IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2012 / 5075

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: BERNADETTE ROGERS

Delivered On:	30 January 2014
Delivered At:	Coroner's Court of Victoria, Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	8 October 2013
Findings of:	HEATHER SPOONER, CORONER
Police Coronial Support Unit	Senior Constable Ross Treverton

I, HEATHER SPOONER, Coroner having investigated the death of BERNADETTE ROGERS

AND having held an inquest in relation to this death on 8 October 2013
at Melbourne
find that the identity of the deceased was BERNADETTE ANGELINA ROGERS
born on 29 January 1947
and the death occurred on 20 November 2012
at Little Sisters of the Poor St Joseph's Home, 112B St Georges Road, Northcote 3070
from:

1 (a) ASPIRATION PNEUMONIA
1 (b) DOWN SYNDROME

in the following circumstances:

1. Ms Rogers was aged 65 when she died. She resided at Little Sisters of the Poor St Joseph's Home. Ms Rogers had a complex past medical history that included grand mal epilepsy, down syndrome, intellectual impairment, left frontal subdural hematoma, recurrent chest infections thought to have been due to poor swallowing and severe oropharyngeal dysphagia leading to recurrent mucus retention and aspiration and was on daily PEG feeding for her total nutritional needs including fluids.

2. The death of Ms Rogers was reported to the Coroner by the Registrar of Births Deaths and Marriages given the reference to Down Syndrome on the death certificate. Initial enquiries of the Department of Human Services (DHS)[1] revealed that Ms Rogers was in fact in the care of the DHS. In an email dated 2 January 2013 DHS advised the court as follows:

> *"Bernadette Rogers (DOB: 29/01/1947) resided in a Department of Human Services managed home directly prior to her death. It is my understanding that she should therefore be deemed as being held 'in the care' of Secretary."*

3. The *'in care'* status having been confirmed by DHS, it was then apparent that the circumstances surrounding the death of Ms Rogers should have been reported at the time of her demise irrespective of it being '*expected*' or due to '*natural causes*' as pursuant to section. 4(1) & 2(c) Coroners Act 2008 the death of a person who immediately before death was a person placed in care is a reportable death. Furthermore, pursuant to section

[1] This advice subsequently turned out to have been provided in error-refer paragraphs 7 & 8 of this finding

52, 2(b) of the Act the coroner is required to convene an Inquest into deaths of persons who immediately before death were placed in care.

4. An inquest was convened on 8 October 2013 and the Coroner's Assistant, Senior Constable Treverton read the following summary:

> *"The deceased, Bernadette Rogers, was born on 29 January 1947. At the time of her death on 20 November 2012 she was 65 years of age.*
>
> *Bernadette was born with Down Syndrome and in late life suffered from epilepsy and dementia. She was non weight bearing and bed and chair bound. She had no understanding of verbal or physical commands and severe communication impairment.*
>
> *She resided at Little Sisters of the Poor at St Joseph's Home in St George's Road, Northcote in the care of the Department of Human Services.*
>
> *On 15 July 2012 Bernadette was observed by staff to be chesty, wheezing and coughing repeatedly. She was seen by a locum up until 5 August 2012 and after that attended to by Dr Chandra Pokharel. She was given Ventolin inhalation and Ventolin nebulised for the wheeziness and over the next few weeks Bernadette was monitored closely due to her ongoing chest problems and at various times Ventolin inhalation to ease congestion.*
>
> *Bernadette's chest condition worsened on 6 November 2012 whereupon a locum attended and her brother, Marty, was informed of her condition.*
>
> *Dr Pokharel attended upon Bernadette the next day. She was given Ventolin inhalation due to breathing difficulties with minimal effect. The following day she was administered 2.5 milligram morphine due to some respiratory distress with effect.*
>
> *Over the next few days a combination of Ventolin inhalation, Ventolin nebuliser and morphine was administered due to Bernadette's ongoing coughing and breathing distress.*
>
> *On 15 November 2012 Bernadette's next of kin, being her sister-in-law and brother, Marty and Mary Rogers, were informed of the decline in Bernadette's medical condition being the onset of aspiration pneumonia and a decision was made to palliate.*

The family was in agreement and all care from this point until the time of death was around end of life and symptom control. She received morphine and Atropine injection to ease breathing distress and her palliative care was maintained over the next few days.

