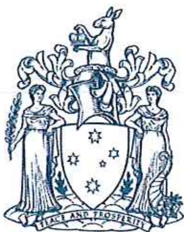


IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2018 3992**

**FINDING INTO DEATH WITHOUT INQUEST**

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

| | |
|---|---|
| Findings of: | **PHILLIP BYRNE, CORONER** |
| Deceased: | **KERRI MICHELLE MOORE** |
| Date of birth: | **2 DECEMBER 1962** |
| Date of death: | **12 AUGUST 2018** |
| Cause of death: | **I (a) ASPIRATION PNEUMONIA IN A WOMAN WITH EPILESY AND INTELLECTUAL DISABILITY** |
| Place of death: | **NORTHERN HOSPITAL, 185 COOPER STREET, EPPING, VICTORIA, 3076** |

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 3992

**FINDING INTO DEATH WITHOUT INQUEST**

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

I, PHILLIP BYRNE, Coroner, having investigated the death of KERRI MICHELLE MOORE without holding an inquest:
find that the identity of the deceased was KERRI MICHELLE MOORE
born on 2 December 1962
and the death occurred on 12 August 2018
at Northern Hospital, 185 Cooper Street, Epping, Victoria, 3076

**from:**

1 (a) ASPIRATION PNEUMONIA IN A WOMAN WITH EPILESY AND INTELLECTUAL DISABILITY

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

## BACKGROUND

1. Kerri Michelle Moore, 55 years of age at the time of her death, resided at a group home managed by the Department of Health and Human Services (**DHHS**). Ms Moore suffered an intellectual disability, progressive neurological deficit and epilepsy.

## CIRCUMSTANCES SURROUNDING DEATH

2. Ms Moore was admitted to the Northern Hospital on 4 August 2018 with status epilepticus. She was commenced on antibiotic therapy for aspiration pneumonia, intubated and transferred to the Intensive Care Unit (**ICU**) for seizure control. She was extubated on 8 August 2018 but had worsening infective markers with ongoing fevers. In consultation, a decision was taken to provide palliative care. Ms Moore died in hospital on 12 August 2018.

## REPORT TO THE CORONER

3. Ms Moore's death was reported to the coroner. Having conferred with a forensic pathologist, having considered the circumstances, and noting the Senior Next of Kin's strong objection to autopsy, I directed an external only post mortem examination. The examination was undertaken at the Victorian Institute of Forensic Medicine by Forensic Pathologist Dr Gregory Young who advised Ms Moore's death was due to:

   *1 (a) aspiration pneumonia in a woman with epilepsy and intellectual disability.*

## CONCLUSION/FINALISATION

4. As I am advised Ms Moore was "in care" within the meaning of the *Coroners Act 2008* at the time of her death, and, as further advised, her death was due to natural causes, I can finalise my coronial investigation by way of Finding Without Inquest.

5. I note on the Coronial Admissions and Enquiries (**CA&E**) log that Mrs Mary Moore, the mother of Ms Moore, advised she was "very happy with the care at both the home and the hospital and does not have any issues that she would like investigated". On the material available, I believe one could not reasonably conclude that the care/treatment of Ms Moore was other than reasonable and appropriate.

## COMMENT

6. Pursuant section 67 (3) of the *Coroners Act 2008*, I make the following comments connected with the death.

7. In earlier correspondence, I advised the Senior Next of Kin I would leave my investigation in abeyance awaiting the outcome of a review by the office of the Disability Services Commissioner (**DSC**) in relation to the provision of services to Ms Moore. However, I now propose to proceed to finalisation of my coronial investigation.

## FINDING

8. I formally find Kerri Michelle Moore died at the Northern Hospital on 12 August 2018 due to aspiration pneumonia in a woman with epilepsy and intellectual disability.

9. Pursuant to section 73 (1) (B) of the *Coroners Act 2008*, I order that this finding be published on the Coroners Court of Victoria website.

## DISTRIBUTION OF FINDING

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

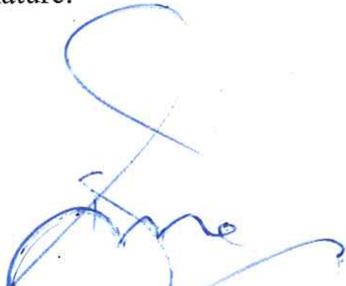
Mrs Mary Moore, Senior Next of Kin;

Ms Jacinda De Witts, Acting General Counsel and Chief Legal Officer, Legal Services, DHHS;

Ms Jackie Petrov, Legal Co-ordinator, The Northern Hospital; and

First Constable R Hughes, Reporting Officer, Victoria Police

Signature:



PHILLIP BYRNE
CORONER

Date: 28 March 2019