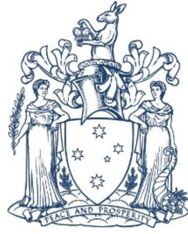

IN THE CORONERS COURT OF VICTORIA AT MELBOURNE	Court Reference: COR 2020 0285

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	Simon McGregor, Coroner
Deceased:	**Joanne Jago**
Date of birth:	16 September 1971
Date of death:	15 January 2020
Cause of death:	Aspiration pneumonia in a woman with Down Syndrome and an upper gastrointestinal tract malignancy
Place of death:	Northern Health Palliative Care Unit 25 Willandra Drive, Epping, Victoria

INTRODUCTION

1. Joanne Jago was a 48-year-old woman who had Down Syndrome and lived in a care facility operated by the Department of Health and Human Services.

2. Ms Jago died in the Northern Health Palliative Care Unit on 15 January 2020.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Ms Jago's death was reported to the Coroner. Immediately before her death Ms Jago was a person in the care of the Department of Health and Human Services and so her death fell within the definition of a reportable death in the *Coroners Act 2008.*

4. The role of a coroner is to independently investigate 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 criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. First Constable Zahan Shafeeg of Victoria Police prepared a coronial brief of evidence in this matter. I have also received medical records from PVH Medical and a report from a forensic pathologist who examined Ms Jago's body.

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

8. I have based this finding on the evidence described above. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

[1] 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.

9. In considering the issues associated with this finding, I have been mindful of Ms Jago's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

10. Ms Jago had a number of medical conditions including liver cancer and chronic bronchitis.[2] The Public Advocate was appointed Ms Jago's limited guardian with the power and duty to make decisions concerning medical treatment.[3]

11. Ms Jago's liver malignancy was first detected in late 2018. Her GP Dr Helen Brough consulted with two gastroenterologists and concluded that, due to Ms Jago's inability to understand and cooperate with investigation and invasive treatment, it was appropriate to offer only symptomatic treatment.[4]

12. On 6 January 2020 Ms Jago was commenced on Targin for pain which was likely related to her liver malignancy. After this time she became more drowsy.[5]

13. On 12 January 2020 Ms Jago's carers found her unresponsive at home. They contacted emergency services and an ambulance took Ms Jago to the Northern Hospital.[6]

14. She was found to have aspiration pneumonia and hospital staff treated her with antibiotics. However, she did not recover. Considering her condition, Northern Hospital staff determined that she should be moved to the Palliative Care Unit (**PCU**).[7]

15. While in the PCU Ms Jago was given fentanyl, midazolam and glycopyrrolate for pain and distress. She passed away in the PCU on 15 January 2020.[8]

IDENTITY AND CAUSE OF DEATH

16. On 15 January 2020, Louise Turner visually identified Ms Jago's body. Identity is not in dispute and requires no further investigation.

17. On 17 January 2020, Dr Melanie Archer, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination of Ms Jago's body and

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[2] PVH Medical records.
[3] Order of Victorian Civil and Administrative Tribunal Guardianship List dated 24 June 2019 (ref G14079/15).
[4] Letter from Dr Helen Brough to Sonia Gardiner dated 9 August 2019, PVH Medical records.
[5] E-medical deposition of Dr Shi Rou Zhang dated 15 January 2020.
[6] Form 83 Police Report of Death to the Coroner.
[7] E-medical deposition of Dr Shi Rou Zhang dated 15 January 2020.
[8] E-medical deposition of Dr Shi Rou Zhang dated 15 January 2020.

reviewed a post mortem computed tomography (CT) scan, medical records and the Police Report of Death for the Coroner. Dr Archer provided a written report, dated 2 March 2020, in which she/ formulated the cause of death as '*I(a) Aspiration pneumonia in a woman with Down's Syndrome and an upper gastrointestinal tract malignancy'*.

18. I accept Dr Archer's opinion as to cause of death, although I will alter the phrasing to use the term '*Down Syndrome*' rather than '*Down's Syndrome*'.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

19. It is clear from medical records that Dr Brough and Sonia Gardiner of the Office of the Public Advocate were proactive and dedicated in providing medical care to Ms Jago. I commend them for their efforts in supporting Ms Jago's comfort and well-being as much as possible despite her terminal illness.

FINDINGS AND CONCLUSION

20. I express my sincere condolences to Ms Jago's carers for their loss.

21. 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 Joanne Jago, born 16 September 1971;

    (b) The death occurred on 15 January 2020 at 25 Willandra Drive, Epping, Victoria from aspiration pneumonia in a woman with Down Syndrome and an upper gastrointestinal tract malignancy; and

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

22. Pursuant to section 73(1B) of the Act I direct that this finding be published on the Internet.

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

(a) State Trustees; and

(b) First Constable Zahan Shafeeg, Victoria Police.

Signature:

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SIMON McGREGOR

CORONER

Date: 28 July 2020