the previous week. He reported feeling cold at times during this period, however when his carers checked his temperature, he was afebrile. His carers further reported ongoing leg pain, a large callus on his left heel, and requested a referral to an ophthalmologist as he had cataracts. His carers explained that Mr Cameron had self-ceased sodium valproate, however MMH had recommenced this with a plan to increase his dose over time.

18. Dr Arif was unable to complete a full physical examination due to Mr Cameron's behaviour, however, was able to ascertain that he was afebrile and had a large weeping callous on his foot. Dr Arif advised that Mr Cameron should be assessed in hospital given the recurrent vomiting and abdominal pain and provided a referral for same. Dr Arif also provided a prescription for antibiotics to treat Mr Cameron's weeping callous.

19. Mr Cameron did not want to go to hospital, so he returned home with his carers. Later that evening, he called 000 complaining of feet and abdominal pain. Upon paramedics' arrival, Mr Cameron was alert and oriented, but required significant encouragement to go to hospital. He eventually agreed and was conveyed by ambulance to WMH.

20. At WMH, Mr Cameron underwent testing and an abdominal CT scan. His blood tests were normal, other than slightly raised urea, likely secondary to dehydration from recent vomiting. His CT scan was also normal with moderate faecal loading and no evidence of obstruction, pneumoperitoneum, or appendicitis. Mr Cameron was discharged home on 26 January 2023 with a plan to take three Movicol sachets thrice daily for three days and a plan to taper off after that time.

21. Mr Cameron was reviewed by Dr Arif on 27 January 2023, following his discharge from WMH. Dr Arif encouraged Mr Cameron to continue to take Movicol as recommended by WMH, although noted this was challenging at times. Dr Arif further noted a letter from Mr Cameron's vascular specialist who explained the multifactorial nature of his lower limb

swelling which included an element of venous insufficiency. They recommended physiotherapy and exercise, however noted this might be challenging with Mr Cameron's mental health and intellectual disability. Dr Arif additionally noted Mr Cameron's recurrent fungal skin infections, particularly on his feet as he rarely took his shoes and socks off. Mr Cameron was provided a new topical antifungal to trial.

22. On 11 February 2023, Mr Cameron started vomiting and had an elevated temperature. He called Ms Culliver the next morning to report his symptoms. One of his carers arranged a telehealth appointment, then called for an ambulance, who transported him to WMH. He underwent an abdominal CT scan, which revealed features suspicious for a small bowel obstruction with transition point at the anterior wall, right lower quadrant. Clinicians initially planned to manage the possible blockage conservatively and without surgery, through nasogastric tube (**NGT**) decompression. Due to Mr Cameron's underlying cognitive and mental health issues, he became extremely agitated when staff attempted to insert the NGT and his behaviour could not be managed. Staff administered ketamine to assist with insertion of the NGT, however upon insertion, Mr Cameron vomited and aspirated. Staff immediately intubated Mr Cameron to protect his airways and commenced a course of antibiotics to prevent the development of aspiration pneumonia.

23. On 13 February 2023, Mr Cameron underwent an emergency diagnostic laparoscopy to assess the extent of his bowel obstruction, however no surgical evidence of a bowel obstruction or a mechanical cause for his symptoms was found. The surgeon who performed the procedure opined that Mr Cameron's abdominal distention, vomiting and CT appearances were due to his "*acute on chronic constipation and that there was a separate, non-surgical cause for his sepsis*". Mr Cameron was admitted to the Intensive Care Unit (**ICU**) for invasive organ support, and received multidisciplinary care from the surgical, mental health, infectious diseases, and rehabilitation teams.

24. Over 14 and 15 February 2023, Mr Cameron continued to suffer respiratory failure and was febrile with an unknown aetiology. His antibiotics were upgraded under the guidance of infectious diseases clinicians. On 16 February 2023, Mr Cameron underwent a CT pulmonary angiogram (**CTPA**), which excluded a pulmonary embolism, although demonstrated a collapse to both lung bases and a small right pleural effusion. He also underwent a bronchoscopy, which revealed thick secretions to the bilateral lobes. Blood cultures revealed gram negative bacteria, which clinicians thought was likely bacteraemia arising from pneumonia, so his antibiotics were modified again.

25. Mr Cameron underwent repeat bronchoscopies on 17 and 18 February 2023, with large mucous plugs suctioned on both occasions. Despite aggressive treatment and maximal support, Mr Cameron remained febrile and required respiratory support. Clinicians considered NMS as a differential diagnosis and titrated Mr Cameron's clozapine dosage accordingly, under the guidance of the psychiatric team.

