IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2016 1916**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**LARRY JAMES FADERSON**
Date of birth:	**30 MARCH 1963**
Date of death:	**29 APRIL 2016**
Cause of death:	**ASPIRATION PNEUMONIA IN A MAN WITH MYOTONIC DYSTROPHY**
Place of death:	**WANGARATTA HOSPITAL** **35-47 GREEN STREET** **WANGARATTA VICTORIA 3677**

HIS HONOUR:

BACKGROUND

1. Larry James Faderson was born on 30 March 1963. He was 53 years old at the time of his death. Larry was a long term resident of a shared community residential unit (CRU) at 1 Olivers Road, Benalla for people with a disability and it was managed by the Department of Health and Human Services (DHHS).

2. Larry had a significant high level of physical and intellectual care needs due to intellectual impairment, myotonic dystrophy[1] and cataracts. He was able to mobilize in a customized wheelchair but was fully dependent for all personal care and transfers. His CRU residence was staffed 24 hours per day with carers and he was able to attend a day centre.

3. Larry had been developing significant additional health problems with recurrent aspiration pneumonia[2] associated with weakness of his swallowing muscles. A statement of choices had been completed in consultation with his next of kin and doctor that supported his wishes to continue with oral feeding of a modified diet despite ongoing aspiration pneumonia risk.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Larry's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as immediately before death he was a person placed under the care of the secretary to the Department of Health and Human Services ('DHHS').[3] Ordinarily, a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and the deceased person was immediately before death a person placed in custody or care.[4] However, a coroner is not required to hold an inquest if they consider that the death was due to natural causes.[5]

5. The jurisdiction of the Coroners Court of Victoria is inquisitorial[6]. The purpose of a coronial investigation is independently to 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.

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[1] A progressive inherited neurological disorder
[2] Serious chest infection due to poor clearance of food from poor swallowing muscles
[3] Section 4, definition of 'Reportable death', *Coroners Act 2008;* Section 4, definition of 'Person placed in custody or care', *Coroners Act 2008.*
[4] Section 52(2)(b) *Coroners Act 2008.*
[5] Section 52(3A), *Coroners Act 2008.*
[6] Section 89(4) *Coroners Act 2008.*

possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

6. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[7] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

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

8. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

9. 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.

10. Coroners are also empowered:

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

    (b) to 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) to 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.

11. 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*.[8] The effect of this and similar authorities is that coroners should

[7] *Keown v Khan* (1999) 1 VR 69.
[8] (1938) 60 CLR 336.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

12. Larry James Faderson was visually identified by Andrea Skelton on 29 April 2016. Identity is not disputed and requires no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

13. On 1 May 2016, Dr Gregory Young, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an inspection on Larry's body and provided a written report dated 4 May 2016, concluding a reasonable cause of death to be "I(a) Aspiration pneumonia in a man with myotonic dystrophy". I accept his opinion in relation to the cause of death.

14. Dr Young noted that the computed tomography (CT) scan showed increased markings in both lungs, consistent with a history of aspiration pneumonia. Aspiration pneumonia occurs when there is aspiration of food, stomach contents or vomitus into the lungs, leading to pneumonia (chest infection). Myotonic dystrophy is a chronic progressive inherited disease that is characterised by wasting of muscles. This increases risk of aspiration due to abnormal swallowing, and reduced ability to cough due to decreased strength of muscles in the chest, abdomen and diaphragm.

15. Dr Young stated that on the basis of the information available, he was of the opinion that the death was due to natural causes.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

16. Larry was admitted on 17 April 2016 to Wangaratta Hospital for treatment of a chest infection. Larry had been unwell for several days and brought by ambulance to Wangaratta Emergency Department with increased respiratory rate and high temperature. He had evidence of type 2 respiratory failure[9]. An indwelling urinary catheter (IDC) was inserted and intravenous antibiotics and oxygen administered. There was a discussion regarding the appropriate goals of care with Larry's medical power of attorney to limit resuscitation and to

[9] A serious respiratory failure with low oxygen and high carbon dioxide readings

aim for comfort measures. Larry was transferred to Benalla Hospital on 24 April 2016 to complete intravenous antibiotics. Larry did respond to the antibiotics and was slowly weaned off the oxygen.

