IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2486/10

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of PAUL COMPTON

Delivered On:	25 January 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne
Hearing Dates:	25 January 2012
Findings of:	IAIN TRELOAR WEST, DEPUTY STATE CORONER
Police Coronial Support Unit:	Leading Senior Constable Greig McFarlane

I, IAIN TRELOAR WEST, Deputy State Coroner having investigated the death of PAUL COMPTON

AND having held an inquest in relation to this death on 25 January 2012
at Melbourne

find that the identity of the deceased was PAUL COMPTON

born on 5 July 1947, aged 62 years

and the death occurred on 30 June 2010

at Austin Hospital, 145 Studley Road, Heidelberg, Victoria 3084

from:

1a. COMPLICATIONS OF ACUTE RENAL FAILURE

in the following circumstances:

1. Paul Compton, was a 62 year old man who resided at a Department of Human Services community residential unit, situated at 36 Fairlie Avenue, MacLeod. Mr Compton had a past medical history of intellectual disability, epilepsy, asthma, shoulder dislocations and urinary tract infections. His vocabulary was very limited so a picture communication aid was utilised in order to assist staff to understand what he was saying. He was able to understand simple instructions and he was able to make a choice. Mr Compton had been non-ambulant since 2009 and was incontinent. He required previous admissions to hospital between the 9th day of April and the 21st day of April 2010, because of decreased oral intake with renal impairment.

2. On the 3rd June 2010, Mr Compton was taken to the Austin Hospital via ambulance for severe dehydration causing hypernatraemia and acute renal failure. He was treated with intravenous fluids and admitted to a high dependency unit bed for close monitoring of his sodium and fluid correction. Following review on the 4th June by the ICU consultant, it was decided that Mr Compton was safe for discharge to the general ward. On the 11th June 2010, a meeting was held involving hospital staff, Department of Human Services representatives and carers from the community residential unit where Mr Compton resided. It was determined that Mr Compton's care needs had increased to the degree that he was unable to return to the community residential unit. The outcome of the meeting was that it was recommended that Mr Compton be referred to the palliative care unit for end of life care, as medical investigations had shown there was no reversible reason for his dehydration and insertion of a PEG tube (percutaneous endoscopic gastrostomy) to facilitate external feeding, was not considered to be in his best interest.

3. On the 17th June 2010, Mr Compton was transferred to the palliative care unit, where he presented with severe dehydration resulting in acute renal failure and hypernatraemia. He was admitted for intravenous fluids and his biochemistry improved with the treatment. He underwent a trial of antibiotics for presumed urinary tract infection, however Mr Compton refused all oral intake except for coffee and coke. Mr Compton developed impaired renal function with hypernatraemia and a raised serum creatinine and was referred for terminal care. He had a marked deterioration on the 30th day of June 2010, following which he became febrile and died at 6.30pm.

4. No autopsy was performed in this case as the coroner, on the advice from Dr Michael Burke, Senior Pathologist with the Victorian Institute of Forensic Medicine, directed that no autopsy was required. Dr Burke performed an external examination of Mr Compton at the mortuary, reviewed the circumstances of his death, the medical deposition and clinical notes, the post mortem CT scan and provided a written report of his findings. Dr Burke reported that in all the circumstances a reasonable cause of death appeared to be complications of acute renal failure.

5. I find that Paul Compton died of natural causes with the cause of death being complication of acute renal failure. On the evidence before me, I am satisfied that his care and management was within the normal parameters of reasonable healthcare practice.

I direct that a copy of this finding be provided to the following:

The family of Mr Compton
Department of Human Services

Signature:

IAIN WEST
DEPUTY STATE CORONER

25 January 2012

Coroners Court of Victoria