IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 4240

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of DEBORAH JANE PARKER

without holding an inquest pursuant to section 52(3A) of the *Coroners Act 2008*:
find that the identity of the deceased was DEBORAH JANE PARKER
born 13 June 1955
and the death occurred on 5 September 2016
at the Austin Hospital, 145 Studley Road, Heidelberg Victoria 3084
from:

1 (a) ASPIRATION PNEUMONIA

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Deborah Jane Parker was 61 years of age at the time of her death. Ms Parker lived in supported accommodation at a group home in Reservoir. She was a registered client of Disability Accommodation Services at the Department of Health and Human Services (DHHS), and required full assistance with activities of daily living. Ms Parker suffered from a moderate to severe intellectual disability and had limited ability to communicate with carers. She had a number of co-morbidities, including a history of pneumonia, type 2 diabetes mellitus and bipolar affective disorder; she had been wheelchair bound for approximately three years.
2. On 17 July 2016, Ms Parker was admitted to the Austin Hospital due to community acquired pneumonia. Upon discharge on 26 July 2016, she returned to her supported accommodation and appeared to improve for a while, before starting to decline. On 9 August 2016, Ms Parker was transported by ambulance to the Austin Hospital after her carer was unable to rouse her to administer night time medication. Ms Parker was examined in the Emergency Department (ED)

and found to be alert and well with stable vital signs. Ms Parker was returned to her residence. Over the next two weeks, Ms Parker attended her General Practitioner at Oak Hill Clinic three times for wheezing and a chest infection. She was prescribed antibiotics and Ventolin.

3. On 26 and 27 August 2016, Ms Parker experienced worsening shortness of breath, a productive cough, and her appetite for food and fluids decreased. On 28 August 2016, Ms Parker was lethargic, dropping items and refusing medication. Her carer contacted nurse-on-call, who advised that emergency services be contacted. Ambulance paramedics attended and transported Ms Parker to the Austin Hospital. Upon admission, Ms Parker was diagnosed with aspiration pneumonia with type 2 respiratory failure, complicated by acute kidney injury and hyperactive delirium. She was treated with intravenous antibiotics, but did not improve. Ms Parker's condition continued to decline, and on 1 September 2016, after discussion with the Office of the Public Advocate, she was transitioned to palliative care. On Monday 5 September 2016 at 8.52pm, Ms Parker was declared deceased.

4. Ms Parker's death was reportable pursuant to section 4 of the Coroners Act 2008 (Vic) ('the Act') because immediately before her death she was considered to be a person placed in care. Pursuant to section 3 of the Act, a person placed in care includes a person who is under the control, care or custody of the Department of Health and Human Services.

INVESTIGATIONS

Forensic pathology investigation

5. Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination upon the body of Ms Parker, reviewed a post mortem computed tomography (CT) scan and e-Medical Deposition Form from the Austin Hospital, and referred to the Victoria Police Report of Death, Form 83. Evidence of increased lung markings were observed on the CT scan, particularly at the bases. Dr Parsons ascribed the cause of Ms Parker's death to natural causes, being aspiration pneumonia.

Police investigation

6. Senior Constable Kylie Barrett, the nominated coroner's investigator,[1] conducted an investigation of the circumstances surrounding Ms Parker's death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by

[1] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

General Practitioner at the Oak Hill Clinic Dr Matthew Daly, Palliative Care Physician at the Austin Hospital Dr Sarah Charlton and Disability Accommodation Services Manager, North East Melbourne Area, North Division, DHHS Ondine Stachnowski.

7. In the course of the investigation, police learned that Ms Parker did not have a next of kin and had no current medical power of attorney when she was admitted to the Austin Hospital prior to her death. Dr Sarah Charlton stated that in view of this, contact was made with the Office of the Public Advocate, which advised that if Ms Parker's condition deteriorated, it would support the process of normal medical decision making. In addition, the Office of the Public Advocate supported the withdrawal of ongoing life-prolonging medical treatments, if they were not thought to be beneficial for Ms Parker.

8. Disability Accommodation Services Manager Ondine Stachnowski stated that Ms Parker was attended by doctors on at least 11 occasions for various co-morbidities in the month following her discharge from the Austin Hospital on 26 July 2016. While Ms Parker appeared to suffer from ongoing respiratory symptoms, treated with antibiotics, I have not identified evidence that she was subject to any further chest x-rays. Ms Stachnowski's statement suggested that DHHS staff were proactive in seeking medical attention for Ms Parker, and contacting the nurse on-call for advice and assistance.

COMMENTS

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

1. Section 52 of the Act mandates the holding of an Inquest if the deceased was, immediately before death, a person placed in care, save for circumstances where the person is deemed to have died from natural causes, pursuant to section 52(3A). In circumstances where Dr Parsons has ascribed Ms Parker's death to natural causes, being aspiration pneumonia, and in the absence of any identifiable issues related to her care, I have determined it is appropriate to conclude this investigation by way of an in-chambers Finding.

FINDINGS

Ms Parker had a significant number of medical co-morbidities. On the evidence available to me, I have not identified a causal relationship between her death and the fact that she was a person in care. I find that the provision of care to Ms Parker appears to have been reasonable and appropriate.

I accept and adopt the medical cause of death as ascribed by Dr Sarah Parsons, and find that Deborah Jane Parker died from natural causes, being aspiration pneumonia.

Pursuant to section 73(1B) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

Mrs Robyn Shea, Austin Health
Senior Constable Kylie Barrett

Signature:

AUDREY JAMIESON
CORONER

Date: **27 June 2017**