IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000191

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	Jason Nicholas Hosie
Date of birth:	11 October 1972
Date of death:	9 January 2021
Cause of death:	1(a) ASPIRATION PNEUMONIA IN A MAN WITH ANGELMAN SYNDROME
Place of death:	Eastern Health, Angliss Hospital, 39 Albert Street, Upper Ferntree Gully, Victoria, 3156
Keywords:	In care, natural causes death, disability

INTRODUCTION

1. On 9 January 2021, Jason Nicholas Hosie (**Jason**) was 48 years old when he died at the Angliss Hospital in Upper Ferntree Gully, Victoria.

2. At the time of his death, Jason resided in specialist disability accommodation, a group home administered by the service provider, Life Without Barriers (**LWB**) in Burwood, under the care of the Department of Families, Fairness and Housing (**DFFH**).

Background

3. Diagnosed with Angelman's Syndrome, Jason had a profound intellectual disability. During his formative years, Jason lived at his family home. From 1990 onwards, however, Jason had been living in various residential facilities to cater for his complex care needs. Jason had been living at the facility in Burwood since 2016.

4. Jason is described as a friendly person who enjoyed the company of others. According to his LWB resident profile, Jason had a close relationship with his family who visited him regularly. Jason also enjoyed community outings and watching his favourite television programmes.

Medical history

5. Jason's complex care needs included, *inter alia*, the following conditions:

   i. Epilepsy diagnosed in 1973;
   ii. Vitamin D deficiency;
   iii. Dysphagia and constipation.

6. Jason's medical records indicate that health management plans were in place to manage his major health concerns including an epilepsy management plan and a texture modified diet to reduce his risk of food aspiration. The medical records indicate further that Jason's epilepsy was managed and regularly monitored by his neurologist.

7. According to the LWB records, Jason was wheelchair bound and required a standing aid for assistance when standing or when he was being transferred. He also required assistance with all his personal care activities or tasks and to communicate with his carers and family, Jason used a communication dictionary and used gestures, body language, single words and vocalisations.

8. Jason's father, John Hosie (**Mr Hosie**) was his medical treatment decision maker and one of his financial administrators.

Decline in Jason's health

9. Throughout December 2020, LWB staff attending to Jason, noticed that he had a persistent cough.

10. On 24 December 2020, LWB records indicate that a doctor reviewed Jason. The records do not indicate, however, whether Jason was treated for his persistent cough. The evidence indicates that Jason's health was in steady decline for the duration of December 2020.

11. On 2 January 2021 at approximately 7.30 am, during a handover meeting, night shift staff informed their day shift colleagues that Jason had been coughing throughout the night.

THE CORONIAL INVESTIGATION

12. Jason'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.

13. 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 suspects 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.

14. Immediately before his death, Jason was a person placed in care. However, section 52(3A) of the Act provides an exception to the position 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 Jason Nicholas Hosie's death.

15. 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.

16. 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.

17. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Jason's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers.

18. This finding draws on the totality of the coronial investigation into the death of Jason Nicholas Hosie 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.[1]

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

Circumstances in which the death occurred

19. On Saturday, 2 January 2021 at approximately 9.30 am, after monitoring Jason's temperature, LWB staff contacted Mr Hosie to inform him of his son's condition. Mr Hosie requested the LWB to continue to monitor Jason and to keep him apprised of his son's condition.

20. At approximately 12 pm, LWB staff phoned Mr Hosie again to inform him that Jason was distressed and that they were concerned about his breathing. Mr Hosie advised the staff to bathe his son and to let him sit in his recliner chair. However, at approximately 12.30 pm, when LWB staff on duty at the time called the LWB after hours line for advice, they were advised to call emergency services.

21. At approximately 2.15 pm, Ambulance Victoria (**AV**) paramedics arrived at the LWB facility in Burwood and after they had assessed Jason, the AV paramedics advised LWB staff that

[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.

Jason's condition required hospitalisation. AV paramedics then conveyed Jason to the Angliss Hospital (**AH**), where clinicians diagnosed a lung infection.

22. Jason was admitted to the AH for further treatment. To manage his condition, AH clinicians administered intravenous (**IV**) antibiotic therapy over the course of the next few days. The AH staff noted that Jason had difficulty swallowing and required supplemental oxygen. The evidence indicates that Jason's health deteriorated even further after he was admitted to the AH.

