IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 220

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: LLONA ELIZABETH DOOLAN

Delivered On:	11 September 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank, VIC 3006
Hearing Dates:	11 September 2014
Findings of:	JOHN OLLE, CORONER
Police Coronial Support Unit	Leading Senior Constable Amanda Maybury

I, JOHN OLLE, Coroner having investigated the death of LLONA ELIZABETH DOOLAN

AND having held an inquest in relation to this death on 11 September 2014
at Melbourne
find that the identity of the deceased was LLONA ELIZABETH DOOLAN
born on 21 December 1957
and the death occurred on 18 January 2012
at Western Hospital, 148 Gordon Street, Footscray VIC 3011
from:

1 (a) COMPLICATIONS OF PROGRESSIVE DYSPHAGIA IN A WOMAN WITH DOWN SYNDROME AND DEMENTIA

in the following circumstances:

1. Llona Doolan was born on 21 December 1957 and was 54 years old at the time of her death. She is survived by her brother, Gregory Doolan, with whom she maintained a close and loving relationship.

2. A coronial brief was provided by Victoria Police to this Court, comprising statements obtained from witnesses, treating clinicians and investigating officers. It has wholly addressed the circumstances surrounding Ms Doolan's death. I have drawn on all of this material as to the factual matters in this finding.

SUMMARY INQUEST

3. At inquest, a summary was read into evidence by Leading Senior Constable Amanda Maybury. I am satisfied that the summary accurately reflects the evidence.

4. Ms Doolan was, immediately before death, a person placed under the care of the secretary to the Department of Human Services ('DHS'). Consequently, this matter is a mandatory inquest.[1] She resided at DHS accommodation, due to having disabilities, since 10 August 1971 and most recently resided at a DHS Residential Care Unit in Sunbury. She lived at this residence since 13 December 2010 and received ongoing care by DHS while residing there.[2]

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[1] See *Coroners Act 2008* (Vic) s 52(2)(b); *Coroners Act 2008* (Vic) s 3(d), definition of 'person placed in custody of care'.

[2] Email of Sharon Samfat, Disability intake worker at the Department of Human Services, dated 1 September 2014.

5. Ms Doolan had a medical history of Down syndrome, epilepsy, dementia, asthma, bilateral cataract removal and bilateral intraocular lens implants.[3] Ms Doolan had a history of health issues. She had difficulty eating and drinking, and was subsequently diagnosed with dysphagia,[4] and she suffered from very poor mobility requiring aid by care workers at all times.[5] From 6 December 2011 to 12 December 2011 she was also admitted to, and treated at, Footscray Hospital for aspiration pneumonia.

6. On 30 December 2011 at 8.45pm Ms Doolan was admitted to Western Hospital Emergency Department after care workers found it increasingly difficult to feed her and administer medication[6] due to Ms Doolan dribbling fluids, experiencing poor swallow and having minimal oral intake. At 9.30pm she was assessed as being non-verbal and having contractures to her upper and lower limbs. Her heart rate was 80, blood pressure 106/50, respiratory rate 18 and her oxygen saturations were 98% on room air. She was admitted to the General Internal Medicine Unit and was re-assessed on 31 December 2011 as having oxygen saturations at 83% on room air, poor swallow and coughing on thick fluids.[7]

7. On 31 December 2011 Ms Doolan was continued with antibiotic therapy of ceftriaxone and metronidazole. A chest x-ray was also undertaken and no collapse, consolidation, pleural effusion or pneumothorax was reported.[8]

8. On 4 January 2012 Ms Doolan was reviewed by a gastroenterology registrar in relation to suitability for a percutaneous endoscopic gastrostomy ('PEG'). She was found to be inappropriate for a PEG as she was aspirating on her own secretions and was at risk of perforation, peritonism, anaesthetic complications and of aspirating during the surgical procedure.[9]

9. On 6 January 2012 a meeting was held between the multidisciplinary team[10] from Western Health, a Department of Human Services domain manager, Ms Doolan's family and Ms Doolan's support worker. Gregory Doolan was informed that his sister was an

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[3] Statement of Edward Janus, dated 30 May 2014, 1.

[4] A medical term for the symptom of difficulty in swallowing.

[5] Statement of Anna Hardiman, support person at the Department of Human Services, dated 19 February 2014, Coronial brief 1.

[6] Ibid 2.

[7] Statement of Edward Janus, above n 2, 1-2.

[8] Ibid 2.

[9] Statement of Edward Janus, above n 2, 2.

[10] Comprising the general internal medicine registrar, nurse unit manager, social worker and speech pathologist.

inappropriate candidate for a PEG, that she continued to be at high risk of aspiration, that her condition was deteriorating and that it was in Ms Doolan's best interests to be made comfortable and be given less intrusive support. Mr Doolan agreed to minimal morphine to assist with his sister's discomfort and requested that the current treatment continue until a second opinion was arranged.[11]

10. On 10 January 2012 Ms Doolan's condition deteriorated. She was in respiratory distress with decreased air entry to both lungs, was non-responsive and upper airway sounds were audible on inspiration. On 11 and 12 January 2012 the General Internal Medicine Team found that Ms Doolan was continually deteriorating and was in respiratory distress.

11. On 12 January 2012 the General Internal Medicine Registrar explained to Mr Doolan that his sister's prognosis was very poor and that her condition had deteriorated. Mr Doolan agreed to a palliative care approach to ensure that his sister was comfortable. From 13 January 2012 to 18 January 2012 Ms Doolan's condition did not improve. The palliative care team implemented comfort measures and Ms Doolan passed away on 18 January 2012.[12]

POST-MORTEM INSPECTION AND REPORT

12. A post-mortem inspection and report was undertaken by Dr Linda Iles, Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr Iles reported that the post-mortem CT scan showed patchy basal lung opacification, fluid in the stomach, and marked cerebral atrophy and associated lacunar malacia.

13. Dr Iles determined that the cause of death is complications of progressive dysphagia in a woman with Down syndrome and dementia.

FINDING

14. I am satisfied, having considered all of the evidence before me, that no further investigation is required.

15. The evidence satisfies me that the medical management and care provided by Western Hospital and the Department of Human Services was reasonable and appropriate in the circumstances, having regard to the complexities involved.

16. I find that Llona Doolan died on 18 January 2012 and that the cause of her death is complications of progressive dysphagia in a woman with Down syndrome and dementia.

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[11] Statement of Edward Janus, above n 2, 2-3.

[12] Ibid 3.

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

The family of Llona Doolan;

Investigating Member, Victoria Police; and

Interested parties

Signature:

JOHN OLLE
CORONER
Date: 11 September 2014