IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 1306

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

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

INQUEST INTO THE DEATH OF SARAH HAMMOUD

Findings of:	CORONER JACQUI HAWKINS
Delivered On:	26 November 2018
Delivered At:	65 Kavanagh Street Southbank, Victoria, 3006
Hearing Dates:	19 – 22 February 2018
Counsel Assisting the Coroner:	Leading Senior Constable Kelly Ramsey
Representation:	Ms Judy Benson of counsel representing the Department of Health and Human Services instructed by Ms Lizzie McMahon of Department of Health and Human Services Mr Ben Mason, Solicitor Advocate representing the Office of the Public Advocate Mr Robert Harper of counsel representing Annecto instructed by Ms Caroline Rubira of K&L Gates Ms Deborah Foy of counsel representing the Melbourne Health instructed by Ms Jan Moffatt of Grindal & Patrick

Mr Paul Burke of counsel representing Eastbrooke Clinic, Dr Mamatha Gandham and Dr Paul Green instructed by Ms Kate Hughes of Avant Law

Catchwords: CEREBRAL PALSY, OSTEOMYELITIS, ADVANCED CARE PLANS, DECISION TO PALLIATE, OFFICE OF PUBLIC ADVOCATE, SUPPORTED RESIDENTIAL SERVICES, MEDICAL POWER OF ATTORNEY

CORONER HAWKINS:

SUMMARY OF INQUEST

1. Sarah Hammoud had cerebral palsy and an intellectual disability and was a client of the Department of Health and Human Services (DHHS). She resided at a residential care unit in Niddre, which was owned and operated by Annecto Incorporated (Annecto). During 2015, Sarah's health and mobility had significantly deteriorated. After several medical and hospital attendances throughout early 2016, Sarah was eventually admitted to the Royal Melbourne Hospital (RMH) on 12 March 2016 with a severe tongue injury and septic shock. She was subsequently palliated and died on 21 March 2016, aged 22.

2. This Inquest examined the care and management provided by Annecto and DHHS and her medical care and management by the Eastbrooke Family Medical Clinic (Eastbrooke Clinic) and RMH in the last few months of her life.

BACKGROUND

3. Sarah was born with a chromosomal disorder which meant she had three X chromosomes instead of two. This caused Sarah to suffer from a severe intellectual disability and cerebral palsy from birth. She also suffered from epilepsy. Sarah had an abnormal gait and required full assistance with her daily activities and self-care and was non-verbal. She had autistic type behaviour with repetitive habits and severe self-harm. Sarah had been a registered client of DHHS since the age of five.

4. At the age of 13 her mother was no longer able to care for Sarah, which resulted in her being placed in supported accommodation. Sarah first resided in a supported residential service (SRS) in Altona, which was operated by Yooralla. In 2005, she moved to a facility in Maribyrnong that provided respite for children aged between eight and 14 years of age. The Maribyrnong facility was operated at Macedon Street, Maribyrnong by Annecto. Annecto are a registered disability service provider under the *Disability Act* 2006 (Vic). In 2011, Sarah moved into 63 Haldane Road, Niddrie on a permanent basis.

5. Sarah's family had minimal involvement with her. Her mother, aunt and two brothers all resided near Sarah's home in Niddrie. Only her mother would visit Sarah infrequently on special occasions such as her birthday.

6. Sarah had a limited range of movement in her limbs and suffered from frequent episodes of cellulitis. In August 2009, Sarah became a client of DHHS and received case management support. She was allocated an Individual Support Package (ISP) which addressed her ongoing support needs.

7. According to Dr Teresa Lazzaro, Consultant Paediatrician, Sarah's behaviour during her teenage years included periods of extreme self-harm, poor sleep and unsettled behaviour, and times where she seemed to be okay. Sarah's epilepsy seemed to resolve over the years. Dr Lazzaro last saw Sarah in 2012 where she attended with her carers from Haldane Street. Sarah remained non-verbal and had repetitive behaviours, but was generally injury free, eating well, and her weight was stable. Dr Lazzaro referred Sarah's care to a general practitioner (GP) when she was 18.

8. Despite her severe disability and her inability to verbally communicate, Sarah was able to communicate her needs with facial expressions and body movements. She was described by her carers as a beautiful, cheeky person who loved socialising. She also had a defiant side and was able to communicate that through her actions.

9. Sarah's self-harm issues continued through to early adulthood and were outlined in her behaviour support plan. There continued to be behaviour such as striking herself on the head with her fist, hitting her head against walls and furniture and dropping to the ground without warning. Sarah received medication to assist with these types of behaviour.

10. In late 2015, staff at Haldane Street noticed an increase in falls and an inability for Sarah to maintain her balance. It was recommended that she should use a wheelchair to minimise her risk of falling and subsequent injury. Other options were also explored, including the use of a high-low bed and arranging assessments in relation to her food intake, swallowing and mobility.

11. Sarah presented on several occasions to her GP at the Eastbrooke Clinic with elbow pain caused by olecranon bursitis. She was prescribed antibiotics at first, which alleviated the problem. In late 2015, a further episode of this saw her placed on a new course of antibiotics and the affected area was drained. The area around the elbow required drainage again in early November 2015. Two further episodes required treatment in December 2015 and February 2016. At the February 2016 appointment, Sarah was referred to an orthopaedic unit at the RMH.

