IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 3584

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**LINDA CHRISTINE STANTON**
Date of birth:	22 February 1950
Date of death:	2 August 2016
Cause of death:	Complications of pulmonary fibrosis and bronchiectasis in a woman with cerebral palsy
Place of death:	Dandenong, Victoria
Catchwords:	Deceased person in care; natural causes.

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HER HONOUR:

BACKGROUND

1. Linda Stanton (**Ms Stanton**) was a 66-year-old woman who resided at Dandenong at the time of her death. Ms Stanton was resident at The Glade Group Home (**The Glade**), a disability accommodation service managed by the Department of Health and Human Services (**DHHS**). She had lived there for 23 years.

2. Ms Stanton's past medical history included cerebral palsy, intellectual disability, asthma, pulmonary fibrosis, pulmonary hypertension, oesophageal stricture and hiatus hernia. Ms Stanton received treatment from general practitioners at Dandenong City Clinic. Her primary health issue was her respiratory health. Ms Stanton's primary General Practitioner was Dr Anthony Karantonis (**Dr Karantonis**).

3. Ms Stanton was significantly affected by her lung condition. As a consequence, she was susceptible to infection, required continuous home oxygen therapy, and took nebulised Ventolin, Atrovent and steroids.

4. From December 2015, Ms Stanton required treatment for her respiratory conditions at hospital, either in the Emergency Department or by means of admission, on six separate occasions.

5. On 21 July 2016, Ms Stanton underwent a review with Respiratory Physician Dr Yee Kuo (**Dr Kuo**). Dr Kuo considered that Ms Stanton had poor respiratory reserve at that time, and would likely need a further presentation to hospital in the near future.

6. On 23 July 2016, Ms Stanton was assessed by Dr Karantonis. At the time she was alert and active. Ms Stanton had early signs of a possible viral illness. Dr Karantonis advised her care staff to monitor her condition and report any deterioration.

THE PURPOSE OF A CORONIAL INVESTIGATION

7. The role of a coroner is independently to investigate reportable deaths to establish, if possible, identity, medical cause of death and, with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally

related to the death. The law is clear that coroners establish facts; they do not lay blame, or determine criminal or civil liability.[1]

8. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The *Coroners Act 2008* (Vic) (**the Act**) provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3]

9. Ms Stanton's death constituted a '*reportable death*' under the Act, as the death occurred in Victoria and, at the time of their death s/he was a person considered to be "*in custody or care*".[4]

10. The Act mandates that a coroner must hold an inquest into all deaths deemed to have occurred while a person is "*in custody or care*",[5] except in those circumstances where the death is considered to be due to natural causes. [6]

11. In accordance with section 52(3B) of the Act, a death may be considered to be due to natural causes if the coroner has received a report from a medical investigator, in accordance with the rules, that includes an opinion that the death was due to natural causes. I have received such a report in this case. Therefore, I limit my findings with respect to the circumstances in which the death occurred and exercise my discretion not to hold an inquest.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

12. Ms Stanton was visually identified by Ebony Lillee on 2 August 2016. Identity was not in issue and required no further investigation.

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[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

[2] Section 89(4) *Coroners Act 2008.*

[3] See Preamble and s 67, *Coroners Act 2008.*

[4] Section 3 and 4 *Coroners Act 2008.*

[5] Section 52(2)(b) of the *Coroners Act 2008.*

[6] Section 52(3A) of the *Coroners Act 2008.*

Medical cause of death, pursuant to section 67(1)(b) of the Act

13. On 3 August 2016, Dr Gregory Young, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination upon Ms Stanton's body and provided a written report, dated 18 August 2016. In that report, Dr Young concluded that a reasonable cause of death was '*complications of pulmonary fibrosis and bronchiectasis in a woman with cerebral palsy*'.

14. Dr Young commented "*pulmonary fibrosis is a form of interstitial lung disease that can result in lung scarring. Bronchiectasis is where there is permanent enlargement of parts of the airways of the lung. These both may result in difficulty breathing, which may be exacerbated by a chest infection (pneumonia). Risk factors for aspiration leading to pneumonia include cerebral palsy and intellectual disability*".

15. On the basis of the information available at the time of completing his report, Dr Young provided an opinion that Ms Stanton's death was due to natural causes.

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

16. On 27 July 2016, staff at The Glade noted that Ms Stanton was distressed and was refusing her medication. An ambulance was contacted and Ms Stanton was taken to Dandenong Hospital. While *en route* to hospital, paramedics observed that Ms Stanton was short of breath, tachycardic, hypotensive, tachypnoeic and hypoxic. She was administered bronchodilators and dexamethasone intravenously to help with her breathing.

17. Following presentation to the Dandenong Hospital Emergency Department, Ms Stanton was transferred to the Acute Assessment Unit. Clinicians considered that Ms Stanton was experiencing an exacerbation of her underlying lung disease. While she had a high carbon dioxide level, Ms Stanton's clinical assessment was not consistent with respiratory failure.

18. Ms Stanton was admitted under General Medicine. Steroid therapy was commenced, and the treating team were advised to commence antibiotics if a fever developed. Clinicians observed that, on previous admissions, Ms Stanton's resuscitation status was not for cardiopulmonary resuscitation (**CPR**), and the ceiling of care was held at non-invasive ventilation.

19. On 1 August 2016 at approximately 11.30am, Ms Stanton's oxygen levels were difficult to maintain with high oxygen requirements and an increased respiratory rate. Ms Stanton was on intravenous antibiotics. Medically, Ms Stanton was considered to not be a suitable candidate

for non-invasive ventilation. A plan was made to refer Ms Stanton to a respiratory consultant, and consider changing the oral steroids to intravenous steroids.

20. On 1 August 2016 at approximately 6.00pm, the Medical Emergency Team (**MET**) were called to Ms Stanton due to an increase in her respiratory rate. They observed that Ms Stanton was not a suitable candidate for non-invasive ventilation.

21. Ms Stanton continued to deteriorate. She was declared deceased at 7.10am on 2 August 2016.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

22. Having considered the evidence I am satisfied that no further investigation is required.

23. I am satisfied that the medical care and management of Ms Stanton was reasonable and appropriate in the circumstances.

FINDINGS AND CONCLUSION

24. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) the identity of the deceased was Linda Christine Stanton, born 22 February 1950;

    (b) the death occurred on 2 August 2016 at Dandenong, Victoria, from ; and

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

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

    (a) Heather Kelly, State Trustees;

    (b) First Constable Adam Golding, Victoria Police, Coroner's Investigator; and

    (c) Ms Jo Hall, Monash Health

26. Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet in accordance with the rules.

Signature:

JUDGE SARA HINCHEY

STATE CORONER

DATE: 28 AUGUST 2017