FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 2885/10

Inquest into the Death of KEVIN FRANCIS HAM

Delivered On:	15th April 2011
Delivered At:	Melbourne
Hearing Dates:	15th April 2011
Findings of:	IAIN TRELOAR WEST
Representation:	
Place of death:	39 Kelsby Street, Reservoir, Victoria 3073
PCSU:	Sgt. Dave Dimsey

FORM 37

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FINDING INTO DEATH WITH INQUEST

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Court reference: 2885/10

In the Coroners Court of Victoria at Melbourne
I, Iain Treloar West, Deputy State Coroner

having investigated the death of:

Details of deceased:

Surname: HAM
First name: KEVIN
Address: 39 Kelsby Street, Reservoir, Victoria 3073

AND having held an inquest in relation to this death on 15th April 2011
at Melbourne
find that the identity of the deceased was KEVIN FRANCIS HAM
and death occurred on or about 27th July, 2010

at 39 Kelsby Street, Reservoir, Victoria 3073

from

1a. CORONARY ARTERY DISEASE IN A MAN WITH RENAL IMPAIRMENT

in the following circumstances:

1. Kevin Ham, aged 63 years, was a client of the Department of Human Services and a long term resident at the Department's E W Tipping residential care facility, located at 39 Kelsby Street, Reservoir. Mr Ham suffered intellectual disability from birth and was cared for by his parents until, in his late 40s, his aging parents were physically unable to maintain the level of care he required.

2. Despite his disability Mr Ham was very active, with a keen interest in football, festivals and parades, or indeed, any type of activity where a happy crowd would be in attendance. In regard to health issues, he had difficulty in expressing medical symptoms, however, he was also known to cover up sickness or ailments, due to his dislike of any form of negativity and also through fear of being prevented from pursuing his love of attending public gatherings.

3. On the evening of the 26th of July 2010, Mr Ham was administered his regular Webster pack medication before retiring to bed at about 10:20 pm. At approximately 7:20 the next morning, Mr Ham was located by a support worker, lying unresponsive on the carpeted floor beside his bed. Ambulance attendance was requested and following arrival and examination, no resuscitation protocols were initiated as it was evident Mr Ham had been deceased for some time.

4. On the 2nd of August 2010, a post mortem examination was performed by Dr Michael Burke, a Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr Burke concluded that the cause of death was coronary artery atherosclerosis having found evidence of significant heart disease. In his report to the Coroner, Dr Burke makes the comment that coronary artery atherosclerosis is a common cause of sudden death, as it can cause an abnormality in cardiac rhythm.

COMMENTS:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment connected with the death:

In order to comment on the care Mr Ham received at the E W Tipping facility, I can do no better than quote from the police statement of Mr Brian Ham, the deceased's brother.

"*My opinion of E W Tipping is that they are a dedicated foundation giving excellent care and they treat all their clients as family. This is the level of service they gave to Kevin*".

I formally find that Kevin Ham died of natural causes and that his care was within normal parametres of reasonable health care management.

Signature:

Iain West
Deputy State Coroner
15th April, 2011

Coroners Court of Victoria

DISTRIBUTION

- Family of the deceased
- Manager, E W Tipping Foundation