12. On 5 March 2016, Sarah was transported by ambulance to the RMH. She was diagnosed with gram-positive cocci bacteraemia and possible olecranon osteomyelitis, secondary to left elbow cellulitis. Hospital staff made several unsuccessful attempts to contact Sarah's mother to discuss her condition.

13. She was deemed not suitable for surgery and discharged home two days later with a further course of antibiotics, continued Royal District Nursing Support (RDNS) assistance and a plan to provide comfort measures and only return to hospital should the situation become too stressful for Sarah.

14. A meeting was set up between Annecto staff and the inpatient palliative care team at the hospital to discuss what would occur if Sarah became acutely unwell.

15. On 8 March 2016, Sarah knocked her head whilst at the care unit which resulted in a small cut above her right eyebrow. She obtained a black eye by unknown means two days later, which was thought to have occurred following an unwitnessed fall the previous night.

16. Sarah's mother attended an appointment with Dr Mamatha Gandham from Eastbrooke Clinic on 10 March 2016 where she signed an Advanced Care Plan on Sarah's behalf, which provided information to medical staff that if Sarah became terminally ill, they would not provide active medical intervention.

17. On 12 March 2016, Sarah was re-admitted to RMH due to the development of a tongue injury which had occurred after her discharge five days earlier. She was assessed by a specialist maxillofacial surgery team who found her to have a crush injury to her lateral tongue, which was not amenable to surgical repair. She was also found to have septicaemia and was felt to be in a terminal phase of care. The decision was made to palliate.

18. On 15 March 2016, Ms Jane Pontin, Manager of Annecto made an application to the Victorian Civil and Administrative Appeals Tribunal (VCAT) for the appointment of a guardian for Sarah. VCAT made a temporary guardianship order for the Office of Public Advocate (OPA) to make decisions concerning Sarah's medical treatment. These powers were delegated to Ms Sheila Narayan, on 16 March 2016, but ultimately, no decisions were required to be made.

19. Further tests conducted by the hospital at this time found that Sarah continued to have ongoing septicaemia that was not survivable. Sarah was admitted under the care of the palliative care service who ensured her comfort while dying.

20. At approximately 9.30pm on 21 March 2016, Sarah peacefully passed away.

THE PURPOSE OF A CORONIAL INVESTIGATION

21. Sarah's death constituted a '*reportable death*' pursuant to section 4 of the *Coroners Act 2008* (Vic) (Coroners Act), as her death occurred in Victoria and was unexpected.

22. The jurisdiction of the Coroners Court of Victoria (Coroners Court) is inquisitorial[1]. The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

23. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

24. The circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

25. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[2] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

26. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

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[1] Section 89(4) *Coroners Act 2008*
[2] *Keown v Khan* (1999) 1 VR 69

Coroners are also empowered to:

(a) report to the Attorney-General on a death;

(b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

(c) make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

27. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[3] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

28. In considering the issues associated with this finding, I was mindful of Sarah's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act* 2006 (Vic), in particular, sections 8, 9 and 10.

CORONIAL INQUEST

Family concerns and Request for Inquest

29. Shortly after Sarah's death, her mother, Susan Alsaeed, wrote to the Coroners Court and raised concerns with her care and management at Annecto.

30. On 4 August 2017, the Office of Public Advocate (OPA) also raised concerns with Sarah's care and management and requested an Inquest be held.

31. On 21 August 2017, I conducted a directions hearing to discuss whether further investigations were required. I conducted a further directions hearing on 30 October 2017, to confirm the witnesses and set the scope of the inquest.

32. Sarah was not under the care control or custody of DHHS at the time of her death, therefore a mandatory inquest was not required. Consequently, I used my discretion pursuant to section

[3] (1938) 60 CLR 336

52(1) of the Coroners Act to conduct an Inquest. An Inquest was held on 19 February 2018 for four days.

Witnesses

33. The following witnesses were called to give *viva voce* evidence at Inquest:

- Ms Susan Alsaeed
- Dr Mamatha Gandham, General Practitioner, Eastbrooke Family Clinic
- Associate Professor Brian Le, Director of Palliative Care, Royal Melbourne Hospital
- Professor David Russell, Consultant Physician, Royal Melbourne Hospital
- Dr Teddy Wu, Consultant Neurologist, Christchurch Hospital
- Ms Sandra Cooper, Volunteer, Community Visitors Program, Office of Public Advocate
- Ms Bianca Whitehead, Coordinator, Community Visitors Program, Office of Public Advocate
- Ms Sheila Narayan, Advocate/Guardian, Office of Public Advocate
- Ms Jacqueline Schultz, Manager, Local Connections in Western Melbourne, DHHS
- Mr Phillip Holden, Support Worker, Annecto
- Ms Michelle Ferguson, Former Support Worker, Annecto
- Dr Paul Green, General Practitioner, Eastbrooke Family Clinic
- Ms Jane Pontin, Manager, Accommodation Services, Annecto

IDENTITY OF THE DECEASED

34. On 21 March 2016, Sarah Hammoud was visually identified by her mother, Susan Alsaeed. Her identity was not in dispute and required no further investigation.

MEDICAL CAUSE OF DEATH

35. On 23 March 2016, Dr Victoria Francis, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM) performed a medical examination on the body of Sarah and reviewed the Form 83 Victoria Police Report of Death, the e-medical deposition from the RMH and the post mortem computed tomography (CT) scan.

