FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 4242/07

Inquest into the Death of PETER JOHN BANNAN

Delivered On:	28th April 2010
Delivered At:	Melbourne
Hearing Dates:	28th April 2010
Findings of:	IAIN TRELOAR WEST
Representation:	No representation

Place of death/Suspected death: Box Hill Hospital, 16 Arnold Street, Box Hill 3128

SCAU:	Leading Senior Constable McFarlane

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FINDING INTO DEATH WITH INQUEST

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

Court reference: 4242/07

In the Coroners Court of Victoria at Melbourne
I, IAIN TRELOAR WEST, Deputy State Coroner

having investigated the death of:

Details of deceased:
Surname: BANNAN
First name: PETER

AND having held an inquest in relation to this death on 28th April 2010
at Melbourne
find that the identity of the deceased was PETER JOHN BANNAN
and death occurred on 20th October, 2007

at Box Hill Hospital
16 Arnold Street
Box Hill 3128

from

1a. PNEUMONIA
1b. QUADRIPLEGIA (ACQUIRED BRAIN INJURY)
2. EPILEPSY

in the following circumstances:

1. Peter Bannan, aged 54 years, had a long-standing history of acquired brain injury resulting in spastic quadriplegia, due to encephalitis after contracting chicken pox at six months of age. He had profound intellectual disability and epilepsy with a history of recurrent seizures. In addition, Mr Bannan had problems with swallowing and was at risk of aspiration, which gave rise to recurrent episodes of pneumonia requiring hospitalization. At the time of his death he was a client of the Department of Human Services and resided at a residential support unit at Nunawading.

2. After being placed in care at Kew Cottages at 5 years of age, Mr Bannan's caring and loving parents maintained regular contact and interest in his welfare. Despite living in New South Wales in recent years, the contact often involved monthly visits, regular calls and lengthy stays during

periods of hospitalization. In 2006 the guardianship division of the Victorian Civil and Administrative Tribunal appointed the Public Advocate as guardian, resulting in Mr Beresford-Smith assuming the role of guardian for Mr Bannan. The order provided decision making powers concerning medical treatment and specific provisions regarding end of life issues, including decisions to withdraw and refuse treatment.

3. On the 4th October 2007, Mr Bannan showed signs of being unwell and was seen by a medical practitioner twice during the day. His condition did not improve and the following morning he was ambulance transferred to the Box Hill Hospital Emergency Department and diagnosed with aspiration pneumonia. The medical plan was to treat him with fluids and antibiotics which initially stabilized his condition, however, medical review on the 9th October found that his condition had not improved any further. Following consultation with family regarding palliation, the plan was put in place to withdraw medications, cease the intravenous fluids and provide appropriate comfort measures. Palliative care continued at Box Hill Hospital until Mr Bannan's death on the 20th October 2007.

COMMENTS:

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

1. It is alarming that on the 9th October, no consultation took place with Mr Beresford-Smith regarding palliation. Despite the hospital being given a copy of the order, and contacting the guardian for treatment clarification during a previous admission, it is apparent that neither the admitting staff nor ward staff had identified that Mr Bannan had a medical guardian. Examination of his medical record identified that an alert form that should have been filed in the front of Mr Bannan's record, to identify to his health team that he had a guardian, was absent. Staff had failed to establish who was legally responsible for Mr Bannan's medical decision making. Nevertheless, I agree with the parents and the guardian, that this failure did not impact on the medical outcome.

2. I do not believe it is necessary to make recommendations in this case, as these failings have since been acknowledged by the hospital and were targeted for improvement and reinforcement.

Signature:

Iain West
Deputy State Coroner
Date: 28th April, 2010