26. Over the last two weeks of February 2023, Mr Cameron underwent further investigations to determine the cause of his persistent fever. He underwent a transthoracic echocardiogram, which excluded infectious endocarditis and valvular sepsis and no abnormalities were found. He also underwent a CT scan of his head, chest, abdomen, and pelvis which revealed pansinusitis, but no other cause for his ongoing fever. The appearances in the chest had vastly improved, other than the collapsed right lung base which persisted. After Mr Cameron's clozapine dose had been titrated down, he was commenced on dantrolene in response to the differential diagnosis of NMS. The clozapine and cariprazine were later ceased, however Mr Cameron continued to suffer respiratory failure and fever.

27. ICU clinicians used a surface cooling device as an attempt to manage Mr Cameron's temperature, and propofol was ceased to rule out a drug-induced fever. He further underwent a lumbar puncture and ultrasound doppler to exclude a central nervous system infection and deep vein thrombosis, respectively. Further opinions were sought from a metabolic physician and a toxicologist. The toxicologist thought NMS was unlikely, however recommended a trial of bromocriptine. The trial was unsuccessful and did not alleviate Mr Cameron's symptoms.

28. A joint ICU-medical meeting was held on 17 March 2023 to discuss Mr Cameron's prognosis. They concluded that his difficulties in weaning off ventilator support were multifactorial and included obesity, his complex mental health disorder, critical illness, weakness, and fever. Clinicians provided regular updates to Ms Culliver, who wanted to continue to pursue active treatment options in the short term, to give her son every chance of recovery. Mr Cameron continue to receive maximal support, however experienced worsening respiratory failure.

29. On 22 March 2023, clinicians held further meetings and discussed Mr Cameron's prognosis with Ms Culliver. Given his poor prognosis, a joint decision was made to transition him to palliative and comfort care. Mr Cameron passed away at 5.20am on 25 March 2023.

Medical cause of death

30. As outlined above, this case was not immediately reported to the coroner. Rather, BDM made the notification to the coroner on 27 March 2023 via email. Forensic Pathologist, Dr Joanna Glengarry, of the VIFM, subsequently reviewed the Medical Certificate Cause of Death (**MCCD**) as prepared by WMH clinicians. The cause of death provided in the MCCD was "*1(a) Aspiration pneumonia*" with "*2 Neuroleptic malignant syndrome*" as a contributing factor.

31. Dr Glengarry reviewed Mr Cameron's medical records in conjunction with the MCCD, although did not examine his body or conduct any of the usual post-mortem testing, as the matter was not reported by WMH at the time of death and Mr Cameron's body was not available for post-mortem medical investigations.

32. Dr Glengarry provided her review and opinion regarding the case in the 'Preliminary Examination Form' and presented the case to me. Dr Glengarry did not dispute the cause of death listed on the MCCD but opined that the cause of death provided was "*unusual*", and noting that that there was insufficient information available to alter it.

33. Following receipt of the coronial brief, I requested Dr Glengarry to review the Western Health statements and advise if they changed her opinion about the cause of death. Dr Glengarry responded that the reason she initially opined the cause of death was "*unusual*" was because NMS is uncommon on death certificates in general and at that point in time, it stood out. However, upon review of the Western Health statements, Dr Glengarry opined the cause of death given on the MCCD was reasonable.

34. I accept Dr Glengarry's opinion.

FAMILY CONCERNS

35. Ms Culliver provided a statement to the Court in which she outlined extensive concerns she had with her son's treatment in both Victoria and the ACT. In response to correspondence from the Court advising Ms Culliver of my intention to finalise the coronial investigation with written findings, Ms Culliver then listed further concerns via email.

36. The concerns pertinent to the care Mr Cameron in Victoria are summarised below:

    a) Appropriateness of the handover from the Dhulwa Mental Health Unit in the ACT to Barwon Health, following Mr Cameron's move from the ACT to Winchelsea.

b) Difficulties with the community of Winchelsea, some of whom "*started a campaign*" against Mr Cameron which necessitated Mr Cameron moving out of the area.

c) Admission to University Hospital Geelong (**UHG**) in September 2022, where staff were reportedly "*keen to get rid of [Mr Cameron] as quickly as possible*".

d) Lack of treatment of Mr Cameron's manic symptoms whilst under the care of Barwon Health (Colac Area Mental Health), which resulted in challenging behaviour and an inability for clinicians to comprehensively assess him.

e) Handover between UHG and respite accommodation in South Morang operated by genU.

f) Allegations that the local mental health service in South Morang, the Noogal Clinic, did not engage well with Mr Cameron.

g) An alleged delay in communication between the Noogal Clinic and MMH, following Mr Cameron's relocation to Wyndham Vale.

h) An allegedly unsatisfactory first home visit by MMH clinicians in December 2022.

i) Allegedly excessive sedation given to Mr Cameron on Christmas Day 2022.