36. External examination revealed a severely emaciated body with a body mass index of 13 kg/m. Some patchy purple bruises were noted on the left hip and lateral left thigh, left ear and medial left eyelid.

37. The post mortem CT scan showed patchy increased lung markings and possible periosteal reaction over the left olecranon process. There was evidence of bone loss and loss of the dental crown in the mandibular first molar and was thought likely to be a chronic dental abscess (which is consistent with the medical records).

38. Dr Francis provided an opinion that the medical cause of death was 1a) SEPTIC SHOCK COMPLICATING OSTEOMYELITIS SECONDARY TO CELLULITIS IN A WOMAN WITH CEREBRAL PALSY and was due to natural causes.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

39. The purpose of the inquest was to understand the circumstances which led to Sarah's death. The following issues were explored:

- Annecto's care and management of Sarah;
- DHHS oversight and management of Annecto; and
- Appropriateness of medical care and management by:
    i. Eastbrooke Family Medical Clinic;
    ii. Royal Melbourne Hospital between 5-7 March 2016; and
    iii. Royal Melbourne Hospital on 12 March 2016 and the decision to palliate.

Annecto's care and management of Sarah

40. Sarah had resided at 63 Haldane Road, a Supported Residential Service (SRS) facility operated by Annecto since 2011. Annecto as her primary carer were funded by DHHS. Sarah had enjoyed a significant period of stability at the house until early 2015 when her health and mobility began to decline. Her deterioration had started to impact her ability to mobilise, feed, and caused an increase in some negative behaviours such as suddenly dropping to the ground.

41. In August 2015, Annecto staff identified that Sarah was not eating as well as she previously had and had been losing weight. Staff brought the issue to the attention of her GP, Dr Paul Green who referred Sarah to RMH for assessment including for occupational therapy, speech therapy, physiotherapy and neurological review.

Community Visitor's concerns

42. The OPA has a Community Visitor program where they can conduct independent visits and review SRS facilities. The role of the community visitor is to observe the environment, the activities, the behaviours and interactions of staff with residents. According to Community Visitor, Ms Sandra Cooper, they communicate with the residents and review documentation and records. In short, the community visitors assess the quality of life of the residents to ensure it meets community standards and public expectations.[4] If they consider things need to be addressed or improved, they provide a report to the SRS.[5] Any issues raised are required to be followed up within 21 days.[6]

43. Ms Cooper conducted several visits to 63 Haldane Road between June 2015 and January 2016 and had raised some concerns with Annecto staff and management.

44. Ms Cooper and Ms Whitehead attended 63 Haldane Road for an unscheduled visit on 18 January 2016 and had concerns about the quality of service generally and specifically in relation to Sarah. Issues identified were in relation to her poor mobility, falls risk, soiled bedsheets and inadequate feeding. Ms Whitehead also observed that Sarah's right elbow was discoloured and swollen, and she enquired as to whether Sarah had been seen by a GP.[7]

45. Due to the seriousness of her observations, Ms Whitehead immediately spoke to her manager and made a notification to the OPA.[8] She was distressed about what she had witnessed and considered there was imminent risk to the safety of Sarah and Annecto staff.[9] Ms Cooper also submitted a report to the Manager, Ms Pontin about her concerns.

46. On 5 February 2016, Ms Pontin provided an Issues Response Form. Ms Pontin advised that she obtained a quote from Scope in February the previous year for a range of assessments for Sarah including an occupational therapy and speech pathology assessment. Delays occurred for several reasons, namely the issue of who would fund the assessments. It was submitted by

[4] Transcript of evidence, p196
[5] Transcript of evidence, p197
[6] Exhibit 10 – Statement of Sandra Cooper dated 29 November 2016, with attachments, coronial brief, p155
[7] Transcript of evidence, p254
[8] Transcript of evidence, p256
[9] Transcript of evidence, p256

counsel for Annecto that the delays in achieving these assessments cannot be attributed to any act or omission on the part of Ms Pontin or Annecto.[10]

Sarah's mobility and weight issues

47. It was submitted by the OPA that an occupational therapist would have identified appropriate supports to minimise risk of falls and potential injury to Sarah. This was because Sarah was prone to wounds because of her movements.[11] Sarah was assessed by an occupational therapist on 29 January 2016 and the recommendation was for a trial of a tilt-in-space wheelchair. However, according to Annecto staff, Sarah disliked using a wheelchair and would potentially drop to the ground in protest when confronted with it, which increased the risk of injury to Sarah. Annecto Support worker, Michelle Ferguson believed the wheelchair would have inhibited Sarah's freedom.[12] Another carer, Phillip Holden's evidence was that they were trying to do what was best for Sarah.[13] Submissions on behalf of DHHS confirmed Sarah detested being restrained in either her meal chair or a wheelchair and engaged in disruptive behaviours to make her wishes known.[14]

48. The OPA submitted that Sarah was severely underweight and would have benefited from a speech pathologist. It was submitted her malnutrition led to her being functionally immune suppressed and more susceptible to recurrent infection and was a factor in her morbidity and mortality.[15]

49. In response, Annecto submitted that Sarah did have a speech pathology assessment performed by Liz Weston on 16-17 February 2016 and 2 March 2016, which revealed that she was able to independently finger feed and eat a range of solid foods so long as they were cut into small pieces. Ms Ferguson said that the carers attempted in every possible way to use a feeding chair. However, it became a hazard to Sarah and her carers because she would try and kick and push it over.[16] According to Mr Holden and Ms Ferguson, Sarah had retained an interest in food and drink throughout this time and could coordinate eating, swallowing and

