IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 002545

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Sarah Gebert, Coroner
Deceased:	Michael Manuel Luno
Date of birth:	16 January 1957
Date of death:	13 May 2023
Cause of death:	1(a) Aspiration pneumonia in the setting of a small bowel obstruction
Place of death:	Dandenong Hospital, 135 David Street, Dandenong, Victoria

INTRODUCTION

1. On 13 May 2023, Michael Manuel Luno was 66 years old when he passed away in hospital following a short illness.

2. At the time of his death, Michael lived in a supported residential service in Noble Park.

THE CORONIAL INVESTIGATION

3. Michael's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). 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. 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.

6. Victoria Police assigned Senior Constable Shannyn Taylor to be the Coroner's Investigator for the investigation of Michael'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.

7. This finding draws on the totality of the coronial investigation into Michael'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.

Background

8. Michael was born in Perth and moved to Melbourne in 1958 where he grew up with his two brothers. During his childhood, Michael was diagnosed with autism and intellectual disability; he remained non-verbal for the rest of his life. He was described as a happy child.

9. From the age of about nine years, Michael resided in care facilities and maintained regular contact with his family. Michael was later diagnosed with epilepsy.

10. In 2004, Michael moved to a supported residential service in Noble Park. In later years, Michael's mobility deteriorated and he began using a wheelchair in 2015.

11. Michael enjoyed attending day programs run by Scope (Aus) Limited (**Scope**) four or five times a week where he could participate in various activities.

12. A statement from Michael's neurologist, Dr Saman Punchihewa, indicated that Michael was also diagnosed with Parkinson's disease and possible bipolar disorder. The Parkinsonism was thought to be related to treatment with haloperidol and his symptoms were well-controlled. His epilepsy was also well-controlled and stable.

13. Michael's general practitioner, Dr Onsy Hanna at TLC Primary Care, added psychosis, schizophrenia, chronic constipation, and swallowing difficulty to Michael's medical history. Michael also had recurrent chest infections and pneumonia which had required hospital admissions with the most recent admission in late April 2023.

14. Michael's father passed away in 2006 and his mother passed away in 2021. Michael's brother, Brendan Luno, thereafter made medical decisions on his behalf.

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

Circumstances in which the death occurred

15. Dr Hanna noted that in the days preceding his death, Michael had normal bowel motions and was well. There was no noted nausea, vomiting, or abdominal pain over the previous weekend.

16. On the morning of 8 May 2023, Michael awoke as usual and had breakfast. At about 8.30am he was taken to his day program at Parkdale Lifestyle Centre.

17. According to Lisa Evans, Chief Operating Officer in Victoria of Scope, staff noticed that Michael appeared tired at about 10.00am. He refused his morning coffee, which was out of character. His temperature was normal, but staff continued to monitor him closely.

18. After consuming a small amount of liquid and lunch, Michael vomited.

19. Following discussion with his carers, he was sent home where he was met by his support worker Muthiah Kanagaraja who thought Michael looked unwell and tired. Muthiah telephoned Michael's doctor but there were no available appointments at the medical clinic. After placing Michael in bed, Muthiah contacted emergency services to request an ambulance.

20. Ambulance Victoria paramedics arrived at about 3.00pm. Their assessment indicated that Michael had fluid on the lung, so they transported him to Dandenong Hospital.

21. At hospital, Michael presented with vomiting, distended abdomen, agitation, and distress. Brendan was informed of proposed tests and investigations and Michael's previous goals of care including that he was not for cardiopulmonary resuscitation (**CPR**), were confirmed.

22. That evening and following insertion of a nasogastric tube, Michael began projectile vomiting faeculent matter and his oxygen saturation levels dropped. A Code Blue was called, and two rounds of CPR were administered as Michael's re-confirmed 'not for resuscitation plan' had not yet been formally documented in the system.

23. Following the arrest, an endotracheal tube was inserted and resuscitation attempts continued. Return of spontaneous circulation was achieved at 9.13pm. He was thereafter transferred to the Intensive Care Unit for ongoing management.

24. A CT abdomen scan showed generalised dilated bowel loops but no clear point of obstruction so there was no indication for surgery. Treatment remained supported and aimed to continue to decompress the stomach with the nasogastric tube.

25. Over the following days, Michael's condition did not improve and it was determined that meaningful recovery would be unlikely. Following discussion with his family, Michael was transitioned to palliative care.

26. Michael sadly passed away on the morning of 13 May 2023.

Identity of the deceased

27. On 13 May 2023, Michael Manuel Luno, born 16 January 1957, was visually identified his brother, Brendan Luno.

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

Medical cause of death

29. Senior Forensic Pathologist, Dr Michael Burke, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 15 May 2023 and provided a written report of his findings dated 18 May 2023.

30. The post-mortem CT scan showed subcutaneous oedema, a few fluid levels in the small bowel, marked increase in lung markings, pleural effusion, and coronary calcification. There were no acute changes in the head.

31. Dr Burke provided an opinion that the medical cause of death was *"1(a) Aspiration pneumonia in the setting of a small bowel obstruction".* Dr Burke noted the cause of death was due to natural causes.

32. I accept Dr Burke's opinion.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Michael Manuel Luno, born 16 January 1957;

    (b) the death occurred on 13 May 2023 at Dandenong Hospital, 135 David Street, Dandenong, Victoria, from aspiration pneumonia in the setting of a small bowel obstruction; and

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

I convey my sincere condolences to Michael's family and friends 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:

Brendan Luno, senior next of kin

Monash Health

Senior Constable Shannyn Taylor, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 11 January 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.