IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 001006

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Sarah Gebert, Coroner
Deceased:	Ms T[1]
Date of birth:	[redacted] 1974
Date of death:	21 February 2023
Cause of death:	1(a) Pneumonia on a background of subacute bowel obstruction secondary to metastatic sigmoid colorectal cancer
Place of death:	Caritas Christi Hospice, 104 Studley Park Road, Kew, Victoria
Key words:	In care, pneumonia, bowel obstruction, metastatic sigmoid colorectal cancer, natural causes

1. At the direction of Coroner Sarah Gebert, the names of the deceased and her family members have been replaced with pseudonyms to protect their identity, with other identifying details redacted.

INTRODUCTION

1. On 21 February 2023, Ms T was 48 years old when she passed away in hospital from natural causes.

2. At the time of her death, Ms T lived in specialist disability accommodation in Burwood East.

THE CORONIAL INVESTIGATION

3. Ms T's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. Generally, reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.[1]

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. Victoria Police assigned Senior Constable Lunden Dorber-Binion to be the Coroner's Investigator for the investigation of Ms T's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as

[1] See the definition of *"reportable death"* in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of *"person placed in custody or care"* in section 3 of the Act. Regulation 7(1)(d) of the Coroners Regulations 2019 provides that a person placed in custody or care now includes *"a person in Victoria who is an SDA resident residing in an SDA enrolled dwelling".* 'SDA resident' has the same meaning as in the *Residential Tenancies Act 1997* (Vic) and captures a person who is an SDA recipient (that is, an NDIS participant who is funded to reside in an SDA enrolled dwelling). 'SDA enrolled dwelling' also has the same meaning as in the *Residential Tenancies Act 1997* and is defined as a: *"long term accommodation for one or more SDA resident and enrolled as an SDA dwelling under the National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016 of the Commonwealth as in force from time to time or under other rules made under the National Disability Insurance Scheme Act 2013 of the Commonwealth."*

family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into Ms T's death, including evidence contained in the coronial brief. 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]

Background

8. Ms T suffered a brain injury during birth, which led to significant neurodevelopmental delays. She was initially cared for at home. In 1981, she began residing in full time care.

9. Ms T's medical history included cerebral palsy, intellectual disability, epilepsy, hypercholesterolaemia, lactose intolerance, panic disorder, essential tremor, lymphocytosis (sodium valproate associated), and cerebellar atrophy. She also experienced chronic bowel issues, being regularly treated for chronic diarrhea.

10. In about 2015, Ms T moved to specialist disability accommodation in Burwood East, which was managed by Life Without Barriers. She communicated with a reduced vocabulary, using mainly gestures.

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

Circumstances in which the death occurred

11. On 7 December 2022, Ms T was admitted to Monash Medical Centre due to an increase in bowel movements and a possible urinary tract infection (**UTI**). She had also been refusing her usual medical in the context of generalised lethargy and irritability. She was prescribed antibiotics for the UTI.

12. On 15 December 2022, Ms T re-presented to Monash Medical Centre due to weakness and generally appearing unwell. Investigations revealed an infection. Following treatment, Ms T was discharged on 26 December 2022.

[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.

13. On 28 December 2022, Ms T attended her general practitioner at Mt Waverley Clinic at which time she was prescribed iron tablets for anaemia.

14. On 10 January 2023, Ms T was taken back to Monash Medical Centre due to ongoing tiredness, loss in appetite, and reduced movement. Over the following days, investigations revealed bowel cancer of the sigmoid colon with marked luminal narrowing. It was determined the tumour was inoperable and a recommendation was made that Ms T be transitioned to palliative care.

15. On 19 January 2023, Ms T underwent diagnostic laparoscopy which revealed a 10cm mass involving mid to distal sigmoid drawing in root of small bowel mesentery, 1cm peritoneal nodule in the pouch of Douglas, and left colic lymph nodes involvement.

16. Ms T was discharged on 3 February 2023 with known high risk of bowel obstruction. The plan was for stool softeners only, no bulking agents, and stimulant laxatives. The plan included symptomatic management only if Ms T developed a bowel obstruction.

17. Following discharge, Ms T experienced pain and nauseousness and her oral intake and ability to take oral medications reduced significantly.

18. On 13 February 2023, Ms T was admitted to Caritas Christi Hospice for symptom management and end of life care. Her sister, [redacted], stayed with her over the following days.