[10] Submissions on behalf of Annecto dated 16 March 2018, p8
[11] Transcript of evidence, p13, Submissions on behalf of Annecto dated 16 March 2018, p3
[12] Transcript of evidence, p476
[13] Transcript of evidence, p415
[14] Submissions on behalf of DHHS dated 16 March 2016, p8
[15] Submissions on behalf of the OPA dated 16 March 2016, p3
[16] Transcript of evidence, p473

breathing.[17] It was submitted by Annecto that while weight loss was an issue, the reason remained largely unexplained.[18]

50. Ms Ferguson did not consider any of the assessments, even if they were done in December 2015, would have changed the course of Sarah's life.[19] Annecto submitted that whether she had received earlier assessments would have made no material difference to the subsequent course of events and the outcome is not established on the evidence.[20]

General medical assistance

51. The evidence is that Annecto staff at 63 Haldane Road, are not, nor are they required to be, medically trained. However, according to Annecto staff, when there was a medical issue, they would take her to the GP for assessment and review and then follow the GP's instructions.[21]

52. The OPA submitted that Dr Gandham believed that a nursing home may have been more appropriate for Sarah considering her increased medical needs and the benefit of having a doctor visit her at the residential facility. The OPA further submitted that Consultant Neurologist, Dr Teddy Wu had concerns in relation to the lack of medical training of Sarah's carers and their ability to respond to Sarah considering the level of sedative medication prescribed to Sarah. However, Dr Wu clarified in evidence that this was in relation to having a clinician supervise the titration of her medications.[22]

53. Annecto submitted that despite Sarah's complex medical needs, the evidence demonstrated how well staff knew Sarah and how closely they cared for her over the years, in part because she did not have the benefit of family support or involvement. Staff members endeavoured to fill that gap.[23]

54. In evidence, Dr Green said that Sarah's care by Annecto seemed to be adequate, that staff were alert to medical problems as they arose and knew when to appropriately call for help.[24]

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[17] Submissions on behalf of Annecto dated 16 March 2018, p9
[18] Submissions on behalf of Annecto dated 16 March 2018, p9
[19] Transcript of evidence, p476
[20] Submissions on behalf of Annecto dated 16 March 2018, p9
[21] Transcript of evidence, p437
[22] Transcript of evidence, p182
[23] Submissions on behalf of Annecto dated 16 March 2018, p11
[24] Transcript of evidence, p494

Ms Pontin's evidence was that Annecto provided support to people with higher support needs than Sarah, therefore they were able to provide adequate care.[25]

55. It was submitted by Counsel for Annecto that the evidence demonstrated that Annecto staff did not delay in taking Sarah to the GP for review when she suffered a series of elbow infections during October 2015 and March 2016.[26] In particular, it was submitted that Annecto staff took Sarah to the GP clinic on 19 occasions for review, management and treatment by a doctor, that Sarah received RDNS care from 7 February 2016 onwards and they requested a locum doctor to review her on 25 January 2016 and 5 March 2016.[27]

56. Submissions made on behalf of Annecto asserted that the evidence does not support a finding that any alleged act or omission on the part of Annecto or its staff caused the death. Further, nor does the evidence provide a sufficient basis for adverse comment against Annecto or any member of its staff.[28]

57. The OPA raised a myriad of other concerns from August 2013 onwards in relation to hygiene or cleaning regimes. Counsel for Annecto submitted that those matters lacked a causal connection to Sarah's death and are disputed by Annecto. Therefore, the Court need not resolve these disputes as they do not illuminate or advance the material issues at Inquest. I agree.

DHHS oversight and management of Annecto

58. Annecto is funded by the DHHS through a Service Level Agreement. DHHS' responsibility is to monitor and provide oversight of the services provided by organisations such as Annecto. Manager of Local Connections for DHHS, Jacqui Schultz, described the role of DHHS to manage any matters of concern in relation to the operation of any funded service.[29] DHHS have monthly meetings to discuss how the organisation is tracking in terms of its service delivery and management of funding. They also review incident reports or complaints and seek clarification from the service, if there are any changes in circumstance.[30] As part of their service agreement, Annecto are required to comply with the DHHS Residential Services

[25] Transcript of evidence, p507
[26] Submissions on behalf of Annecto dated 16 March 2018, p3
[27] Submissions on behalf of Annecto dated 16 March 2018, p3
[28] Submissions on behalf of Annecto dated 16 March 2018, p11
[29] Transcript of evidence, p341
[30] Transcript of evidence, p341

Practice Manual.[31] DHHS conduct mandatory desktop reviews annually, which include an independent review to ensure that the organisation is meeting their human service standards.[32]

59. Ms Schulz said she had a good working relationship with Ms Pontin who would not hesitate to contact the DHHS and Ms Schultz personally if there were ever any concerns.[33] Accordingly, no concerns had been raised about Sarah during the time she was manager of local connections.[34] DHHS also had never received any complaints from Sarah's mother about Annecto.[35] The evidence of Ms Schultz was that all appropriate actions were taken by Annecto.[36]

