IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005470

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Russell James Aldridge
Date of birth:	24 June 1966
Date of death:	1 October 2023
Cause of death:	1(a) Complications of congenital rubella (palliated) Contributing factor(s) 2 Renal cell carcinoma
Place of death:	14 Shannahan Drive Norlane Victoria 3214
Keywords:	In care death; natural causes; congenital rubella

INTRODUCTION

1. On 1 October 2023, Russell James Aldridge was 57 years old when he passed away at his home. At the time of his death, Mr Aldridge lived in a specialist disability care facility in Norlane, Victoria, managed by Scope.

2. Mr Aldridge lived in care from about 1972, when he was six years old, in various care facilities. He had a complex medical history which included asthma, cervical myelopathy, congenital rubella, dysphagia, epilepsy, intellectual disability and two prior strokes. He was deaf, blind, and non-verbal and communicated by writing in a notebook or by Key Word Signs. He required assistance with meal preparation, personal care, medication administration, mobility, and continence management.

3. In September 2022, Mr Aldridge began to experience frequent loose bowel movements, which led to a colonoscopy. Unfortunately, due to non-compliance by Mr Aldridge, the first colonoscopy scheduled in December 2022 was unsuccessful. He underwent a CT scan in January 2023, which revealed polyps and/or masses in his bowels and kidney. Mr Aldridge was referred to a urologist for the kidney mass and was rescheduled for another colonoscopy.

4. A second colonoscopy was performed in March 2023, in which some polyps and/or masses were removed. These were deemed to be abnormal. A follow-up CT scan revealed Mr Aldridge's kidney mass had increased in size. His urologist determined that this mass could not be removed surgically. Clinicians consulted with Mr Aldridge's brother and jointly decided not to pursue chemotherapy or radiotherapy.

THE CORONIAL INVESTIGATION

5. Mr Aldridge'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 Aldridge was a "*person placed in custody or care*" pursuant to the decision in s 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]

[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 information that Mr Aldridge resided at an address where the residents meet these criteria.

6. 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.

7. 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.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Aldridge's death. The Coroner's Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Russell James Aldridge 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.[3]

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

Circumstances in which the death occurred

10. From August 2023, Mr Aldridge's health began to deteriorate. He experienced several hospital admissions to treat seizures, a urinary tract infection (**UTI**), and aspiration pneumonia. Mr Aldridge's general practitioner (**GP**) and urologist were in regular contact with the carers at his home and provided information regarding his various medical conditions.

11. Over the course of September 2023, Mr Aldridge regularly presented as tired and with shortness of breath, however he was able to engage with staff when he was awake. His GP provided a referral for palliative care, and regular palliative care nurses visited him to monitor his condition.

[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.

12. On 29 and 30 September 2023, Mr Aldridge was noted by his carers to experience increased pain levels and somnolence. On 1 October 2023, the palliative care team visited Mr Aldridge and recommended that he not receive any food or fluids orally, as he was no longer alert enough to tolerate same. The palliative care nurses provided morphine for pain relief at 1.00pm and 5.30pm that day and gave instructions to his carers to monitor Mr Aldridge every 30 minutes.

13. At about 7.15pm, Mr Aldridge was in bed when his carers noted that he was diaphoretic, so they attempted to change his shirt to make him more comfortable. During this process, Mr Aldridge became unresponsive, so his carers immediately contacted 000, Mr Aldridge's brother, the palliative care team, and their manager. In accordance with his advance care plan, Mr Aldridge was not resuscitated and was declared deceased at the scene.

14. Police attended Mr Aldridge's care home and confirmed that there were no suspicious circumstances or signs of third-party intervention in connection with Mr Aldridge's passing. In his statement to the Court, Mr Aldridge's brother commended the carers and opined that they provided great compassion and care to his brother during his time at the home.

Identity of the deceased

15. On 1 October 2023, Russell James Aldridge, born 24 June 1966, was visually identified by his carer, Shinae Colville.

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

Medical cause of death

17. Forensic Pathologist Dr Victoria Francis, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 3 October 2023 and provided a written report of her findings dated 11 October 2023.

18. The post-mortem examination revealed findings consistent with the reported circumstances.

19. Examination of the post-mortem CT scan showed an enlarged heart, long-standing white matter changes, particularly in the right cerebral hemisphere as well as a left pleural effusion and calcified coronary arteries. There was no obvious renal lesion.

20. Toxicological analysis of post-mortem samples was not indicated and was therefore not performed.

21. Dr Francis provided an opinion that the medical cause of death was "*1(a) Ccomplications of congenital rubella (palliated)*" with "*2 Renal cell carcinoma*" as a complicating factor. She opined that the death was due to natural causes.

22. I accept Dr Francis' opinion.[4]

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Russell James Aldridge, born 24 June 1966;

    b) the death occurred on 1 October 2023 at 14 Shannahan Drive Norlane Victoria 3214, from complications of congenital rubella (palliated) with renal cell carcinoma as a complicating factor; and

    c) the death occurred in the circumstances described above.

I convey my condolences to Mr Aldridge'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:

Lawrence Aldridge, Senior Next of Kin

Senior Constable Daniel Watson, Victoria Police, Coroner's Investigator

Signature:

Coroner Catherine Fitzgerald

[4] Pursuant to s 52(3A) of the Act, a coroner is not required to hold an inquest where the deceased was, immediately before death, a person placed in custody or care, if the coroner considers that the death was due to natural causes.

Date : 13 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.