IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002437

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Kevin Arthur Stanton
Date of birth:	5 November 1947
Date of death:	2 May 2024
Cause of death:	1(a) Urosepsis in a man with spastic quadriplegia, cerebral palsy, epilepsy and chronic kidney disease
Place of death:	Austin Hospital 145 Studley Road Heidelberg Victoria
Keywords:	In care – disability – natural causes – supported disability accommodation

INTRODUCTION

1. On 2 May 2024, Kevin Arthur Stanton was 76 years old when he passed away at the Austin Hospital. At the time of his death, Mr Stanton lived in a residential care facility in Bellfield, Victoria.

2. Mr Stanton's medical history included spastic quadriplegia, cerebral palsy, epilepsy, chronic kidney disease and glaucoma. He also had an intellectual disability. He was non-verbal and required a hoist for transfers. He enjoyed interacting with others and watching television.

THE CORONIAL INVESTIGATION

3. Mr Stanton'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. Mr Stanton was a person in care at the time of his death as he was a Specialist Disability Accommodation (**SDA**) resident living in an SDA dwelling pursuant to Regulation 7(1)(d) of the *Coroners Regulations 2019*. However, an inquest was not required to be held pursuant to section 52(3A) of the Act given that Mr Santon's death was 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. This finding draws on the totality of the coronial investigation into Mr Stanton's death including information obtained from his medical records. While 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]

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

Circumstances in which the death occurred

7. On 14 May 2024, Mr Stanton was admitted to the Austin Hospital with poor oral intake and severe hyponatraemia presumed to be the result of a urinary tract infection. He was treated with intravenous antibiotics and fluids but his condition deteriorated and he was transferred to a palliative pathway in consultation with family. He subsequently passed away on 2 May 2024.

Identity of the deceased

8. On 2 May 2024, Kevin Arthur Stanton, born 5 November 1947, was visually identified by his niece, Donna Gervasoni.

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

Medical cause of death

10. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine conducted an external examination on 3 May 2024 and provided a written report of her findings dated 27 May 2024.

11. There were no injuries found which may have caused or contributed to the death. Dr Archer expressed the opinion that the death was due to natural causes.

12. Dr Archer provided an opinion that the medical cause of death was 1 (a) Urosepsis in a man with spastic quadriplegia, cerebral palsy, epilepsy and chronic kidney disease.

13. I accept Dr Archer's opinion.

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[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.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Kevin Arthur Stanton, born 5 November 1947;

    b) the death occurred on 2 May 2024 at the Austin Hospital, 145 Studley Road, Heidelberg, Victoria, from urosepsis in a man with spastic quadriplegia, cerebral palsy, epilepsy and chronic kidney disease; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Mr Stanton'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:

Patricia Gervasoni, Senior Next of Kin

Austin Health

Constable Rocky Gao, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 02 August 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.