IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 2590

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Peter Charles White, Coroner
Deceased:	Lesley Fallon
Date of birth:	12 May 1961
Date of death:	3 June 2017
Cause of death:	Aspiration Pneumonia in the setting of Cerebral Palsy and Epilepsy
Place of death:	41 Victoria Parade, Fitzroy

I, PETER CHARLES WHITE, Coroner,
having investigated the death of Lesley Fallon
without holding an inquest:
find that the identity of the deceased was Lesley Fallon
born on 12 May 1961
and that the death occurred 3 June 2017
at 41 Victoria Parade, Fitzroy
from:

I (a) ASPIRATION PNEUMONIA IN THE SETTING OF CEREBRAL PALSY AND EPILEPSY

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

1. Ms Fallon was 56 years old at the time of her death. By age one she was diagnosed with cerebral palsy and at 11 years old she was living in Department of Human Services (**DHS**) high level residential care. She remained in DHS care until her death.

2. 22 May 2017, Ms Fallon presented at St Vincent Hospital in Fitzroy. She was in an altered conscious state showing signs of fever.[1] Closer examination and testing revealed Ms Fallon was suffering from abnormal liver function, anaemia, raised white blood cell count, abdominal pain and anorexia. These symptoms indicated Ms Fallon was suffering from sepsis.[2]

3. Ms Fallon underwent a chest x-ray which revealed the possibility of Ms Fallon suffering from pneumonia.[3] She was accordingly treated for pneumonia and sepsis. An ultrasound of Ms Fallon's abdominal region demonstrated evidence of cholecystitis or biliary obstruction.[4]

4. On 23 May 2017, Ms Fallon's health continued to deteriorate and she required the attendance of the Medical emergency Team (**MET**) twice for stabilisation.[5] Further x-rays demonstrated rapidly evolving pneumonia changes within her upper right lung. Precautions

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[1] Coronial Brief, statement of Dr Chong Weng ONG dated 10 October 2017 [6].
[2] Ibid [7].
[3] Ibid.
[4] Ibid [9].
[5] Ibid [11].

were initiated to mitigate severity.[6] Ms Fallon's sepsis continued to worsen and she became hypotensive. Due to her instability further testing was postponed.[7]

5. On 24 May 2017, a speech pathologist evaluated Ms Fallon was at risk of pulmonary aspiration and that she should avoid oral feeding.[8] She was iron deficient, hypoxic and had a low haemoglobin count. She underwent a blood transfusion to stabilise her state.[9]

6. On 26 May 2017, a cardiothoracic surgery consultant made the recommendation to drain the fluid from Ms Fallon's right lung due to large build up.[10] Although Ms Fallon was physiologically more stable, she was still showing signs of sepsis despite the aggressive antibiotics she was prescribed.[11]

7. Due to Ms Fallon's prolonged state of starvation, dietetics service made the decision a nasogastric feeding tube should be fitted.[12] On 29 May 2017 the tube was inserted but shortly after Ms Fallon became unstable. Attendance of the MET team was required once again and the decision was made not to re-insert the tube.[13]

8. Surgery was considered to control the sepsis, however, the surgery did not proceed due to the high risk associated with Ms Fallon's physiological state.[14]

9. From 29–30 May, Ms Fallon's physiological state continued to deteriorate. Ms Fallon's treating team and family members made the decision based on the low likelihood of full recovery to switch treatment to palliative care.

10. On 2 June 2017 Ms Fallon was transferred. On the morning of 3 June 2017 at approximately 7:30 Ms Fallon was found by staff to have died overnight.[15]

11. On the 3 June 2017, Jean Kokshoorn identified the deceased to be that of her sister, Lesley Fallon, born 12 May 1961.

12. On 5 June 2017, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon Ms Fallon's body and provided a written report, dated 6 June 2017. In that report, Dr Lynch concluded the

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[6] Ibid [12].
[7] Ibid.
[8] Ibid.
[9] Ibid [14].
[10] Ibid [18]
[11] Ibid [21].
[12] Ibid [22].
[13] Ibid.
[14] Ibid [23].
[15] Ibid [27].

reasonable cause of death was *'Aspiration Pneumonia in the setting of Cerebral Palsy and Epilepsy'*. No toxicological analysis of post mortem was conducted.

13. I adopt the cause of death as found by Dr Lynch.

14. Having considered all of the available evidence, I find that Ms Fallon, late of Department of Human Services high level residential care, died on 3 June 2017, and that the cause of her death was aspiration pneumonia in the setting of cerebral palsy and epilepsy.

15. Pursuant to section 73(1B) of the **Coroners Act 2008**, I direct this finding be published on the internet.

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

Jean Kokshorn, Senior Next of Kin; and

SC Joel Butler, Fitzroy Police Station.

Signature:

PETER CHARLES WHITE
CORONER

Date: 8 March 2018