IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002342

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	QBT[1]
Date of birth:	02 July 1959
Date of death:	26 April 2024
Cause of death:	1a : Complications of congestive cardiac failure on a background of cardiac hypertrophy 2 : Chronic obstructive pulmonary disease, hypertension
Place of death:	Bendigo Health 100 Barnard Street Bendigo Victoria 3550
Keywords:	In care death, congestive cardiac failure, natural causes.

[1] This finding has been de-identified at the direction of Coroner Despot.

INTRODUCTION

1. On 26 April 2024, QBT was 64 years old when he passed away at Bendigo Hospital. Prior to his death, QBT resided alone at his home in Kyabram. He is survived by his sister, RT.

2. QBT had a complex medical history including chronic paranoid schizophrenia, post-traumatic stress disorder, hepatitis C, personality disorder, chronic obstructive pulmonary disease **(COPD)**, acquired brain injury (following a motor vehicle incident in 1986), generalised anxiety and hypertension.

3. In 2020, QBT was treated under a Community Treatment Order **(CTO)** and received fortnightly Flunaxol 100mg depot injections. The CTO was later revoked, and he was treated as a voluntary patient with Echuca Community Mental Health Team **(ECMHT)**. QBT refused further treatment with depot injections in October 2022 and his ongoing care was referred back to his general practitioner.

4. QBT attended various medical practitioners at the Scope Medical Clinic in Kyabram. His last attendance at the clinic was on 27 March 2024 where he presented in a disorganised and agitated state and left without consultation.

THE CORONIAL INVESTIGATION

5. QBT'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. 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.[2]

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.

[2] See the definition of "reportable death" in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of "person placed in custody or care" in section 3 of the Act.

7. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of QBT's death. The Coronial Investigator, First Constable Zachary Mekeham, conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of QBT 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

9. QBT was known to local police due to his mental health issues. On 15 April 2024, Bendigo Health Regional Triage Service were contacted by Kyabram police seeking to refer QBT due to a deterioration in his mental health. Police had received numerous calls from the public regarding QBT, that he had been witnessed laying down in the park and other locations around town for long periods. He was reported to be more heightened and disheveled and did not appear to be taking care of himself.

10. On 18 April 2024, QBT was visited by the ECMHT and police for an assessment. His home was noted to be in an appalling and squalid state, and he appeared to have breathing difficulties. QBT would not make eye contact and at times, his ramblings were incomprehensible. He was unable to participate in his mental health assessment and was found to be physically compromised and mentally not displaying capacity.

11. QBT was placed on an Assessment Order under the *Mental Health & Wellbeing Act 2022* (Vic) and transferred to Bendigo Hospital. He required physical restraints and chemical sedation to manage his aggressive behaviour. He was then transferred to the Adult Acute Unit **(AAU**-inpatient mental health unit**)** following medical clearance.

[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 19 April 2024, QBT was reviewed by Consultant Psychiatrist Dr Ravindra Reddy **(Dr Reddy)** and the AAU's Consultant Psychiatrist. QBT was difficult to understand and thought disoriented. He was responding to internal stimuli (hallucinations) and lacked insight into his illness. He was placed on a Temporary Treatment Order.

13. On 20 April 2024, QBT was reviewed by the Psychiatry on-call Registrar. He was angry about his admission and asked for painkillers. Later that day, he was noted to be breathless on minimal exertion. He refused medication and any nursing interventions. The on-call Registrar considered that QBT likely had viral exacerbation of asthma. A septic screen was suggested along with blood cultures and tests.

14. A Medical Emergency Team **(MET)** call occurred at 9.20pm that evening due to ongoing concerns with QBT's breathing. The MET team advised a full septic screen including blood and urine cultures and respiratory viral swabs. He was reviewed on 21 April 2024 and his care was discussed with the Medical Registrar. His vital signs were within normal range and his medical condition was stable.

15. QBT continued to have intermittent shortness of breath, but his vitals remained within the normal range. He was reviewed by Dr Reddy on 24 April 2024 and his observations and saturations were stable and normal. The extended respiratory panel testing and blood cultures had returned negative results. Dr Reddy noted that QBT's mental state was gradually improving, though he lacked insight and remained disordered.

16. On 25 April 2024, QBT was found to be unsteady on his feet and reported abdominal pain with ongoing shortness of breath. His vital signs were within normal range.

17. On 26 April 2024, QBT was drowsy, short of breath and had pitting oedema of his legs. The impression was that the pitting oedema was possibly due to heart failure or could be due to untreated hepatitis. He was started on Furosemide 40mg daily.

