MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of David John King

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is David John King;
b) Mr King died in the circumstances set out further in this finding;
c) The cause of Mr King's death was aspiration pneumonia; and
d) Mr King died on 15 June 2017 at the Royal Hobart Hospital, Hobart in Tasmania.

Background

Mr King, aged 59 at the time of his death, was severely injured in a motorcycle crash in 2005 in which he suffered an acquired brain injury. His injury left Mr King with intellectual and neurological impairment which included difficulty swallowing, speaking and walking. This affected his ability to care for himself and as a result he lived in a group home for a number of years.

In the lead up to his death Mr King travelled to the United Kingdom with a carer principally to see the annual Isle of Man TT motorcycle races. Mr King and his carer spent several weeks in the United Kingdom and returned to Australia on Tuesday 13 June 2017. On, or shortly after, the day of his arrival in the United Kingdom (11 May 2017) Mr King complained of soreness in his knee. Concerned that the pain Mr King was experiencing might be attributable to Deep Vein Thrombosis (DVT) - just having undertaken a "long haul" flight from Australia to the United Kingdom - his carer took him to hospital. In the affidavit sworn by the carer as part of the investigation he said:

> *"I went in to the hospital with David and explained the situation. They took blood samples from David and said they would be running some tests. They did not seem overly concerned. The tests they did were for DVT, and for a few other things I can't recall. After they had taken the blood we waited around for an*

hour. The whole time David was saying that it was bullshit and was annoyed at having to be there. I could see him becoming more and more frustrated.

They came back to us and said the other tests had come back fine but that the DVT test had failed. They explained that it had not worked and they couldn't give an answer on the possibility of DVT without another test which would require more blood to be taken. I spoke to the doctor to get a sense of whether he thought that David had a DVT or not. The impression I got from the doctors [sic] conversation was that more time needed to go by before they could get a clear answer as to whether he had a DVT. He seemed to say that David would need two or three more days before it would effectively show up on a blood test. He didn't seem overly worried but said we could do another blood test. The general impression was that it was not a DVT.

David heard that they wanted to do another blood test and wasn't keen to stay. The blood test didn't seem necessary and David obviously wasn't wanting to stay longer. I thought we would go back if the knee started hurting more however, even as we were leaving the hospital David said his knee was feeling better."

As a result Mr King and his carer left the hospital and continued with the holiday. They returned to Australia arriving in Hobart on Tuesday 13 June 2017. They were picked up at the airport and taken to Mr King's group home.

Circumstances of death

Two days after his return Mr King was found on the floor of a bathroom at the group home by a staff member. It would appear that Mr King had fallen however no one witnessed it. Although the carers who found him thought he may have hit his head on a shower railing a CT scan subsequently carried out at the Royal Hobart Hospital showed no acute intracranial haemorrhage or traumatic injury. The same carers subsequently told police that Mr King was conscious when he was found. Ambulance Tasmania were called and attended within a short time. By the time the paramedics arrived Mr King was found to be in pulseless electrical activity (that is to say electrical rhythm in the absence of a pulse). Carers had already commenced CPR. The paramedics took over treatment and continued CPR, as well as administering IV adrenaline and ventilation. Mr King was transported to the Royal Hobart Hospital arriving there at 5.12pm. Medical records indicate that in the immediate lead up to his death, after his admission to the Royal

Hobart Hospital, the wishes indicated by him in his advanced care plan that he not be resuscitated in the event of a cardiac arrest were respected. Consistent with those wishes Mr King was extubated and transferred to the short stay unit of the Hospital for palliation. His condition did not improve and he passed away at 11.58pm on the same day.

Forensic Pathology Evidence

Given the circumstances of Mr King's death, and in particular the suspicion that a fall, and possible head injury, was the cause of his death, the fact of his death was reported to the Coroner's Office. After formal identification an autopsy was carried out upon his body at my direction by experienced forensic pathologist Dr Donald McGillivray Ritchey. Dr Ritchey did not find any injuries of significance and in particular no scalp contusions, skull fractures or intracranial collections of blood. In light of these findings and the results of the CT scan of his brain I am satisfied a head injury was not the cause of Mr King's death and indeed it is doubtful he hit his head in the fall.

Other possible causes were considered. Dr Ritchey found no evidence to suggest Mr King had suffered a seizure and no evidence suggestive of his having suffered a DVT. Microscopic sections of Mr King's lung revealed marked aspiration of foreign debris into the alveoli and early acute inflammation. In the circumstances Dr Ritchey expressed the opinion that the cause of Mr King's death was aspiration pneumonia. I accept this opinion.

Samples taken at autopsy were subsequently analysed at the laboratory of Forensic Science Service Tasmania. Along with various prescription drugs, alcohol was found to have been present in those samples. The amount of alcohol – 0.052 g/100mL – was, relatively speaking, low. However, Mr King was hospitalised approximately seven hours before he died and did not consume any alcohol during the time he was in hospital. Accordingly, having general regard to average metabolism rates, it is reasonable to assume that at the time of his fall, some time prior to 4.00pm, his blood alcohol level was considerably higher. This is consistent also with the fact that Mr King was known to consume alcohol via his Percutaneous Endoscopic Gastrostomy (PEG) tube. The fact that Mr King consumed alcohol on 15 June 2017 is also consistent with care staff advising police that he had been seen to administer alcohol through his PEG tube that day and ambulance officers reporting a smell of alcohol about his person when they attended.

I am satisfied that Mr King consumed alcohol on the day of his death and that the alcohol is likely to have contributed to his fall. Having said that I am also satisfied, for the reasons set out above, that the fall did not cause his death but rather that it was due to aspiration pneumonia, a condition that Mr King was very vulnerable to on account of his myriad of pre-existing health conditions due to his motorcycle crash in 2005.

There is no evidence suggesting the involvement of any person in Mr King's death. The evidence satisfies me that there are no suspicious circumstances surrounding his death.

Finally, I note that there is no evidence to suggest that the care Mr King received at the group home or from Ambulance Tasmania or at the Royal Hobart Hospital fell short of an acceptable standard.

Comments and Recommendations

The circumstances of Mr King's death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.

I convey my sincere condolences to the family and loved ones of Mr King.

Dated 26 February 2018 at Hobart in Tasmania.

Simon Cooper
Coroner