IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 005164

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Margaret Rose Ryan
Date of birth:	12 April 1956
Date of death:	13 October 2018
Cause of death:	1(a) Complications of progressive motor neurone disease
Place of death:	Mercy Health, Werribee Mercy Hospital, 300 Princes Highway, Werribee, Victoria, 3030

INTRODUCTION

1. On 13 October 2018, Margaret Rose Ryan was 62 years old when she died at Werribee Mercy Hospital. At the time of her death, Ms Ryan resided in a Department of Health and Human Services (**DHHS**) group home in Werribee and was receiving disability support funded by DHHS and regulated by the Disability Services Commissioner (**DSC**).

2. Ms Ryan suffered a hypoxic brain injury at birth that resulted in a moderate intellectual disability. Her medical history also included motor neurone disease, bipolar disorder, epilepsy, constipation, incontinence, osteoporosis and dementia. She experienced between two to three seizures each year and was prescribed sodium valproate.

3. Ms Ryan was non-verbal at the time of her death, having lost her ability to speak upon developing symptoms of motor neurone disease. She communicated through vocalisations and facial expressions. From early 2014, Ms Ryan required a wheelchair.

4. In July 2018, Ms Ryan was reviewed by her neurologist, who found that her ability to swallow was deteriorating. Discussions took place between her family and treating clinicians and a decision was made to commence her on a palliative pathway as she was deemed unsuitable for feeding via percutaneous endoscopic gastronomy (**PEG**) or nasogastric tube (**NGT**). On 6 September 2018, Ms Ryan began receiving services from Mercy Palliative Care and received home visits from a palliative care nurse.

THE CORONIAL INVESTIGATION

5. Ms Ryan'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 Ryan'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.

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

6. 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.

7. 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.

8. This finding draws on the totality of the coronial investigation into the death of Ms Ryan including evidence contained in her medical records and a review conducted by the Disability Services Commissioner (**DSC**). While 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

9. Ms Ryan's ability to swallow continued to deteriorate in early October 2018, when she was observed to have reduced jaw tone and muscle wastage, and was pooling food and drink in her mouth. Further discussions took place between her family, Mercy Palliative Care staff and the group home supervisor about admitting Ms Ryan to the palliative care unit as staff considered they could no longer care for Ms Ryan in the group home setting.

10. On 5 October 2018, Ms Ryan was admitted to the palliative care unit at Werribee Mercy Health where measures were implemented for her comfort. She subsequently passed away at 3.10am on 13 October 2018.

[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.

Identity of the deceased

11. On 13 October 2018, Patricia Bownas visually identified the deceased as her sister, Margaret Rose Ryan, born 12 April 1956.

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

Medical cause of death

13. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 15 October 2018 and provided a written report of her findings dated 16 October 2018. Ms Ryan's family expressed a preference that an autopsy not be conducted.

14. Dr Baber reviewed a post-mortem computed tomography (**CT**) scan, which revealed widened left ventricles and cerebral atrophy, left lower lobe pneumonia, and aspiration changes in the right lung.

15. Dr Baber provided an opinion that the medical cause of death was 1(a) Complications of progressive motor neurone disease. She considered that Ms Ryan's death was due to natural causes.

16. I accept Dr Baber's opinion.

REVIEW OF CARE

17. Following Ms Ryan's death, the DSC undertook a review of the disability services provided to her by DHHS. During the course of its review, the DSC examined Ms Ryan's health support plans, incident reports, the group home file notes, and other records that outlined the disability support provided to Ms Ryan. The review focused on responsiveness of the group home to Ms Ryan's deteriorating health.

18. The DSC identified issues relating to the management of Ms Ryan's prolonged constipation and complex communication needs, and issued a Notice to Take Action to DHHS (now Department of Families, Fairness and Housing). The DSC did not identify any issues arising from the circumstances that gave rise to Ms Ryan's death, and ultimately considered that no further action was required in this regard. I am satisfied with this course adopted by the DSC. I am also satisfied that the care provided by DHHS staff to Ms Ryan in the period proximate to her death was both reasonable and appropriate.

19. As noted above, Ms Ryan'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 Ryan 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

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

    a) the identity of the deceased was Margaret Rose Ryan, born 12 April 1956;

    b) the death occurred on 13 October 2018 at Mercy Health, Werribee Mercy Hospital, 300 Princes Highway, Werribee, Victoria, 3030, from complications of progressive motor neurone disease; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Ms Ryan'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:

Laura Ryan, Senior Next of Kin

Suhan Baskar, Mercy Health

Senior Constable Susan Robinson, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 28 January 2022

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.