IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2018 4042**

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**PHILLIP BYRNE, CORONER**
Deceased:	**VICKI MAREE HAY**
Date of birth:	**13 AUGUST 1968**
Date of death:	**15 AUGUST 2018**
Cause of death:	**I (a) ASPIRATION PNEUMONIA** **1 (b) SEVERE INTELLECTUAL DISABILITY**
Place of death:	**BENDIGO HOSPITAL, 100 BARNARD STREET, BENDIGO, VICTORIA, 3550**

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Section 67 of the ***Coroners Act 2008***

I, PHILLIP BYRNE, Coroner, having investigated the death of VICKI MAREE HAY without holding an inquest:
find that the identity of the deceased was VICKI MAREE HAY
born on 13 August 1968
and the death occurred on 15 August 2018
at Bendigo Hospital, 100 Barnard Street, Bendigo, Victoria, 3550

from:

1 (a) ASPIRATION PNEUMONIA

1 (b) SEVERE INTELLECTUAL DISABILITY

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

BACKGROUND

1. Vicki Maree Hay, 50 years of age at the time of her death, resided in a group home at 97 Rowan Street, Bendigo, managed by the Department of Health and Human Services (**DHHS**). Consequently, she was "in care" within the meaning of the *Coroners Act 2008* (**the Act**). Ms Hay had a severe intellectual disability, was asthmatic and non-verbal.

2. Despite Ms Hay's death apparently being due to natural causes, her death was a "reportable death" within the meaning of the Act due to her being in the care of DHHS.

BROAD CIRCUMSTANCES SURROUNDING DEATH

3. Ms Hay was admitted to Bendigo Hospital on 8 August 2018 following treatment at the group home over the previous two weeks by her general practitioner (**GP**) for a lower respiratory tract infection. On the day of transfer to the hospital, Ms Hay experienced severe vomiting which continued in the Emergency Department (**ED**) upon admission. Ms Hay was

intubated in the ED for airway protection. A computed tomography (**CT**) scan demonstrated aspiration. Ms Hay was transferred to the Intensive Care Unit (**ICU**) for invasive ventilation support. Upon assessment by the consultant intensivist, Ms Hay was extubated on 10 August 2018, however, within an hour she required reintubation. After consultation with her family, on 14 August 2018, Ms Hay was again extubated with agreement that she not be reintubated. End of life care was initiated and Ms Hay passed away at 10.20am on 15 August 2018.

REPORT TO CORONER

4. Ms Hay's death was reported to the coroner. Having considered the circumstances, having conferred with a forensic pathologist and being advised the family did not consent to autopsy, I directed an external only post mortem examination. The examination was undertaken by Forensic Pathologist Dr Paul Bedford who confirmed Ms Hay's death was due to:

    1 (a) aspiration pneumonia

    1 (b) severe intellectual disability.

    Dr Bedford advised Ms Hay's death was due to natural causes.

5. The Senior Next of Kin, Ms Hay's sister, Karen, has advised the family has no concerns regarding Ms Hay's care and treatment. I conclude no further investigation is warranted.

CONCLUSION

6. On the material available, I believe one could not reasonably conclude that the care/treatment of Ms Hay was other than reasonable and appropriate.

COMMENT

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

8. 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 Hay. However, I now propose to proceed to finalisation of my coronial investigation.

FINDING

9. I formally find Vicki Maree Hay, suffering a severe intellectual disability, died at Bendigo Hospital on 15 August 2018 due to aspiration pneumonia.

10. 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

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

    Mrs Karen Fuller, Senior Next of Kin;

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

    Mrs Stacy Thackray, Bendigo Health; and

    Senior Constable Matthew Trist, Reporting Officer, Victoria Police.

Signature:

PHILLIP BYRNE
CORONER
Date: 28 March 2019