

FORM 37

Rule 60(1)

**FINDING INTO DEATH WITH INQUEST**

*Section 67 of the Coroners Act 2008*

**(Amended pursuant to s76 of the Coroners Act 2008  
on the 12th September, 2011)**

**Court reference:** 2898/10

**Inquest into the Death of STEPHEN ROSS GAMBLE**

Delivered On: 5th September, 2011

Delivered At: Coroners Court of Victoria  
Level 11, 222 Exhibition Street  
Melbourne, Victoria 3000

Hearing Dates: 5th September, 2011

Findings of: Coroner Paresa Antoniadis SPANOS

Representation: Senior Constable Amanda MAYBURY, Police Coronial Support  
Unit, to assist the Coroner

No other appearances.

**FORM 37**

Rule 60(1)

**FINDING INTO DEATH WITH INQUEST**

*Section 67 of the Coroners Act 2008*

**Court reference:** 2898/10

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

**Details of deceased:**

Surname: GAMBLE

First name: STEPHEN

Address: 44 Powley Parade, Watsonia, Victoria 3087

AND having held an inquest in relation to this death on 5th September, 2011 at Melbourne

find that the identity of the deceased was STEPHEN ROSS GAMBLE born on the 19th March, 1961

and that death occurred on the 28th July, 2010

at the Austin Health Repatriation Hospital, Banksia Street, Heidelberg West, Victoria 3081

from: 1(a) COMPLICATIONS OF CRANIOPHARYNGIOMA AND PAN-HYPOPITUITARISM

in the following circumstances:

1. Mr Gamble was a forty-nine year old man who resided in a community residential unit (CRU) operated by Yooralla. He had a significant past medical history which included craniopharyngioma, sleep apnoea, cortical blindness, narcolepsy, recurrent seizures, chronic hyponatremia and chronic headache. Most of Mr Gamble's medical problems were thought to be secondary to surgery and subsequent treatment for craniopharyngioma, a benign tumour of the pituitary gland located in the brain which had first been diagnosed when he was twelve. From March 2009, Mr Gamble's sister Jenny held an enduring power of attorney regarding medical treatment, and in May 2010, had signed a refusal of treatment certificate regarding resuscitation and intensive care treatment for her brother.

2. In the months preceding his death, staff at the CRU had noticed that Mr Gamble's general health was gradually deteriorating. This was documented in file notes, medical outcome forms and incident reports. In the month immediately preceding his admission to hospital on 6 July 2010, there were six reported incidents involving increased confusion, absconding and refusing medication, and three admissions to hospital.

3. On 6 July 2010, Mr Gamble was admitted to the Austin Hospital via ambulance due to seizure activity and low blood pressure. After discussions between medical staff and Mr Gamble's family, he was transferred to the Palliative Care Unit at the Repatriation Hospital for symptom management and end of life care on a background of recurrent seizures and hypothermia secondary to craniopharyngioma and panhypopituitarism. Mr Gamble developed aspiration pneumonia and died on 28 July 2010.

4. There was no autopsy, however, Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine (VIFM) performed an external examination in the mortuary, reviewed the circumstances as reported by the police, the medical deposition and medical records from Austin Health, and postmortem CT scanning of the whole body. Having done so, she advised that a reasonable medical cause of death was available without the need for an autopsy, namely "complications of craniopharyngioma and pan-hypopituitarism." Dr Parsons noted that postmortem CT scans were reviewed with a Consultant Radiologist who advised that they showed multiple craniectomies and residual tumour in a suprasellar location.

5. As a person in care immediately before his death, Mr Gamble's death was reportable to the coroner irrespective of the cause of death. In this way, the *Coroners Act 2008* extends some protection to those vulnerable people who are in the care of the state, by requiring a coronial investigation including an inquest into their deaths, thereby providing a degree of scrutiny and accountability of the care provided to them.<sup>1</sup> There is no suggestion in the material before me that any want of clinical care or management caused or contributed to Mr Gamble's death.

6. I find that Mr Gamble was a person in care who died from natural causes, namely complications of craniopharyngioma and pan-hypopituitarism.

Signature:



Coroner: PARESA ANTONIADIS SPANOS

Date: 12th September, 2011

<sup>1</sup> See definition of a person placed in custody or care in section 3 (d), the definition of "reportable death" in section 4(2)(c) and section 52(2)(b) of the *Coroners Act 2008*.