18. At 2.15pm, QBT had a MET call for hypoxia following a vomiting episode. The medical team agreed to transfer him to the medical ward when a bed became available. His condition deteriorated further whilst awaiting transfer and a second MET call was activated at 4.15pm. QBT had hypoxia and saturation of 82% on room air with a Glasgow Coma Score **(GCS)**[4] of

[4] The Glasgow Coma Scale is a clinical scale used to reliably measure a person's level of consciousness after a brain injury. It is scored between 3 and 15.

11/15. Supplemental oxygen was commenced. QBT was to have a CT brain scan and was to commence on intravenous (IV) antibiotics for presumed chest sepsis.

19. QBT arrived on the medical ward at 5.35pm following a brain CT scan. Intravenous access was obtained with blood samples sent to the lab. Medical staff administered IV antibiotics as well as dexamethasone.

20. Medical records documented that QBT had a rapid deterioration with reduction in GCS later that same evening and a third MET call was activated at 6.45pm. He became unresponsive, and a Code Blue was called. Cardiopulmonary resuscitation was in progress and advanced life support was instituted.

21. On a review of formal bloods, it was noted that QBT had multiorgan failure-including renal failure, worsening hepatic function and coagulopathy. It was determined by the treating team that further treatment would not be beneficial. QBT was declared deceased at 7.13pm. The medical e-deposition noted the possible cause of death as *"Pneumonia resulting in acute renal failure, possible acute liver failure".*

Identity of the deceased

22. On 11 May 2024, QBT, born 2 July 1959, was visually identified by his acquaintance, GM.

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

Medical cause of death

24. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine conducted an autopsy on 2 May 2024 and provided a written report of her findings dated 18 October 2024.

25. The post-mortem examination revealed cardiac hypertrophy, biventricular dilatation, congestive hepatopathy, bilateral pleural effusions and bilateral anterior rib fractures. Dr Archer noted that the cause of death was congestive cardiac failure. This is a form of heart failure where fluid accumulates in the body. Dr Archer noted that it is a gradually progressive condition which can also suddenly become worse due to provoking factors such as stress, illness or medication changes. The aetiology of QBT's heart failure was not clear, but his risk factors were hypertension and COPD.

26. Post-mortem toxicology testing was performed on antemortem blood specimen collected on the 26 April 2024. There were no blood specimens available from the time of hospital admission. However, the toxicology analysis did not show any immediate toxicological contribution to the death, with detection of the benzodiazepine diazepam (and its metabolites nordiazepam, and temazepam). There was also detection of the antipsychotic olanzapine, and the antinausea drug ondansetron, along with trace detection of the analgesic paracetamol. This was most in keeping with therapeutic use. There was no evidence of infection seen at autopsy. The inflammatory maker C-reactive protein was mildly elevated, and not suggestive of sepsis.

27. Dr Archer provided an opinion that the medical cause of death was *1(a) Complications of congestive cardiac failure on a background of cardiac hypertrophy, 2) Contributing factors chronic obstructive pulmonary disease, hypertension.* Dr Archer was of the opinion that the death was due to natural causes.

28. I accept Dr Archer's opinion.

FURTHER INVESTIGATIONS

29. Given the medical matters raised above, I referred the matter to the Coroners Prevention Unit **(CPU)**[5] for review. The CPU considered the available medical materials and noted that QBT's presenting signs and symptoms on 18 April 2024 were not consistent with his cause of death. He did not have signs and symptoms or investigations to suggest cardiac failure (pitting oedema), even at autopsy.

30. QBT had his shortness of breath investigated on 20 April 2024 via x-ray which noted cardiomegaly and clear lung fields (no pulmonary oedema). On 24 April, he dropped his conscious and oxygen saturations, and he had right upper quadrant pain. Bloods were performed which showed multiorgan impairment. He had low sodium, high potassium, and impaired renal function compared to his bloods on admission. The CPU noted that QBT was not on any medications that could account for these changes.

[5] 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.

31. The CPU considered that medical staff appropriately recognised and responded to the deterioration but as there was no specific reversible cause found, these interventions were unsuccessful. The CPU concluded that it remained unclear why QBT deteriorated during his stay.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was QBT, born 02 July 1959;

    b) the death occurred on 26 April 2024 at Bendigo Health, 100 Barnard Street Bendigo Victoria 3550 from complications of congestive cardiac failure on a background of cardiac hypertrophy, with contributing factors of chronic obstructive pulmonary disease and hypertension and;

    c) the death occurred in the circumstances described above.

33. Having reviewed all the evidence, I am satisfied that QBT's death was due to natural causes.

I convey my sincere condolences to the family of QBT 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:

RT, Senior Next of Kin

Stacy Thackray, Bendigo Health

First Constable Zachary Mekeham, Coronial Investigator

Signature:

Coroner Kate Despot

Date: 11 April 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.