60. DHHS had not been contacted about any concerns about Sarah directly by the Community Visitors Program.[37] The Community Visitors Protocol (Protocol)[38] between the Community Visitors and DHHS provides that if an issue is identified by a Community Visitor, it is to be addressed at a local level first. If there is no resolution, it is then elevated to senior management at DHHS, who can initiate any necessary action based on the concern.[39]

Quality of Service Review

61. Depending on the nature and extent of the incident, DHHS can at any time initiate a Quality of Support Review (QSR) through incident reports.[40]

62. A QSR was completed in October 2015 by the DHHS and touched upon the need for further assessments for Sarah, being occupational therapy, speech therapy, physiotherapy and communication issues. State Trustees were asked for funding and Scope was ready to proceed with three of the four assessments by early December 2015. Around that time the OPA raised concerns about Sarah's own personal funds being used for the assessments. In response, Annecto cancelled the assessments and sought funding from DHHS, which was subsequently approved in January 2016.

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[31] Transcript of evidence, p371
[32] Transcript of evidence, p371
[33] Transcript of evidence, p343
[34] Transcript of evidence, p341
[35] Transcript of evidence, p376
[36] Transcript of evidence, p342
[37] Transcript of evidence, p345
[38] Ex 14 – Statement of Jacqueline Schultz dated 4 September 2017 with annexures and Exhibit 12 Notification Protocol for Serious and/or Unresolved Issues.
[39] Transcript of evidence, p345
[40] Transcript of evidence, p349

63. At Inquest, Ms Schulz gave evidence of the immediate responses she and DHHS took in response to the OPA notice. According to Ms Schultz, once DHHS had received notification from the OPA, DHHS funded the assessments as soon as possible.[41]

64. The OPA submitted that DHHS failed to ensure the actions required by the QSR were completed by Annecto which contributed to Sarah not receiving the support services she required. It was submitted that the evidence supports the conclusion that had DHHS ensured the QSR findings were promptly conveyed to Annecto within a reasonable time following the QSR in September 2015, Sarah would have benefitted from multiple supports and actions in the six months immediately preceding her death.[42]

65. DHHS submitted that but for the OPA intervention the assessments would have been done. Regardless, it was submitted that even if these assessments had occurred it might not have made any significant contribution to improving Sarah's condition or preventing her ultimate hospitalisation or palliation. [43]

66. Counsel for Annecto submitted that the DHHS QSR Action Plan was apparently sent to Annecto on 6 October 2015 however, for reasons which were unexplained, Ms Pontin did not receive a copy of the document. Otherwise, she would have immediately actioned the directive. [44]

67. The DHHS submitted that Sarah was appropriately managed by Annecto at all material times. When the DHHS became aware of concerns raised by the OPA in January 2016, it took immediate action in accordance with the protocol and the QSR.[45] DHHS submitted that its responses to her primary carer Annecto and to OPA were timely, targeted and appropriate.[46] It was further submitted by Counsel for DHHS that no OPA witness provided any evidence in respect to what way, if any, DHHS' response was inadequate. It was therefore submitted that in all the circumstances it was appropriate and timely. DHHS submitted that its oversight and management of Annecto in no way contributed to Sarah's death.[47]

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[41] Transcript of evidence, p347
[42] Submissions on behalf of Annecto dated 16 March 2018, p2
[43] Submissions on behalf of DHHS dated 16 March 2018, p5
[44] Transcript of evidence, p581 & Submissions on behalf of Annecto dated 16 March 2018, p4
[45] Submissions on behalf of DHHS dated 16 March 2018, p6
[46] Submissions on behalf of DHHS dated 16 March 2018, p9
[47] Submissions on behalf of DHHS dated 16 March 2018, p9

Appropriateness of medical care and management by Eastbrooke Family Medical Clinic

68. Sarah's general medical care and management was transferred from her paediatrician, Dr Lazarro to Eastbrooke Clinic in 2011.[48] Due to Sarah's inability to communicate, most of the consultations involved Sarah's carers from Annecto giving the medical history and the reason for the visit.[49]

69. Sarah's regular GP, Dr Green's evidence was that he saw Sarah for repeated elbow infections and weight loss. He assumed the frequent elbow infections were due to some sort of chronic friction, rather than from repeated impacts. This chronic friction caused a break in the skin and Dr Green considered the infection gained access that way.[50] According to him, Sarah deteriorated over time.[51] Dr Green referred Sarah to the RMH on 21 August 2015 based on her presentation and reported decline.[52]

70. Dr Mamatha Gandham first saw Sarah, towards the end of 2015, for an issue related to her left elbow.[53] Dr Gandham asserted that because of Sarah's restricted movements, she was more prone to opening the bursa and causing wounds.[54] Dr Gandham did not see any injuries that made her concerned about any potential neglect.[55]

Referral for neurological review

71. Neurologist, Dr Teddy Wu was asked to assess her because there had been a decline in her behaviour.[56] Dr Wu explained that cerebral palsy is a degenerative condition involving the brain.[57] He further stated one would expect the brain to continually degenerate over time which can result in a decline in motor/cognitive function and can result in behavioural issues.[58] It is an irreversible process that would get worse over time.[59] In a patient with abnormal brain function and cognition, sedation may well cause someone to deteriorate in