On 20 November 2012 Bernadette's breathing ceased at 6.15am. Her brother, Marty, attended at 9.30am and Dr Pokharel at 10.30am.

Your Honour, given that Bernadette was in the care of the Department of Human Services at the time of her death, Your Honour may benefit from a report from them in respect of this inquest. Dr Pokharel provided progress notes and they should be attached to the court file but it may also benefit Your Honour to have him provide a statement for your consideration. That's the summary of this inquest."

5. As the death of Ms Rogers was not reported as I had been lead to believe by DHS that it should have been, there was no post mortem examination performed. I directed the nursing home and medical records to be obtained. These records were reviewed by a clinician and pathologist from Victorian Institute of Forensic Medicine who formulated the cause of death and noted:

"Bernadette Rogers 65 year old woman with Down Syndrome under guardianship act in High Level Care. She had Down's, epilepsy and dementia. A subdural haemorrhage is mentioned throughout her notes in her medical history. There is no recent event. She had frequent episodes of aspiration pneumonia and was PEG fed. During the last episode, she was palliated in the nursing home by St Vincents outreach team. I think the subdural is not relevant to the death natural."

6. A statement was obtained from Dr Pokharel who was responsible for Ms Rogers' care. He stated in part:

"Ever since I have known her and she came under my care, she had always been totally bed bound, immobile and non communicative needing full nursing care for her activities of daily living. Scope of my management involved attending her medical needs on a day to day basis including liaison with other health care providers, nursing staff, carers and family members.

In relation to the issue of informing coroner of her death, regrettably I was not aware of the fact that she was under the care of DHS and it had not been brought

to my attention. I very much regret this fact and provide sincere apology for any inconvenience."

7. A statement from the Director of Nursing St Joseph's Home indicated that she was not aware that Ms Rogers was allegedly in the care of the Secretary of DHS and that her death was reportable as such. She stated in part:

> *"Bernadette Rogers was admitted to St Joseph's Home the 31st December 2007 and she was in our care until the date of her death being the 20th November 2012.*
>
> *Dr Chandra Pokharel was her treating General Practitioner. In consideration of the resident's deteriorating condition over a long period of time, Bernadette Rogers' death was an expected death. The resident was in end of life care for several days before her passing away.*
>
> *Under the Department of Health and Ageing, an expected death is not classified as reportable incident; therefore this is the reason why the Approved Provider did not notify Bernadette Rogers' death to the relevant authority."*

8. In January 2013, I had directed that a full statement be provided by DHS setting out the history of their involvement with Ms Rogers. This was not received until 23 January 2014 and it was only then that it became apparent that Ms Rogers was not in fact *'in care'* at the time of her death and as such her death was not reportable under the Act.[2]

9. It is regrettable that the court was provided with initial erroneous advice from DHS when enquiries were first made about the status of Ms Rogers and from which flowed an investigation and inquest into a death that would otherwise have been determined to be due to natural causes and not reportable.

Finding

I ultimately found that this death was not reportable and Ms Rogers, who was not in the care of DHS, unfortunately died from aspiration pneumonia in the circumstances set out in this finding.

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[2] refer statement of Mr S. Beaumont dated 22 January 2014

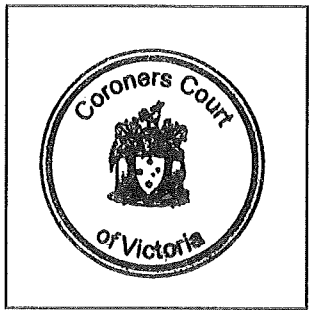
I direct that a copy of this finding be provided to the following:

The Family of Ms Bernadette Rogers

Senior Constable Ross Treverton, Investigating Member, Victoria Police

Department of Human Services

Signature:



HEATHER SPOONER
CORONER
Date: 30 January 2014