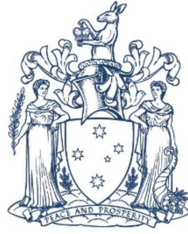

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 006295

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	Donald Walter Thoms
Date of birth:	21 July 1933
Date of death:	12 November 2023
Cause of death:	1a : COMPLICATIONS FOLLOWING ASPIRATION OF FOOD
Place of death:	84 Mackie Road Bentleigh East Victoria 3165
Keywords:	'In care' death, natural causes

INTRODUCTION

1. On 12 November 2023, Donald Walter Thoms was 90 years old when he passed away at his specialist disability residential care accommodation after a period of palliative care. At the time of his death, Mr Thoms lived at 84 Mackie Road, Bentleigh East, a supported living facility operated by Life Without Barriers.

2. Mr Thoms began receiving community palliative care support from the Calvary Bethlehem Palliative Care Team on 15 July 2023.

3. Mr Thoms had a medical history of intellectual disability, lobar aspiration, aspiration pneumonia, recurrent fall and pressure ulcer. He started using a wheelchair a few years prior to his death.

4. Mr Thoms was at high risk of aspiration[1]. Therefore, he was limited to eating smooth, pureed foods and thickened drinks.[2]

5. According to the group home supervisor, Mohammed Iproliya, Mr Thoms was nonverbal and could not communicate that he was in pain or discomfort, so support staff monitored him closely during mealtime. He also required assistance with all aspects of daily living.

6. Mr Thoms' niece, Catherine Garrett, visited him regularly and liaised with his carers regarding his care. Ms Garrett was also Mr Thoms' medical treatment decision maker.

THE CORONIAL INVESTIGATION

7. Mr Thoms' 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.

8. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspect that the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

[1] Coronial Brief (**CB**), Incident Report.
[2] Coronial Brief, Mealtime Support Plan.

9. Immediately before his death, Mr Thoms' was a person placed in care within the meaning of section 4 of the Act as he was a prescribed class of person[3] due to his status as an "SDA[4] resident residing in an SDA enrolled dwelling".

10. However, section 52(3A) of the Act provides an exception to the requirement under section 52(2) that the coroner is not required to hold an inquest if the coroner considers the death to have been due to natural causes. Having considered all the evidence in this matter, pursuant to section 52(3A) of the Act, I determined not to hold an inquest into Mr Thoms' death.

11. 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.

12. 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.

13. Victoria Police assigned Senior Constable (**SC**) Harry Thompson to be the Coronial Investigator for the investigation of Mr Thoms' death. SC Thompson 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.

14. This finding draws on the totality of the coronial investigation into the death of Donald Walter Thoms 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]

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[3] Section 4(2)(j)(i), *Coroners Act 2008* (Vic).

[4] Specialist Disability Accommodation.

[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.

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

Circumstances in which the death occurred

15. On the evening of 10 November 2023, Mr Thoms was unwell, vomited his meal and became less responsive. An ambulance was requested, and he was transported by ambulance to Monash Medical Centre, where he was presented to the Emergency Department (**ED**).[6]

16. The ED physician's clinical impression was that it was likely aspiration and potentially a pre-terminal event, given Mr Thoms' advanced frailty.[7] In consultation with Ms Garrett, it was decided that Mr Thoms would not receive further invasive treatment, and he was discharged back to his accommodation the same evening.

17. On the morning of 12 November 2023, Mr Thoms had breakfast and support staff administered medication without issue.

18. At approximately 3.00pm, Mr Thoms had a further dose of his medication and continued to sleep. Support staff later attempted to provide him with more fluid but observed that he had fluid in his mouth and was unable to swallow. They then ceased providing him fluid to avoid aspiration and kept him under constant observation.

19. At approximately 4.30pm, Mr Thoms finished most of his meal but continued to struggle to keep fluid down. Support staff administered him medication without issue, and he went to sleep.

20. At approximately 5.30pm, support staff attempted to provide Mr Thoms with fluid, but he was unable to be roused. He was observed to be lethargic and sweating. Support staff contacted the Calvary Bethlehem Palliative Care Team, who advised them to continue monitoring Mr Thoms and cease administering his usual medications if he remained unrousable.

21. At approximately 7.33pm, support staff checked on Mr Thoms after hearing him cough. He vomited and had difficulty breathing. They immediately called an ambulance and commenced cardiopulmonary resuscitation.

22. Ambulance paramedics arrived at 7.56pm and assessed Mr Thoms as beyond the effort of resuscitation. He was declared deceased at 8.15pm.

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[6] CB, Monash Health Discharge Summary.
[7] Ibid.

Identity of the deceased

23. On 12 November 2023, Donald Walter Thoms, born 21 July 1933, was visually identified by his support worker, Donglian Li.

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

Medical cause of death

25. On 23 November 2023, Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and provided a written report of his findings dated 4 December 2023.

26. The post-mortem examination was unremarkable.

27. The post-mortem computed tomography (**CT**) scan revealed coronary calcification, hiatus hernia, increase in lung markings (right greater than left), a few fluid levels in the small bowel, bladder diverticulum and cerebral atrophy.

28. Dr Burke provided an opinion that the medical cause of death was 1(a) *Complications following aspiration of food*.

29. Dr Burke further opined that Mr Thoms' death was due to natural causes.

30. I accept Dr Burke's opinion.

FURTHER INVESTIGATION

31. At my request, the Health and Medical Investigations Team (**HMIT**) within the Coroners Prevention Unit[8] reviewed Mr Thoms' medical care and management.

32. The HMIT did not identify any concerns regarding the medical care and management provided by Life Without Barrier and the Calvary Bethlehem Palliative Care Team.

[8] 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.

33. The HMIT advised that facility staff took appropriate measures to provide Mr Thoms nutrition in the safest possible way, and the risk of aspiration leading to death was understood and accepted by Ms Garrett.

34. The HMIT explained that the decision to risk feeding to provide oral pleasure and avoid a parched throat is common, especially when there is a meal management plan to minimise the risk of aspiration.

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 Donald Walter Thoms, born 21 July 1933;

    b) the death occurred on 12 November 2023 at 84 Mackie Road Bentleigh East Victoria 3165, from *complications following aspiration of food*; and

    c) the death occurred in the circumstances described above.

36. Having considered the factual matrix within which the death occurred, I am satisfied that the weight of the available evidence does not support a conclusion that a causal nexus existed between the fact that Mr Thoms was 'in care' at the time of his death and the medical cause of his death. Consequently, on the evidence available to me, I am unable to find that Mr Thoms' status as a person who was 'in care' at the time of his death is connected with or contributed to the medical cause of his death.

37. Further, the weight of the available evidence supports a conclusion that the medical care Mr Thom received while he was 'in care' at the facility in Bentleigh East administered by Life Without Barriers, as well as the palliative care he received from the Calvary Bethlehem Palliative Care Team in the period leading to his death was reasonable in the circumstances. Accordingly, I find that Donald Walter Thoms died by natural causes.

I convey my sincere condolences to Mr Thoms' 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:

Catherine Garrett, Senior Next of Kin

Life Without Barriers

National Disability Insurance Agency

Senior Constable Harry Thompson, Coronial Investigator

Signature:

Coroner John Olle

Date: 12 February 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.