[48] Transcript of evidence, p19
[49] Transcript of evidence, p9
[50] Transcript of evidence, p483 &p492
[51] Transcript of evidence, p482
[52] Submissions on behalf of Eastbrooke Family Medical Clinic, p1
[53] Transcript of evidence, p17
[54] Transcript of evidence, p13
[55] Transcript of evidence, p9
[56] Transcript of evidence, p170
[57] Transcript of evidence, p170
[58] Transcript of evidence, p170
[59] Transcript of evidence, p171

terms of functionality because of the effect and impact it has on their level of alertness.[60] Dr Wu noted there were no indications at the time he saw Sarah that she was suffering from a severe debilitating infection or illness.[61]

Advanced Care Plan

72. Following Sarah's discharge from the RMH on 7 March 2016, Dr Gandham remembered receiving a phone call from a Registrar at the RMH which involved a comment about "*let nature take its course*".[62] She understood that Sarah would be actively treated with antibiotics for her condition, which could lead to septicaemia.[63] Dr Gandham recalled the main conversation with the Registrar was around preparing an Advanced Care Plan.[64]

73. The next day, Ms Alsaeed attended a meeting with RMH In-Reach Service together with Ms Pontin and Ms Ferguson. The In-Reach service provided advice about nursing care and their ability to liaise with the hospital and community-based services like GP and residential care facilities in an attempt to ensure continuity of care.[65] In-Reach workers explained the Advance Care Plan.[66] Ms Pontin was unable to remember the exact conversation but it was generally that Sarah had become ill and doctors needed some advice as to the preferred types of treatment. Despite Ms Pontin[67] and Ms Ferguson[68] providing evidence of this meeting, Ms Alsaeed denied it occurred.[69] It was submitted on behalf of Eastbrooke Clinic that Ms Alsaeed's evidence should be rejected due to its unreliability. I agree and favour the evidence of Ms Pontin and Ms Ferguson in relation to this aspect of the evidence.

74. Ms Alsaeed also attended a meeting with Dr Gandham on 10 March 2016, along with Sarah and Ms Ferguson to sign the Advanced Care Plan.[70] Dr Gandham stated it was done solely in conjunction with Sarah's mother.[71] In describing the conversation with Ms Alsaeed, Dr Gandham claimed she definitely did not use the word 'palliative' to explain the Advanced

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[60] Transcript of evidence, p172
[61] Transcript of evidence, p169
[62] Transcript of evidence, p11
[63] Transcript of evidence, p26
[64] Transcript of evidence, p11
[65] Transcript of evidence, p44-45
[66] Transcript of evidence, p512-513
[67] Transcript of evidence, p512
[68] Transcript of evidence, p441
[69] Transcript of evidence, p129
[70] Transcript of evidence, p12
[71] Transcript of evidence, p21

Care Plan.[72] In evidence, Ms Alsaeed acknowledged that she understood the meaning of Sarah being made "comfortable".[73]

75. Submissions made on behalf of Eastbrooke Clinic said that Ms Alsaeed expressed no contemporaneous concerns about medical information received about Sarah.[74] Counsel for Eastbrooke Clinic submitted that the medical care and management provided by the Eastbrooke Clinic was reasonable and appropriate. There was no evidence that would warrant any adverse finding against any of the clinicians or nursing staff and there was no suggestion of inadequate medical care or attention by them.[75]

Appropriateness of medical care and management of Royal Melbourne Hospital

Admission to RMH between 5 and 7 March 2016

76. On 5 March 2016, Sarah was admitted to the RMH and was found to be tachycardic, febrile and in pain. She was also found to have bacteraemia, as she had *staphylococcus aureus* in her blood. Clinicians suspected the possibility of underlying osteomyelitis, which according to Associate Professor Brian Le, Director of Palliative Care is a serious condition and difficult to treat.[76]

77. An x-ray of the elbow failed to determine a diagnosis of osteomyelitis.[77] Consultant Physician, Professor David Russell explained that osteomyelitis is a deep-seated infection of the bone. The portal of entry of the infection is usually through skin to the bone but it can also be *de novo*. He noted that 90 per cent of staph osteomyelitis is due to infection, particularly where the portal of entry is a skin break. He said it is a very serious infection because antibiotics do not get into the bone very well and it requires a prolonged course of antibiotics.[78]

78. There are two ways to make the diagnosis, either radiologically or surgically.[79] Radiological imaging is either a CT scan or an MRI to show destruction of bones. Surgery requires dissection to the periosteum, which is the lining on the outside of the bone. If the periosteum

[72] Transcript of evidence, p14
[73] Transcript of evidence, p131
[74] Transcript of evidence, p137
[75] Submissions on behalf of Eastbrooke Family Medical Clinic, p1
[76] Transcript of evidence, p40
[77] Transcript of evidence, p71
[78] Transcript of evidence, p74
[79] Transcript of evidence, p76

is broken, then the infection is in the bone.[80] A clinical decision had been made not to perform an MRI, as it would have required Sarah to have a general anaesthetic which would have been technically difficult in her case. The reason as explained by Professor Russell was that Sarah weighed 29 kilograms and as a result she was very immunosuppressed. Therefore, having a general anaesthetic for an MRI or major surgery had a very high morbidity and mortality rate in these circumstances. According to Professor Russell, the treatment path depends on the goals of care and a discussion with the medical power of attorney.[81] The decision to take that route was deferred due to the fact the RMH were unable to contact Ms Alsaeed and they were unsure who the medical power of attorney was.[82]

Treatment and management

79. Professor Russell explained that there were two types of treatment for suspected osteomyelitis: conservative or aggressive. Conservative treatment is with antibiotics. More aggressive treatment involves surgery and debriding of the infected abscesses or bone[83] and according to Associate Professor Le in some cases could involve amputation of the limb.[84]

80. The tissue penetration of antibiotics into bone is very slow.[85] According to Professor Russell, staph grows quickly in the blood.[86] Staphylococcal osteomyelitis requires a minimum of four to six weeks of intravenous antibiotics and between six to 12 months of oral antibiotics.[87] Due to the seriousness of her condition, Sarah received emergency treatment by way of intravenous antibiotics.