17. Significant challenges were reported in providing nursing care for Larry whilst in Benalla hospital including verbal disruption, calling out and refusing personal care. Benalla hospital staff believed that Larry would be best cared for in his CRU and that discharge to a familiar environment would decrease his agitation and behavioural disturbance. Nursing notes report that Larry was calling out 'I want to go home'.

18. Documented communication between Benalla Hospital staff Registered Nurse Currie and the operations manager for the CRU Mr Dean Williams confirmed that a medical review considered Larry was stable for discharge and it was hoped that he be more settled in his familiar environment. CRU staff documented that they had visited and did not feel Larry was well enough to return and informed the nursing staff at Benalla. It was subsequently decided that Larry was for discharge after multiple phone calls discussing these concerns between nursing staff and CRU management.

19. The transport options for Larry's discharge were between a Maxitaxi[10] which allowed Larry to travel in his customized wheelchair, or a stretcher ambulance. The Maxitaxi was decided upon as the stretcher ambulance could not provide a reliable timeframe and would not transport Larry's wheelchair or his belongings.

20. Larry was discharged to his CRU on 22 April 2016. CRU staff were immediately concerned that he did not appear well, he declined oral intake and staff did not have nursing expertise in managing an indwelling catheter. CRU staff requested an ambulance attendance later that same day and readmission to Wangaratta Hospital followed. Larry's clinical course did not improve and he received palliative care and died on 29 April 2016.

[10] A form of public transport for disabled persons who can be transported whilst seated in their wheelchair which is driven into the rear of the vehicle.

Review and Assessment of Medical Treatment

21. Larry received appropriate palliative care in keeping with his and his families' wishes. It is evident that Larry's nursing care needs were greater than could be provided in the CRU and his unsuccessful discharge from Benalla Hospital was quickly remedied after the staff called the ambulance to arrange a readmission.

22. Larry was very unsettled in the hospital environment and was asking (loudly) to go home. He had completed his course of intravenous antibiotics and his advance care directive was clearly only for further comfort care and subsequently did not require further acute medical treatments. Nursing staff at Benalla Hospital reasonably postulated that his oral intake may improve when he was returned to his more familiar environment. However the CRU staff were not adequately trained to provide palliative care and there appeared to be a miscommunication between the two services, in that CRUs cannot provide the appropriate level of nursing support for catheter care or palliative care.

23. The decision to use a Maxitaxi to transport Larry home was made expeditiously, in order to ensure that his customized motorized wheelchair was not left behind in the hospital. The distance between Benalla hospital and his CRU was 3.2 km. It is likely that the journey was completed in under five minutes.

24. Larry's death was in keeping with his progressive neurological decline and his wishes. His short return to the CRU would have had minimal impact on his outcome. The challenges of providing good palliative care in disabled persons within their preferred residence is demonstrated. End of life care for persons with progressive disability within CRUs are disadvantaged by the lack of trained staff who can provide care in familiar environments.

FINDINGS

25. Having investigated Larry James Faderson's death, and having considered all of the available evidence, I am satisfied that no further investigation is required.

26. I find that the care provided to Larry James Faderson by the Department of Health and Human Services and Benalla Hospital was reasonable and appropriate in the circumstances.

27. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Larry James Faderson, born 30 March 1963;

(b) that Larry James Faderson, who had myotonic dystrophy, died on 29 April 2016, at Wangaratta Hospital, 35-47 Green Street Wangaratta, Victoria from aspiration pneumonia; and

(c) that the death occurred in the circumstances described in the paragraphs above.

28. I convey my sincerest sympathy to Larry's family and friends.

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

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

(a) Larry's family, senior next of kin;

(b) Investigating Member, Victoria Police; and

(c) Interested Parties.

Signature:

MR JOHN OLLE

CORONER

Date: 25 October 2017