IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003583

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Craig John Reynolds
Date of birth:	18 April 1961
Date of death:	Between 1 and 2 July 2023
Cause of death:	1(a) HYPERTENSIVE AND ISCHAEMIC HEART DISEASE IN A MAN WITH DIABETES MELLITUS
Place of death:	73 Thomas Street, South Morang, Victoria, 3752
Keywords:	In care; natural causes

INTRODUCTION

1. On 2 July 2023, Craig John Reynolds was 62 years old when he was found deceased at his residence.

2. At the time of his death, Mr Reynolds lived in a self-contained unit in Carroll House at 73 Thomas Street, South Morang – short-term accommodation funded by the National Disability Insurance Scheme (NDIS). Carroll House is operated by GenU[1] and Mr Reynolds was in the process of moving to specialist disability accommodation (SDA) in Wallan (which was under construction).

THE CORONIAL INVESTIGATION

3. Mr Reynolds' 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 is a mandatory report to the coroner, even if the death appears to have been from natural causes.

4. Although Mr Reynolds was not an SDA resident living in an SDA dwelling at the time of his death, he was receiving NDIS funded daily independent living support and was in short term accommodation and scheduled to move into an SDA dwelling. On 1 July 2024 an amendment to the definition of SDA resident became operational, expanding the definition to include a person who "proposes to reside in an SDA dwelling".[2] Accordingly, had Mr Reynolds passed away after this amendment came into operation, he would be a 'person placed in custody or care' within the meaning of section 4 of the Act.[3] Mr Reynold's death occurred after the commencement of the amending Act[4] but before the relevant amendment came into operation.

5. In these circumstances, I have determined it appropriate to conduct the coronial investigation as though Mr Reynold was a person in care at the time of his death – this includes the requirement to publish findings.

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1 A division of Karingal St Lawrence Ltd and a National Disability Insurance Scheme (NDIS) provider.
2 Section 3(1) of the *Residential Tenancies Act 1997* – as amended by section 141(2)(b) of the *Disability and Social Services Regulation Amendment Act 2023*
3 Section 4(2)(j)(i) of the *Coroners Act 2008*; Regulation 7 of the *Coroners Regulations 2019*.
4 The *Disability and Social Services Regulation Amendment Act 2023* commenced on 23 May 2023.

6. 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.

7. Senior Constable (SC) Alexandria Dane acted as the Coroner's Investigator for the investigation of Mr Reynolds' death. SC Dane conducted inquiries on my behalf and compiled a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Craig John Reynolds 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.[5]

BACKGROUND

9. Mr Reynolds' medical history included Type 2 diabetes, hypertension, arterial vascular disease, ischaemic heart disease, L5 disc prolapse, alcohol and amphetamine use disorder, chronic pain and depression. He had previously lived with his parents until his father passed in February 2023 and his mother was admitted to a residential aged care residential.

10. On 6 March 2020, Mr Reynolds underwent a below-knee amputation of his left leg due to recurring ulceration and infection. He used a motorised wheelchair following the amputation.

11. Mr Reynolds moved into Carroll House in March 2023, following his discharge from the Austin Hospital.

12. At Carroll House, Mr Reynolds self-directed his care needs and was independent with daily personal care tasks. Mr Reynolds also requested to self-manage and administer his medications. An Extreme Functional Impairment report completed by an occupational therapist identified him as not requiring support for transferring to or from his wheelchair.

[5] 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.

13. Mr Reynolds' support plan identified that he may become agitated if his personal space was encroached upon, and he did like being supervised. He regularly refused staff assistance with meals, cleaning and personal care tasks.

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

Circumstances in which the death occurred

14. On 22 June 2023, Mr Reynolds fell when moving by himself from his bed to his wheelchair. It did not appear that he had suffered any injury, and he reported no pain and declined further medical attention. He told his support worker that he had an appointment with his GP the following day.

15. On the morning of 23 June 2023, a support worker found Mr Reynolds laying on his bed – he was lethargic and appeared confused with slurred speech. He was conveyed to the Northern Hospital and was subsequently admitted to the gastroenterology unit with signs of severe anaemia and hypoglycaemia.

16. On 27 June 2023, Mr Reynolds underwent a gastroscopy which revealed multiple gastric ulcers and gastritis.

17. On 28 June 2023, Mr Reynolds became hypotensive, and he was transferred to the Intensive Care Unit (ICU). The ICU treating team found gastrointestinal bleeding and infection and advised Mr Reynolds to remain in the ICU for haemodynamic support and further medical investigation.