81. Professor Russell said at no stage during this admission did they make her palliative. This was demonstrated by the fact she was treated with antibiotics.[88] Professor Russell explained that this was not a difficult diagnostic case. The difficulty in this case was determining what was clinically appropriate because there was no family member or responsible person with which to have that discussion.[89]

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[80] Transcript of evidence, p76
[81] Transcript of evidence, p80
[82] Transcript of evidence, p76
[83] Transcript of evidence, p80
[84] Transcript of evidence, p41 & p43
[85] Transcript of evidence, p75
[86] Transcript of evidence, p77
[87] Transcript of evidence, p75
[88] Transcript of evidence, p80
[89] Transcript of evidence, p82

82. Surgery presented a high risk of death and a decision for surgery could not be made without seeking the proper consent. Professor Russell said the decision for surgery was not urgent due to the stabilising effect of the antibiotics. Professor Russell agreed that Sarah should be treated conservatively, pending a discussion about aggressive treatment.[90]

Advanced Care Plan and Goals of Care

83. Over the weekend of 5 and 6 March 2016, the junior and senior medical staff made multiple attempts to obtain information regarding goals of care for Sarah,[91] including multiple attempts to contact Sarah's mother.[92] He confirmed the Health Medical Officer contacted a GP at Eastbrooke Clinic and found that no advanced care directive or goals of care forms had been completed.

84. The OPA were not approached for this decision due to the fact the clinicians were concerned that Ms Alsaeed was the medical power of attorney.[93] Professor Russell considered that appropriate care was given in the circumstances and every attempt was made to obtain external information regarding treatment.[94]

85. Consent is not required in an emergency. However, if there is a decision to be made about treatment and there is no substitute decision maker available, there are processes to follow which includes making a section 42K application pursuant to the *Guardianship and Administrations Act 1986* (Vic) (GA Act) to the OPA and requesting a guardianship order.[95]

86. The evidence established that Sarah's mother was not the medical power of attorney.[96] Ms Bianca Whitehead's evidence was that given there was no medical guardian, Ms Alsaeed would have been the person responsible. She referred to a hierarchy in the GA Act that doctors must follow if an adult patient lacks capacity to consent to any form of treatment that might be considered invasive, significant, or even insignificant treatment.[97]

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[90] Transcript of evidence, p80
[91] Transcript of evidence, p71
[92] Transcript of evidence, p71
[93] Transcript of evidence, p72
[94] Transcript of evidence, p73
[95] Transcript of evidence, p66
[96] Transcript of evidence, p263
[97] Transcript of evidence, p264

87. Ms Whitehead considered that once RMH were unable to contact Ms Alsaeed, the treating team should have contacted the OPA and filed a section 42K form to obtain medical consent.[98] This did not occur during this admission.

88. Counsel for RMH acknowledged there was some debate about this issue at Inquest.[99] However, it was submitted that there was no evidence before the Court to suggest that any of those issues, however interpreted and applied, would have had any impact on the cause of her very serious illness or the medical management of Sarah at the RMH. It was further submitted that any suggestion that they may have was entirely speculative. In support of that conclusion, she was treated as an emergency during the first admission and given intravenous antibiotics which had a beneficial effect in the short term.[100] It was further submitted that there was no evidence before the Court that another decision maker or a guardian would or could have made a different decision in the circumstances.[101]

Discharge from RMH on 7 March

89. On 7 March 2016, Sarah's condition had improved. Professor Russell explained that at the time of Sarah's discharge she was haemodynamically stable, her temperature and pulse rate were normal, and the plan was for continued antibiotics.[102] She was discharged from the RMH, with support from the In-Reach hospital in the home.[103]

RMH admission on 12 March 2016 and decision to palliate

90. Several events occurred which changed Sarah's course after her discharge from RMH, which included that she lacerated her tongue, the antibiotics were unable to contain the symptoms of the infection and Ms Alsaeed signed an Advanced Care Plan which indicated the preference for comfort measures only.

91. Consequently, Sarah was re-admitted to the RMH on 12 March 2016 in septic shock, which according to Associate Professor Le is a dangerous and life-threatening condition. [104] Septic shock is a progression of septicaemia to the point where vital organ functioning starts to be

[98] Transcript of evidence, p264
[99] Submissions on behalf of RMH dated 16 March 2018, p7
[100] Submissions on behalf of RMH dated 16 March 2018, p7
[101] Submissions on behalf of RMH dated 16 March 2018, p8
[102] Transcript of evidence, p103
[103] Transcript of evidence, p88
[104] Transcript of evidence, p40

impacted, such as low blood pressure, an increased heart rate and an altered conscious state.[105] Associate Professor Le explained when someone is in septic shock, every effort is made to stabilise them before going to theatre due to the high risk of death during surgery.[106]