j) Appropriateness of medication reviews in Victoria, given Mr Cameron's blood serum concentration of clozapine was found to be above the therapeutic level in January 2023.

k) Allegations that some of Mr Cameron's carers had become desensitised to his complaints and did not react in a timely manner when he reported concerning symptoms.

l) That clinicians from Barwon Health, the Noogal Clinic and MMH should have provided statements in the investigation.

m) That none of the services in Victoria engaged closely enough with Mr Cameron and therefore were unable to properly read his mental or physical health symptoms.

n) The cariprazine prescribed by Dr Scott Hall of Barwon Health was at an insufficient level to provide therapeutic benefit.

o) That Mr Cameron was not appropriately treated for his mental illness in Victoria which meant that his admission to WMH in February 2023 was challenging and required sedation and intubation. If intubation did not occur, Ms Culliver opined that it was possible that her son would not have aspirated on vomitus and therefore may not have developed aspiration pneumonia.

FURTHER INVESTIGATIONS AND CPU REVIEW

37. As part of my investigation, I directed the Coroner's Investigator (**CI**) to compile a coronial brief, which included statements from WMH regarding their treatment of Mr Cameron during his February to March 2023 admission. The CI also obtained statements from treating GPs and the disability support services involved in Mr Cameron's care.

38. WMH provided two statements outlining their care and treatment of Mr Cameron which explained the extensive tests, referrals and other investigations conducted during his near seven-week admission to the ICU. Several differential diagnoses were considered throughout his admission, and various medications, therapies and approaches were trialled with limited success.

39. In his statement to the Court, Dr Mainak Majumdar, Director of Intensive Care Services at Mercy Health, explained that NMS is a diagnosis of exclusion and that there are no specific tests for it. Furthermore, there are no specific treatments available for NMS; rather, treatment is largely supportive in nature.

40. It is clear from the WMH medical records that clinicians were aware of Mr Cameron's previous NMS experience. Clinicians attempted several supportive therapies in response to this differential diagnosis, however Mr Cameron did not show any signs of improvement.

41. I referred this case to the Coroners Prevention Unit (**CPU**),[4] for an independent review of the care, treatment and management received by Mr Cameron at WMH, and consideration of the concerns raised by Ms Culliver. The CPU considered all the medical evidence and noted the complex nature of Mr Cameron's presentation. They noted that he received maximal medical care during his admission to the ICU, which included multi-disciplinary consultation from

[4] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

many teams such as general physicians, respiratory physicians, infectious diseases experts and the general surgical team.

42. The CPU concluded that the investigations that Mr Cameron underwent were thorough and appropriate, and that a broad range of differential diagnoses were considered. The CPU did not identify any deficiencies in the care provided or any prevention opportunities. I accept their opinion.

43. I acknowledge Ms Culliver's concerns regarding her son's care from the time he arrived in Victoria in mid-2022, and in the ACT. However, the scope of a coronial investigation is limited. I can only examine matters that are sufficiently proximate to and causative of, or contributory to the death, and in my view the concerns do not fit within that remit.

44. Mr Cameron's death resulted from an aspiration event which occurred when he was sedated and intubated after presenting to hospital with a medical condition. I note that WMH clinicians took immediate steps to treat the possible aspiration as soon as it occurred and trialled a wide range of therapies over the nearly seven weeks he spent in the ICU, but without success. The treatment he received at WMH was confirmed by the CPU to be appropriate and comprehensive, which included both the decision to sedate and intubate, and the response to the aspiration event.

45. The evidence does not support a conclusion that his physical illness, which necessitated attendance at hospital, was caused by mismanagement of his needs in the community, or that sedation and intubation would not have been required when he presented had there been different interventions in the community. To attempt to come to such a conclusion would be an a speculative exercise, noting the complexity of Mr Cameron's physical and mental health conditions and the numerous support services, and clinicians, involved in his care from his time before, and after, moving to Victoria.

46. There is therefore no proximate causal nexus between Ms Culliver's allegations of inadequate psychiatric and other care, and Mr Cameron's subsequent death. As such, concerns about the treatment he received from Barwon Health and the Noogal Clinic do not require further investigation.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Alexander Cameron, born 14 August 1982;

b) the death occurred on 25 March 2023 at Werribee Mercy Hospital, 300-310 Princes Highway, Werribee, Victoria, 3030, from aspiration pneumonia with neuroleptic malignant syndrome as a contributing factor; and

c) the death occurred in the circumstances described above.

I convey my condolences to Mr Cameron'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:

Helen Culliver, Senior Next of Kin

Mercy Health

Northern Health

Leading Senior Constable Fiona Nation, Victoria Police, Coroner's Investigator

Signature:

Coroner Catherine Fitzgerald

Date : 12 February 2025

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.