19. Ms T sadly passed away on the morning of 21 February 2023.

Identity of the deceased

20. On 23 February 2023, Ms T, born [redacted] 1974, was visually identified by her brother, Mr T.

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

Medical cause of death

22. Forensic Pathologist, Dr Brian Beer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 24 February 2023 and provided a written report of his findings dated 2 March 2023.

23. The post-mortem examination was in keeping with the clinical history. The post-mortem CT scan findings demonstrated, moderate hydrocephalus, no intracranial haemorrhage and no

fracture, left lower lobe lobar consolidation and patchy but extensive bronchopneumonia changes in other lobes, and a large bowel obstruction at distal sigmoid level with mass at this level, but not markedly dilated and no features of perforation.

24. Dr Beer provided an opinion that the medical cause of death was *"1(a) Pneumonia on a background of subacute bowel obstruction secondary to metastatic sigmoid colorectal cancer".* Dr Beer also determined that the cause of death was due to natural causes.

25. I accept Dr Beer's opinion.

FURTHER INVESTIGATION

Coroners Prevention Unit review

26. Ms T's family voiced concerns that there had been a delay in diagnosing the cancer and that they had requested additional investigations be undertaken when she was admitted to hospital in November 2022, however these were not done.

27. At her hospital admission in January 2023, investigations revealed the bowel cancer. The family were advised that she was not for treatment. They felt that her doctors *"were just seeing a handicapped person"* and not the person who was her sister. Ms T was then admitted to Dandenong Hospital for bowel surgery, which was subsequently aborted due to the size and location of the tumour.

28. In light of their concerns and as part of my investigation, I obtained advice from the Coroners Prevention Unit (**CPU**) as to whether there were any missed opportunities to treat Ms T's cancer sooner.[3]

29. The CPU reviewed Ms T's Monash Health records, which included correspondence from her general practitioner, Dr Andrew Edwards at Vermont Health Care. This revealed that he held concerns from approximately November 2022 about a deterioration in Ms T's condition and general lethargy. He noted that blood tests had showed a mild anaemia and referred her for a neurology review.

[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.

30. Ms T was later admitted to hospital in December 2022. Records from Monash Health indicate her family were concerned about the possibility of a lymphoma due to the raised white blood cell count given recent family history, but tests for lymphoma were normal. Blood tests taken did reveal a borderline low serum iron and a mild anaemia. However, the CPU explained that the blood film was not typical for an iron deficiency anaemia, which would have been a potential clue to an underlying bowel malignancy.

31. There was no other record of family being concerned about lack of investigations. There were family concerns about medication refusal, but it appeared that this had been a longstanding issue.

32. Ms T's blood tests and overall wellbeing subsequently improved with treatment. Monash Health notes reveal there was a family meeting/discussion prior to her discharge but there was no record of a request for other investigations during this meeting.

33. Ms T subsequently re-presented to hospital on 10 January 2023 with ongoing functional decline and was re-admitted for investigation of this. The CPU advised that Ms T's haemoglobin level had fallen significantly since discharge several days previously and accordingly a CT of the abdomen was ordered, and this demonstrated the large bowel malignancy.

34. Following the diagnosis of the malignancy, the Monash Health notes record Ms T's sister being concerned that Ms T had been discharged earlier without adequate investigation of the iron deficiency. However, the CPU was of the view that this was borderline at the time and had worsened following her initial discharge.

35. Following their review, the CPU did not identify any concerns of care regarding the treatment Ms T received from Monash Health or opportunities for prevention. I accept and agree with the CPU's advice.

FINDINGS AND CONCLUSION

36. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was Ms T, born [redacted] 1974;

    (b) the death occurred on 21 February 2023 at Caritas Christi Hospice, 104 Studley Park Road, Kew, Victoria, from pneumonia on a background of subacute bowel obstruction secondary to metastatic sigmoid colorectal cancer; and

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

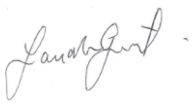
I convey my sincere condolences to Ms T's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published (in redacted form) 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:

Mr T, senior next of kin
St Vincent's Hospital Melbourne
Life Without Barriers (care of Barry Nilsson Lawyers)
Senior Constable Lunden Dorber-Binion, Victoria Police, Coroner's Investigator

Signature:



Coroner Sarah Gebert

Date: 27 June 2024

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.