IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 006322

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Audrey Jamieson
Deceased:	Maxwell Bernard Howard
Date of birth:	28 June 1939
Date of death:	14 November 2023
Cause of death:	1a: Bronchopneumonia in the setting of pulmonary emphysema and hypertensive heart disease
Place of death:	Steel Haughton Acute Unit, Queen Elizabeth Centre, 1101 Dana Street, Ballarat Central, Victoria 3350

INTRODUCTION

1. On 14 November 2023, Maxwell Bernard Howard was 84 years old when he died in hospital. At the time of his death, Maxwell had recently been admitted into care.

2. Maxwell enjoyed listening to music and the radio and watching the Bathurst 1000. He had previously worked as a builder and a publican when he owned a hotel.

3. Maxwell experienced several acute and chronic health conditions including congestive heart failure, left ventricular failure, aortic stenosis, osteoarthritis, hypertension, chronic obstructive pulmonary disease and hypercholesterolemia. He had alcohol dependence and was dismissive of any interventions to reduce his alcohol use.

4. Maxwell was diagnosed with Bipolar Affective Disorder Type II in 1973. This was generally well managed with carbamazepine and quetiapine until around 2018, when Maxwell became non-compliant with medication. Around this time, his physical health also deteriorated, and he avoided medical appointments unless absolutely necessary.

5. Maxwell had close to 40 admissions to Grampians Health between 2011 and 2023, including 7 admissions in 2023 due to recurrent falls, chest pain, gastroenteritis, refusal of care and agitation.

6. Grampians Health and Maxwell's son Paul discussed placing him into care due to his deteriorating health, increasing hospital attendances and living conditions at home. Maxwell was staunchly against receiving assistance or entering care, however Paul reported that Grampians Health advised they would seek an involuntary treatment order.

THE CORONIAL INVESTIGATION

7. Maxwell's 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. Additionally, Maxwell was, immediately before death, 'a person placed in custody or care' for the purposes of the Act as he was on a Temporary Treatment Order pursuant to the *Mental Health and Wellbeing Act 2022*. 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.

8. Section 52(2) of the Act prescribes when a coroner must hold an Inquest into a death. This includes where the deceased was, immediately before death, a person placed in custody or

care. However, as Maxwell's death was due to natural causes, I am not required to hold an Inquest.[1]

9. 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.

10. 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.

11. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Maxwell's death. The Coronial 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.

12. This finding draws on the totality of the coronial investigation into the death of Maxwell Bernard Howard 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.[2]

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

Circumstances in which the death occurred

13. Maxwell was admitted to Grampians Health on 9 November 2023. He was initially admitted to the Jim Gay Unit but transferred to the Steele Haughton Aged Acute Unit, a short-term inpatient mental health unit, due to his non-compliance with medication and challenging

[1] Section 52(3A) *Coroners Act 2008* (Vic).

[2] 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.

behaviours. He presented with symptoms of pressured speech, disinhibited behaviour towards female staff, verbal abuse and derogatory comments.

14. Maxwell's placement in the unit caused him distress and he regularly removed his feeding tube. According to Paul, Maxwell was of sound mind and while he often objected to other people's decisions, he was aware of his surroundings.

15. On 11 November 2023, Maxwell was assessed by a Registered Nurse who determined that he met the criteria in section 142 of the *Mental Health and Wellbeing Act 2022* to be placed on an Inpatient Assessment Order.

16. On the same day, Paul and his partner Rebecca visited Maxwell at the Steel Haughton unit. Maxwell told them that he had been thrown onto a bed and threatened by a male nurse, after Maxwell had thrown a coffee at him.

17. On 12 November 2023, Maxwell was assessed by a Consultant Psychiatrist who considered him to be at *"high risk of harm by misadventure and risk of harm by aggression"* and noted that he was *"declining recommended care and treatment including medication"*. He was placed on a Temporary Treatment Order.

