IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 005326

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Darren J. Bracken
Deceased:	Beryl Maloney
Date of birth:	30 April 1942
Date of death:	23 October 2018
Cause of death:	1(a) Aspiration pneumonia and cholangitis 1(b) Obstructive jaundice from intraduct tumour in a woman with cerebral palsy
Place of death:	The Northern Hospital, 185 Cooper Street, Epping, Victoria

INTRODUCTION

1. On 23 October 2018, Beryl Maloney was 76 years old when she died at The Northern Hospital. At the time of her death, Ms Maloney resided in a group home in Bundoora managed by Department of Health and Human Services (**DHHS**). Ms Maloney received high level care from DHHS staff with all aspects of her daily life, including dressing, eating, bathing and toileting. Ms Maloney is survived by her sister, Susan McGhee, who played an active role in medical decision-making for her sister.

2. Ms Maloney's medical history included epilepsy, osteoporosis, dysphagia, gastro-oesophageal reflux disease, constipation, ischaemic stroke in 2015, liver disease, dermatitis, chest infections, and aspiration pneumonia. As a result of a cerebral haemorrhage Ms Maloney suffered as an infant, she was unable to speak, had a moderate intellectual disability and was fed via a percutaneous endoscopic gastronomy (**PEG**) tube.

THE CORONIAL INVESTIGATION

3. Ms Maloney's death was reported to the Coroner as it fell within the definition of a reportable death in the Coroners Act 2008 (the Act). Ms Maloney's death was reportable as she was in care of the State immediately before the time of her death.[1] Deaths of persons in the care of the State are reportable to ensure independent scrutiny of the circumstances surrounding their deaths. If such deaths occur as a result of natural causes, a coronial investigation must take place, but the holding of an inquest is not mandatory.

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.

[1] Section 4(2)(c).

6. This finding draws on the totality of the coronial investigation into the death of Ms Maloney including evidence contained in her medical records and the review conducted by the Disability Services Commissioner (**DSC**). 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

7. In the months leading up to her death, Ms Maloney's health had been poor and she had been prescribed several rounds of antibiotics for recurrent chest, urinary tract infections and aspiration pneumonia.

8. On 13 August 2018, Ms Maloney was referred by her general practitioner (**GP**) to The Northern Hospital due to increased drowsiness, low oxygen levels and a chest infection. On admission, Ms Maloney was diagnosed with hypothermia in the setting of aspiration pneumonia. A dietitian reviewed Ms Maloney's PEG feed regime and recommended continuous feeds, as opposed to her regular meals of formula, to reduce her risk of aspiration pneumonia. She was subsequently discharged home on 21 August 2018.

9. On 7 October 2018, Ms Maloney was admitted to the emergency department (**ED**) of The Northern Hospital with obstructive jaundice,[3] sepsis[4] and cholangitis.[5] A computed tomography (**CT**) scan confirmed an obstruction to the bile duct and Ms Maloney was commenced on intravenous antibiotics. She underwent an endoscopic retrograde cholangiopancreatography (**ERCP**) procedure and removal of a bile duct polyp.

10. On 13 October 2018, Ms Maloney underwent a further ERCP, which identified a bile duct tumour, and a biliary stent was inserted. When she returned to the ward, she developed a fever from suspected sepsis.

11. On 14 October 2018, Ms Maloney was recommenced on intravenous antibiotics due to increased fever and rapid breathing. She remained stable throughout 15 October 2018;

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[2] 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.

[3] Yellowing of the skin or whites of the eyes, commonly caused by obstruction of the bile duct or liver disease.

[4] A serious bacterial blood infection that can lead to shock, organ failure and death if not immediately treated.

[5] Inflammation of the bile duct.

however, on 16 October 2018 she was recorded as having a low haemoglobin count requiring transfusion of one unit of packed red blood cells, after which diuretics were administered.

12. On 17 October 2018, Ms Maloney underwent a chest X-ray that identified features of fluid overload and she required oxygenation to maintain oxygen saturation. In the days that followed, Ms Maloney required increasing oxygen therapy. A further chest X-ray undertaken on 21 October 2018 identified right lower lobe consolidation. Ms Maloney subsequently developed hypoxia[6] and tachycardia[7] and was diagnosed with aspiration pneumonia.

13. Due to her poor prognosis, Ms Maloney was commenced on a palliative pathway and comfort measures were implemented. Ms Maloney's condition continued to deteriorate, and she was subsequently pronounced deceased at 10.00am on 23 October 2018.

Identity of the deceased

14. On 23 October 2018, Michelle Hansen, a DHHS staff member, visually identified the deceased as her long-term client, Beryl Maloney, born 30 April 1942.

15. Identity is not in dispute and requires no further investigation.

Medical cause of death

16. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 25 October 2018 and provided a written report of his findings dated 26 October 2018.

17. Dr Burke consulted a post-mortem computed tomography (CT) scan, which revealed a common bile duct stent and increased lung markings.

18. Dr Burke provided an opinion that the medical cause of death was 1(a) Aspiration pneumonia and cholangitis; 1(b) Obstructive jaundice from intraduct tumour in a woman with cerebral palsy, and considered that Ms Maloney's death was due to natural causes.

19. I accept Dr Burke's opinion.

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[6] A pathological condition in which the body as a whole or a region of the body is deprived of an adequate oxygen supply.

[7] Rapid pulse rate.

REVIEW OF CARE

20. Following Ms Maloney's death, the DSC undertook a review of the disability services provided by DHHS staff, including such elements as health and support planning, risk management, service policies, service provide actions and responses. The DSC ultimately considered that no further action was required, and I am satisfied with this course. I am also satisfied that the care provided by DHHS staff to Ms Maloney in the period proximate to her death was reasonable and appropriate.

21. As noted above, Ms Maloney's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before her death, she was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Ms Maloney died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an Inquest into her death.

FINDINGS AND CONCLUSION

22. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    (a) the identity of the deceased was Beryl Maloney, born 30 April 1942;

    (b) the death occurred on 23 October 2018 at The Northern Hospital, 185 Cooper Street, Epping, Victoria, from 1(a) Aspiration pneumonia and cholangitis; and 1(b) Obstructive jaundice from intraduct tumour in a woman with cerebral palsy; and

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

I convey my sincere condolences to Beryl's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Susan McGhee, Senior Next of Kin

Jackie Petrov, Northern Health

Senior Constable Michelle Wilkins, Coroner's Investigator

Signature:

Coroner Darren J. Bracken

Date: 01 June 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.