IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 3619

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Sarah Gebert, Coroner
Deceased:	Elizabeth Geiger
Date of birth:	25 November 1947
Date of death:	25 July 2017
Cause of death:	Aspirational pneumonia in a woman with intellectual disability
Place of death:	The Monash Medical Centre, 246 Clayton Road, Clayton, Victoria

Introduction

1. Elizabeth Geiger, born on 25 November 1947, was a 69 year old woman who had resided at a Department of Health and Human Service (**DHHS**) managed group home in Mount Waverley since May 2006.

2. She had formally been a resident of Kew Cottages until it closed down.

3. According to her General Practitioner (**GP**) who had treated her since 2006, Ms Geiger had severe physical and intellectual disabilities since birth.[1] Her stated medical history included Anxiety Disorder and Autistic Spectrum Disorder, renal disease, hiatus hernia, and constipation.

4. Ms Geiger was non-verbal, required a wheelchair for mobility and received ongoing assistance with her daily care needs.

5. Ms Geiger's family were *most* important to her, and regularly visited.[2]

6. Ms Geiger died at the Monash Medical Centre at Clayton on 25 July 2017.

The Coronial Investigation

7. Ms Geiger's death was reported to the coroner as it occurred in Victoria, appeared unexpected and so fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).

8. In addition, it was noted that Ms Geiger was in receipt of disability services from DHHS provided at DHHS managed residential accommodation where it appeared she was dependent for all her daily living needs, her general welfare as well as her medical requirements. In those circumstances, it was open to me to regard her as *a person placed in custody or care* at the time of her death.[3] This category of death is also reportable under the Act.

9. A coroner independently investigates reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine

[1] Statement of Dr L Comrie dated 25 September 2017
[2] Resident Profile, Disability accommodation service file
[3] S3(d) of the Act includes a person in the care of the Secretary of the DHHS

criminal or civil liability. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[4]

10. Victoria Police assigned Senior Constable Andrea Ward to be the Coroner's Investigator for the investigation into Ms Geiger's death. Senior Constable Ward conducted inquiries on my behalf[5], including taking statements from witnesses and submitting a coronial brief of evidence. The brief includes statements from Ms Geiger's family, the forensic pathologist, treating clinicians and investigating officers.

11. In addition to the material contained in the coronial brief, Ms Geiger's medical records from the Monash Medical Centre and her Disability Accommodation Services file were obtained.

12. As part of the investigation this case was referred to the Coroners Prevention Unit (**CPU**) for review of the adequacy of Ms Geiger's medical care proximate to her death. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are not associated with the health professionals and institutions under consideration and are therefore able to give independent advice to coroners.

Disability Services Commissioner

13. I also considered the *Investigation Report into disability services provided by DHHS to Ms Geiger* prepared by the Disability Services Commissioner (**DSC**) which was provided to the Court on a confidential basis. This investigation is conducted under the auspices *Disability Services Act 2016* with a different scope to that of a coronial investigation (although it may overlap). Consistent with the Act, a coroner should liaise with other investigative bodies to avoid unnecessary duplication and expedite investigations.[6] Ultimately the thoroughness of the investigation is improved.

14. Having considered the DSC Report however, I noted that the deficiencies identified regarding the adequacy of disability services provided to Ms Geiger were unrelated to the cause of death of Ms Geiger's death.

15. I have based this finding on the review conducted by CPU, information contained in the medical records provided by Monash Medical Centre, Ms Geiger's Disability Accommodation Services File and evidence contained in the coronial brief.

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[4] This is 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.

[5] The carriage of the investigation was transferred from Acting State Coroner English.

[6] S. 7 of the Act.

16. As advice was received from a pathologist that the death was due to natural causes[7], a mandatory inquest was not required.[8]

17. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my tasks as coroner and that further investigation was not required.

18. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

19. At 2.00pm on 24 July 2017, Ms Geiger was seen by her GP, Dr Crombie for treatment of constipation with the assistance of the house supervisor at the DHHS facility. Dr Crombie recommended Coloxyl and that Ms Geiger's fluids be increased.[9]

20. After returning home, Ms Geiger had dinner before being assisted to bed by the house supervisor at approximately 7.00pm.

21. Shortly after, a carer at the DHHS facility went to check on Ms Geiger. She was found unresponsive in her room. Emergency services were contacted, and chest compressions were commenced until the arrival of Ambulance Victoria paramedics.

22. Upon arrival Ms Geiger was reported by paramedics to be in cardiac arrest with pulseless electrical activity at a rate of 53/min. Resuscitation was performed at the scene, which included endotracheal intubation, chest compressions and adrenaline. On return of circulation, Ms Geiger was transferred to Monash Medical Centre at Clayton.[10]

23. On admission to the Intensive Care Unit at 4.00am on 25 July 2017, medical staff informed Ms Geiger's family of the poor prognosis of her condition. Treating clinicians noted that, given Ms Geiger's comorbidities and the significant hypoxic brain insult sustained during the arrest, the prognosis of meaningful recovery was limited. [11]

24. In consultation with Ms Geiger's family measures were taken for her comfort. Ms Geiger died at approximately 12.12am on 25 July 2017.

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[7] Paragraph 30.
[8] S52(3A) of the Act.
[9] According to Ms Geiger's file the plan was to 1. Take 2 tablets Coloxyl at night time for 3 days, 2. To encourage plenty of fluid. 3 Review her again if condition worsens.
[10] Letter from Monash Health dated 30 October 2107.
[11] Letter from Monash Health dated 30 October 2107.

IDENTITY

25. On 25 July 2017, Jennifer Geiger visually identified her sister Elizabeth Geiger, born 25 November 1947.

26. Identity is not in dispute and required no further investigation.

CAUSE OF DEATH

27. On 27 July 2017, Dr Gregory Young, a forensic pathologist practising at the Victorian Institute of Forensic Medicine, conducted an inspection and provided a written report, dated 28 July 2017. In that report, Dr Young concluded that a reasonable cause of death was *'Aspirational pneumonia in a woman with intellectual disability'*.

28. Dr Young reviewed a post-mortem computed tomography scan which revealed '*increased lung markings, pleural effusions, faecal loading in the large bowel, and basal ganglia calcification of the brain.*'

29. He noted that aspiration pneumonia is an infection of the lungs that occurs after inhaling (aspirating) foreign matter, such as vomitus or food and that risk factors include intellectual disability, epilepsy, intoxication and pathology causing difficulty swallowing.

30. Dr Young included in the report, his opinion that Ms Geiger's death was due to natural causes.

31. I accept Dr Young's opinion as to cause of death.

REVIEW OF GP CONSULATION

32. The CPU concluded that the review conducted by Ms Geiger's GP on 24 July 2017 was reasonable and that there were no concerns in relation to her medical management on this occasion. They noted that Ms Geiger was physically examined and there was a plan in place to address her chronic constipation, which was appropriately modified at the time. It was also noted by the CPU that Ms Geiger's death was due to natural causes.

33. I accept the advice of the CPU on this matter.

34. I further note that the cause of death appears unrelated to the presenting condition (constipation).

FINDINGS

35. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the Act that Elizabeth Geiger, born 25 November 1947, died on 25 July 2017 at Monash Medical Centre, Clayton, Victoria, from *Aspirational pneumonia in a woman with intellectual disability*, in the circumstances described above.

36. I convey my sincere condolences to Ms Geiger's family for their loss.

37. I order that this finding be published pursuant to section 73(1B) of the Act.

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

Ms Jennifer Geiger, senior next of kin

The Disability Services Commissioner

DHHS

Ms Tammy O'Connor, Monash Health

Senior Constable Andrea Ward, Victoria Police, Coroner's Investigator

Signature:

SARAH GEBERT
CORONER
Date: 17 September 2019