IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 000657

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Raylene Barbara Armstrong
Date of birth:	1 October 1963
Date of death:	5 February 2019
Cause of death:	1(a) Aspiration pneumonia in a woman with cerebral palsy (spastic quadriparesis)
Place of death:	Eastern Health, Wantirna Hospital, 251 Mountain Highway, Wantirna, Victoria, 3152

INTRODUCTION

1. On 5 February 2019, Raylene Barbara Armstrong was 55 years old when she died at Wantirna Hospital. At the time of her death, Ms Armstrong resided in a Department of Health and Human Services (**DHHS**) group home in Mitcham, having moved to the facility approximately 12 years prior, and was receiving DHHS funded and regulated disability support. Ms Armstrong is survived by her brother, Michael Redford Armstrong.

BACKGROUND

2. Ms Armstrong's medical history included an intellectual disability, cerebral palsy (spastic quadriplegia), scoliosis, achalasia, dysphagia, constipation, hiatus hernia, gastro-oesophageal reflux disease, vitamin D deficiency, and incontinence. She was non-verbal and communicated with facial expressions that were documented by staff in a communication dictionary.

3. In 2017, Ms Armstrong was prescribed Lyrica to alleviate pain associated with her spastic quadriplegia. She subsequently experienced side effects, including drowsiness and an inability to clear mucous. Ms Armstrong's Lyrica was ceased in 2018 and replaced with six-monthly injections into her synaptic nerves.

4. Ms Armstrong underwent regular speech pathology, occupational therapy and physiotherapy assessments and reviews to maintain her support needs. Due to issues with swallowing and her gastrointestinal tract, Ms Armstrong was provided with five small meals each day of a smooth pureed consistency with thickened fluids, as well as meal supplements. Her weight was recorded twice monthly to ensure she not losing weight.

5. Ms Armstrong was supported by staff at the group home to participate in activities she enjoyed, including long baths, going shopping, coffee outings, music, watching musicals, and baking.

6. In the month leading up to her death, Ms Armstrong's health began to decline.

7. On 2 January 2019, Ms Armstrong was accompanied to her general practitioner (**GP**) for coughing and swallowing difficulties. Her GP prescribed antibiotics for suspected aspiration pneumonia and asked that group home staff monitor and record her food intake.

8. On 5 January 2019, group home staff contacted emergency services after observing that Ms Armstrong was unable to eat or drink and was experiencing increased gurgling noises in her upper respiratory tract. She was transferred by ambulance to Maroondah Hospital where her swallowing issues were assessed and managed.

9. On 16 January 2019, a discharge planning meeting occurred with the group home manager and Ms Armstrong's GP, dietician, occupational therapist and speech pathologist. On 18 January 2019, Ms Armstrong was discharged back to her group home.

THE CORONIAL INVESTIGATION

10. Ms Armstrong'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 Armstrong's death was reportable as she was in care of the State immediately before the time of his 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.

11. 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.

12. 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.

13. This finding draws on the totality of the coronial investigation into the death of Ms Armstrong, 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]

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

[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

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

Circumstances in which the death occurred

14. On 20 January 2019, group home staff observed that Ms Armstrong was lethargic with shallow breathing, unable to eat or drink more than a few mouthfuls, and had not passed any urine. Staff contacted emergency services and Ms Armstrong returned by ambulance to Maroondah Hospital. On admission, she was found to have a blood infection, urinary retention and renal dysfunction.

15. On 28 January 2019, Ms Armstrong was transferred to Wantirna Hospital and commenced on a palliative pathway for suspected aspiration pneumonia. Ms Armstrong was last seen alive in bed by hospital staff at approximately 8.20am on 5 February 2019. Ms Armstrong was later found unresponsive in bed and subsequently pronounced deceased at 9.50am.

Identity of the deceased

16. On 5 February 2019, Alexandra Smith visually identified the deceased as her client, Raylene Barbara Armstrong, born 1 October 1963.

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

Medical cause of death

18. Head of Forensic Pathology and Forensic Pathologist Dr Linda Iles from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 6 February 2019 and provided a written report of her findings dated 19 February 2019.

19. Dr Iles reviewed a post-mortem computed tomography (**CT**) scan, which revealed severe scoliosis, hip dysplasia, marked cerebral atrophy and ventriculomegaly, and bilateral bronchopneumonia predominantly to the right lung.

20. Dr Iles provided an opinion that the medical cause of death was 1(a) Aspiration pneumonia in a woman with cerebral palsy (spastic quadriparesis).

21. I accept Dr Iles' opinion.

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evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

REVIEW OF CARE

22. Following Ms Armstrong's death, advice was sought from the Coroners Prevention Unit (**CPU**)[3] in relation to the medical care she received at Wantirna Hospital immediately prior to her death. The CPU considered that Ms Armstrong's oropharyngeal dysphagia placed her at an increased risk of developing aspiration pneumonia. The CPU did not identify any opportunities for prevention in respect of Ms Armstrong's care at Wantirna Hospital.

23. The DSC also undertook a review of the disability services provided to Ms Armstrong by DHHS, in which the DSC examined Ms Armstrong's health support plans, incident reports, the group home file notes, and other records that outlined the disability support provided to Ms Armstrong. The DSC concluded that staff at the group home were attentive to Ms Armstrong's health and wellbeing needs in accordance with her support plans, and that her care was appropriately escalated as her health deteriorated. The DSC considered that the disability service provision to Ms Armstrong was provided in a manner that sufficiently promoted her rights, dignity, wellbeing and safety.

24. In conducting its review, the DSC was advised by DHHS that two separate quality of care service reviews were undertaken with respect to other residents at the group home. The DSC subsequently examined the outcomes of these reviews and was satisfied that these quality of care service reviews led to overall service improvements for residents within the group home. 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 Armstrong in the period proximate to her death was both reasonable and appropriate.

25. As noted above, Ms Armstrong'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 Armstrong 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.

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[3] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Raylene Barbara Armstrong, born 1 October 1963;

    b) the death occurred on 5 February 2019 at Eastern Health, Wantirna Hospital, 251 Mountain Highway, Wantirna, Victoria, 3152, from aspiration pneumonia in a woman with cerebral palsy (spastic quadriparesis); and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Ms Armstrong'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:

Michael Redford Armstrong, Senior Next of Kin

Yvette Kozielski, Eastern Health

Constable Jason Hare, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 25 November 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.