23. On 6 January 2021 Jason was moved to the intensive care unit (**ICU**) at the AH because of his declining health. On assessment in the ICU, clinicians noted that Jason was not responding to treatment. On the following day, 7 January 2021, in consultation with Mr Hosie, given that Jason was not responding to treatment, ICU staff took the decision to provide him with palliative care.

24. On 9 January 2021 at 11.21 pm. Jason passed away.[2]

Identity of the deceased

25. On 9 January 2021, the body of Jason Nicholas Hosie, born 11 October 1972, was visually identified by his father, John Hosie, who signed a formal Statement of Identification.[3]

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

Medical cause of death

27. Forensic Pathologist Dr Melanie Archer of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 11 January 2021 and provided a written report of her findings dated 23 March 2021.[4]

28. In the execution of her duties. Dr Archer considered the following sources:

    i. Victoria Police Report of Death, *Form 83*;
    ii. Post-mortem computed tomography (**CT**) scan;
    iii. VIFM Coronial Admissions and Enquiries (**CAE**) contact log;

[2] Court File, E-Medical Deposition Form
[3] Court File, Statement of Identification.
[4] Court File, Medical Examiner's Report. At my direction, by *Form 9* dated 11 January 2021, Dr Archer did not perform an autopsy upon the body of Jason Nicholas Hosie. At my further direction toxicological analysis of post-mortem biological samples was not conducted.

iv. E-medical Deposition Form; and

v. Medical records of Jason Nicholas Hosie.

29. The post-mortem CT scan revealed a left lung lesion and Dr Archer commented that the external examination did 'not show evidence of an injury of a type likely to have caused or contributed to death'.[5]

30. Dr Archer provided an opinion that the medical cause of death was 1 (a) ASPIRATION PNEUMONIA IN A MAN WITH ANGELMAN SYNDROME.

31. Dr Archer commented further that 'on the information available' to her, she formed 'the opinion that this death was due to natural causes'.

INVESTIGATION BY THE DISABILITY SERVICES COMMISSIONER

32. Pursuant to section 128I of the *Disability Act 2006 (Vic)* the Disability Services Commissioner (DSC) commenced an investigation into the standard of care provided to Jason and the circumstances of his death.

33. On 18 April 2023, the DSC provided me with their Investigation Report (**IR**) and advised me that appropriate action had been taken to address the key concerns or issues identified by their investigation. The DSC advised me further that LWB had accepted the IR and abided by the terms set out therein.

34. I have perused the IR and, given that the LWB had accepted the findings of the DSC, I am satisfied that the concerns surrounding Jason's care have been adequately addressed. I endorse the findings and recommendations of the DSC.

35. Accordingly, I make no adverse comments about or findings against any person or entity.

36. I now make pertinent findings in this matter.

[5] Ibid.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Jason Nicholas Hosie, born 11 October 1972;

    b) the death occurred on 09 January 2021 at Eastern Health, Angliss Hospital, 39 Albert Street, Upper Ferntree Gully, Victoria, 3156.

    c) I accept and adopt the medical cause of death as ascribed by Dr Archer and I find that Jason Nicholas Hosie died from ASPIRATION PNEUMONIA IN A MAN WITH ANGELMAN SYNDROME.

38. Having considered all the circumstances, I am satisfied with the outcome of the Disability Service Commissioner's investigation into Jason Nicholas Hosie's death, and I make no further adverse comments about or findings against any person or entity.

39. Further, 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 that a causal nexus existed between the fact that Jason Nicholas Hosie 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 definitively find that Jason Nicholas Hosie's 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.

40. AND FURTHER, the weight of the available evidence supports a conclusion that the medical care Jason Nicholas Hosie received at the Angliss Hospital at the time of his death was reasonable and appropriate in the circumstances and I find that Jason Nicholad Hosie died by natural causes.

I convey my sincere condolences to Jason'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:

John Hosie, Senior Next of Kin

Disability Services Commissioner

Eastern Health

Senior Constable Jodie Holmes, Coroner's Investigator

Signature:

Coroner John Olle

Date: 30 July 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.