18. At 5:57am on 14 November 2023, Maxwell requested a cotton pad to clean the saliva in his throat, which nursing staff declined explaining this could obstruct his airway. He was not satisfied with this and yelled at staff.

19. At around 1pm, Maxwell complained of abdominal pain. A Medical Officer attempted to review him while he sat at the dining room table, but he refused to have them physically examine him and told them to go away. The medical officer advised staff to give him paracetamol for the pain.

20. At 2:34pm, nursing staff noted that Maxwell was spitting excess saliva into cups and had small oral intake. He declined for his vitals to be checked by the Medical Officer.

21. At 3:15pm, Maxwell had afternoon tea in the lounge area.

22. At 4:10pm, a nurse requested a medical review as Maxwell had been sitting still in his chair since the last review. The Medical Officer observed that he was pale and unresponsive with no pulse or heartbeat. He was declared deceased by paramedics shortly afterwards.

Identity of the deceased

23. On 14 November 2023, Maxwell Bernard Howard, born 28 June 1939, was visually identified by Nurse Unit Manager Jane Lockhart, who completed a Statement of Identification.

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

Medical cause of death

25. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Maxwell Howard on 20 November 2023. Dr Lynch considered materials including the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, and medical records and E-Medical Deposition Form from Grampians Health and provided a written report of his findings dated 24 January 2024.

26. The autopsy revealed significant natural disease in the form of widespread bronchopneumonia involving both the right and left lungs, which Dr Lynch commented may be reflective of an aspiration episode or represent an infective exacerbation of Maxwell's obstructive pulmonary disease. There was also evidence of cardiomegaly and coronary artery atherosclerosis.

27. The post mortem CT scan showed cerebral atrophy, coronary calcification, aortic and mitral valvular calcification, pulmonary emphysema and metal within the right hip.

28. Toxicological analysis of post mortem blood samples identified the presence of acetone (~ 41 mg/L), oxycodone (~ 0.02 mg/L) and bisoprolol (~ 0.01 mg/L).

29. Dr Lynch provided an opinion that the medical cause of death was 1(a) BRONCHOPNEUMONIA IN THE SETTING OF PULMONARY EMPHYSEMA AND HYPERTENSIVE HEART DISEASE.

FAMILY CONCERNS

30. In their statements forming part of the Coronial Brief, Paul and Rebecca stated that Maxwell had disclosed to them being thrown onto his bed by a male nurse and threatened. Rebecca submitted a complaint form on Maxwell's behalf on the day of that disclosure, and Paul and Rebecca had since attempted to contact Grampians Health regarding their concerns.

31. I have been unable to substantiate Maxwell's allegations as there is no record of such an incident in the medical record. And, while such an incident would certainly be extremely concerning, there is no causal nexus between Maxwell's care and his death from natural causes. I do however encourage Grampians Health to liaise with Maxwell's family regarding their concerns if they have not done so already.

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 Maxwell Bernard Howard, born 28 June 1939;

    b) the death occurred on 14 November 2023 at Steel Haughton Acute Unit, Queen Elizabeth Centre, 1101 Dana Street, Ballarat Central Victoria 3350,

    c) I accept and adopt the medical cause of death ascribed by Dr Matthew Lynch and I find that Maxwell Bernard Howard, a man with pulmonary emphysema and hypertensive heart disease, died from bronchopneumonia;

2. AND, I have determined that the application of section 52(3A) of the Act is appropriate in the circumstances as I accept that Maxwell Bernard Howard's death was due to natural causes and I find there is no relationship or causal connection between his death and his status as a person placed in custody or care immediately before his death.

I convey my sincere condolences to Maxwell'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.

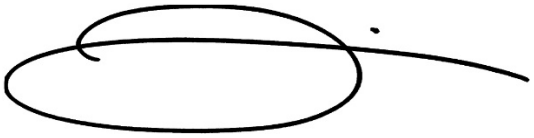
I direct that a copy of this finding be provided to the following:

Paul Howard, Senior Next of Kin

Grampians Health

Senior Constable Cameron McCallum, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 14 July 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.