Decision to palliate

92. By the time Associate Professor Le became involved with Sarah on 12 March 2016, she was in a terminal phase of life.

93. When Ms Sheila Narayan, Advocate at the OPA became aware of Sarah's condition, she spoke to the clinicians involved in Sarah's care to satisfy herself that they were not making decisions around palliation based on her disabilities and that decisions were being made *"in the interests of Sarah"*.[107] She said she had a conversation with Associate Professor Le who explained the severity of the injuries to Sarah's tongue, the septic shock and that she was actively dying.[108]

94. Associate Professor Le articulated that they do consider a person's quality of life, as a signpost as to how physically well they are.[109] He explained that if they consider treatment is futile or even harmful to a patient, then it is not reasonable to continue to provide it.[110] Ultimately, Associate Professor Le stated he did not think the outcome, regardless of any other therapies that may or may not have been given, would have made a difference.[111]

95. Counsel for RMH submitted that at the time of the second admission, any surgery or invasive investigation was very likely to be fatal due to Sarah's underlying bone infection, septic shock, emaciation and the inability of her body, at that time, to tolerate any anaesthesia and/or surgery, given her poor health. Therefore, it was submitted no criticism should be made about the medical management of Sarah by RMH clinicians before her death.[112]

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[105] Transcript of evidence, p40
[106] Transcript of evidence, p64-65
[107] Transcript of evidence, p320
[108] Transcript of evidence, p321
[109] Transcript of evidence, p50
[110] Transcript of evidence, p67
[111] Transcript of evidence, p52
[112] Submissions on behalf of RMH dated 16 March 2018, p8

Potential prevention opportunity

96. According to Professor Russell, this case highlights the difficulty of acute physicians in public hospitals providing appropriate care to patients who live in residential care, including nursing homes.[113] Professor Russell opined SRS facilities should be required to have documents such as medical powers of attorney, financial powers of attorney and a goals of care forms recorded in the clients file.[114] He suggested the documents should also be annually updated because goals of care change.[115]

97. It was submitted by counsel for DHHS, that while DHHS makes no specific submissions on these matters, it would appear *prima facie* that these recommendations would create tension, if not collide with the existing provisions of Parts 2, 5 and 6 of the *Disability Act* 2006 (Vic).

98. Considering these comments, I do not propose to make any recommendations.

FINDINGS

99. Having investigated the death of Sarah Hammoud and having held an Inquest in relation to her death on 19-22 February 2018 at Melbourne, I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Sarah Hammoud born on 19 March 1994; and

    (b) that Sarah died on 21 March 2016 at the Royal Melbourne Hospital from 1a) SEPTIC SHOCK COMPLICATING OSTEOMYELITIS SECONDARY TO CELLULITIS IN A WOMAN WITH CEREBRAL PALSY;

    (c) in the circumstances described above.

100. I accept that the OPA held genuine concerns about the care and management of Sarah particularly in relation to her poor mobility, falls risk and lack of suitable aids and equipment. However, having considered all the evidence, I find that the care and management by Annecto was reasonable in the circumstances. They had obtained relevant and appropriate assessments in February 2015. The only reason these assessments had been delayed was due to the OPA making enquiries about which organisation should pay.

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[113] Transcript of evidence, p73
[114] Transcript of evidence, p111
[115] Transcript of evidence, p112

101. I find that Sarah had complex needs that were being managed by Annecto staff as well as could be expected, given she was resistant to being put in a wheelchair and fed in a chair. I agree with Counsel for Annecto that on the evidence before me, there is no causal relationship between the issues of care provided by Annecto and Sarah's death.

102. I consider that Annecto staff did the best they could in the circumstances. I was impressed with the genuine level of care and affection provided to Sarah, which was demonstrated by the heartfelt evidence of Mr Holden and Ms Ferguson.

103. Having considered all the evidence, I find that the DHHS response, oversight and management of Annecto and the issues raised by the OPA in relation to Sarah were appropriate in the circumstances and in no way contributed to her death.

104. I find that the care and management provided to Sarah by the medical practitioners from the Eastbrooke Family Medical Clinic was reasonable in the circumstances.

105. The evidence of Professor Russell and Associate Professor Le was extremely important in assisting me to understand the circumstances surrounding Sarah's admissions to the RMH in March 2016. Having heard their evidence, I can now appreciate and acknowledge the difficulty that was faced by the clinicians in adequately diagnosing, treating and managing someone like Sarah, particularly with her intellectual disability and multiple co-morbidities and eventual septic shock. I understand that a clinician must balance appropriate medical treatment with the best interests of the patient. Accordingly, I am comfortably satisfied that the medical care and management of Sarah at the RMH was reasonable and appropriate in the circumstances.

106. Pursuant to section 73(1) of the Coroners Act 2008, I order that the finding be published on the internet.

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

- Ms Susan Alsaeed
- Ms Colleen Pearce, Public Advocate, Office of the Public Advocate
- Ms Estelle Fyffe, Chief Executive Officer, Annecto Incorporated
- Mr Mamatha Gandham, General Practitioner, Eastbrooke Family Clinic
- Dr Malcolm Mohr, Medical Administrator, Royal Melbourne Hospital
- Ms Kym Peake, Secretary of Disability, Department of Health and Human Services
- Mr Arthur Rogers, Disability Services Commissioner, Disability Services Commission

Signature:

JACQUI HAWKINS
CORONER
Date: 26 November 2018