18. On 30 June 2023, Mr Reynolds self-discharged against the advice of his treating physicians. Prior to discharge, he was advised of the risks of bowel perforation and hypotension, and he was noted to have understood these risks.

19. Mr Reynolds was collected by a support worker and arrived back at Carroll House at approximately 1.00pm. He did not provide his discharge summary despite multiple requests from support workers, and he later insisted that they were not to assist with administering his medications. His support workers continued to monitor him closely, and he was noted to be settled.

20. On 1 July 2023, after breakfast, Mr Reynolds took a taxi to a shopping centre. He returned to Carroll House at approximately 1.30pm and then spent the rest of the afternoon watching

television and playing games with other residents. He showed no signs of discomfort throughout the afternoon. In the evening, he had dinner and retired to his room.

21. On 2 July 2023, at 8.00am, a support worker conducted a visual check on Mr Reynolds from the door as she did not want to wake him. At 10.00am, she entered his room to serve breakfast but did not wake him as he appeared asleep.

22. At 12.30pm, the same support worker attempted to wake Mr Reynolds, but he was unresponsive. Staff called 000 Emergency and performed CPR according to instructions.

23. Ambulance Victoria paramedics arrived at 12.50pm and took over CPR. Despite their efforts, Mr Reynolds could not be revived, and he was declared deceased at 1.05pm.

24. There is no evidence to suggest that Mr Reynolds's care was anything other than appropriate.

Identity of the deceased

25. On 5 July 2023, Craig John Reynolds, born 18 April 1961, was visually identified by his daughter, Davyn Reynolds.

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

Medical cause of death

27. Forensic Pathologist, Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an autopsy on 6 July 2023 and provided a written report of his findings dated 16 August 2023.

28. The post-mortem examination revealed no evidence of an acute injury that may have contributed to or led to death. There was evidence of an enlarged heart with focal coronary artery disease. There was no evidence of myocardial fibre disarray on microscopic examination of the heart (a classic feature of cardiomyopathy).

29. The post-mortem CT scan revealed no evidence of intracranial haemorrhage and skull fracture. There was evidence of distended bowel loops but no clear calibre change. There was also evidence of calcification of the coronary arteries and mitral valve, bilateral pleural effusions, distended bladder and bilateral anterolateral rib fractures.

30. Dr Burke commented that the degree of heart disease is consistent with a sudden death due to a sudden cardiac arrhythmia.

31. Dr Burke explained that hypertension and cardiomyopathies are the risk factors for the development of an enlarged heart in the absence of significant valve disease.

32. Toxicological analysis of post-mortem samples identified the presence of oxycodone, nordiazepam[6], mirtazapine[7], verapamil[8], norverapamil[9], quetiapine[10], pregabalin, metformin[11], sitagliptin[12]. The presence and concentration of these drugs was unremarkable in the circumstances.

33. Dr Burke provided an opinion that the medical cause of death was 1 (a) HYPERTENSIVE AND ISCHAEMIC HEART DISEASE IN A MAN WITH DIABETES MELLITUS.

34. I accept Dr Burke's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Craig John Reynolds, born 18 April 1961;

    b) the death occurred between 1 and 2 July 2023 at 73 Thomas Street, South Morang, Victoria, 3752, from HYPERTENSIVE AND ISCHAEMIC HEART DISEASE IN A MAN WITH DIABETES MELLITUS; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Mr Reynolds' family and carers for their loss.

I thank the Coroner's Investigator and those assisting for their work in this investigation.

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.

[6] Metabolite of diazepam.
[7] Mirtazapine is indicated for the treatment of depression.
[8] Verapamil is a drug used to treat high blood pressure, angina and irregular heartbeat (arrhythmias).
[9] Metabolite of verapamil.
[10] Quetiapine is an atypical antipsychotic agent.
[11] Metformin is an antidiabetic drug used to treat maturity-onset diabetes.
[12] Sitagliptin is a dipeptidyl peptidase-4 inhibitor which is used as an oral hypoglycemic agent.

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

Davyn Reynolds, Senior Next of Kin

Northern Health

GenU (Karingal St Laurence Ltd)

Senior Constable Alexandria Dane, Coroner's Investigator

Signature:

Coroner Paul Lawrie

Date : 16 October 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.