IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 000917

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Jonathan Travis Palmer
Date of birth:	17 January 1982
Date of death:	24 February 2018
Cause of death:	1(a) Bronchopneumonia in a man with epilepsy
Place of death:	2 Towle Court, Echuca, Victoria, 3564
Keywords:	Disability services, In care, Epilepsy

INTRODUCTION

1. On 24 February 2018, Jonathan Travis Palmer was 36 years old when he died at home. At the time of his death, he lived in a group home at 2 Towle Court, Echuca, funded by the Department of Health and Human Services[1] (**DHHS**). Mr Palmer resided at the address with three other residents who also received full-time care from the staff on site. He had been a resident since July 1998.

2. At approximately 5 years of age Mr Palmer began having epileptic seizures and was subsequently diagnosed with a moderate intellectual disability. He was autistic and had limited speech ability.[2]

3. The DHHS' records indicate that Mr Palmer required assistance from support staff with his daily living activities, including personal hygiene and occasionally with drinking and eating. Importantly, they supported Mr Palmer's health by assisting him with attending medical appointments and administering medication as indicated by his medication charts.

4. Neurologist Dr Graeme Gonzales, and General Practitioners (**GPs**) regularly attended to Mr Palmer's health care and management during his stay. His most recent medications included lamotrigine, risperidone and sodium valproate.

5. Mr Palmer's medical records indicate that he had two to three clusters of complex seizures a month, but he had no history of nocturnal seizures.[3] He was also not considered to be of high risk of sudden unexpected death in epilepsy (**SUDEP**).[4]

THE CORONIAL INVESTIGATION

6. Mr Palmer'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. His death also meets the reportability criteria of a person *"in care"* as defined in section 3 of the Act.

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[1] Currently the Department of Families, Fairness and Housing (**DFFH**), formed following the dissolution of the Department of Health and Human Services (**DHHS**) on 1 February 2021.

[2] Mr Palmer was reported to have been able to understand simple instruction and verbal commands. He used simple phrases to express himself and would verbally or physically command his choice by pointing to things and touching them. He also understood simple sign language and used this in conjunction with verbal language.

[3] Court File (**CF**), Medical Records.

[4] Ibid.

7. Section 52(2) provides that a Coroner must hold an Inquest if a person was a person who *immediately before death* was in the care of the State unless the Coroner considers the death was due to natural causes.[5]

8. An investigation into Mr Palmer's death was also conducted under the auspices of the *Disability Services Act 2006* (Vic) by the Disability Services Commissioner (**DSC**), who has a different scope to that of a coronial investigation, although it can sometimes overlap. The DSC's jurisdiction expands to the services provided to the deceased during their lifetime, whether or not those services are connected with the death.

9. Pursuant to section 7(a) of the Act, a Coroner should liaise with other investigation bodies to avoid unnecessary duplication and expedite the investigation. I have therefore conducted my investigation through a restorative and preventative lens, without mirroring the DSC's investigation.[6]

10. 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.

11. 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.

12. This finding draws on the totality of the coronial investigation into the death of Jonathan Travis Palmer, including evidence contained in the coronial brief. In writing this Finding, I do not purport to summarise all the material and evidence but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.[7]

[5] Section 52(3A) of the Coroners Act 2008 (Vic) ("the Act").
[6] See paragraphs 51 to 66.
[7] 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.

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

Circumstances in which the death occurred

13. On 23 February 2018, at approximately 3.30pm, support staff collected Mr Palmer from his day program and were informed by staff at the day program that he was coughing up "a lot" of phlegm for about 20 minutes.

14. Upon arriving home at approximately 4.00pm, support staff noticed that Mr Palmer continued coughing up clear fluid and had a runny nose. Support staff suspected that he may have developed a cold.

15. About 45 minutes later, one of the support staff contacted a local clinic to organise a medical consultation. The support staff member was informed that there was no appointment available and was advised to monitor Mr Palmer's condition by watching for signs of deterioration.

16. At 6.00pm, Mr Palmer refused dinner and support staff administered his medication as usual.[8] Support staff reported that although his symptoms had improved, they noticed he still had a runny nose and puffy eyes. His body temperature was noted to be within normal limits. Thereafter, support staff continuously supplied Mr Palmer with fluids, and he was noted to be feeling comfortable.

17. Support staff devised a plan that if Mr Palmer had not improved by 8.00pm, they would arrange for him to be transported to an Emergency Department (**ED**).

18. At 8.00pm, two support staff assessed Mr Palmer and considered his symptoms had improved.

19. At 9.00pm, a support staff commencing the sleepover shift stopped by and checked on Mr Palmer in his bedroom and turned off the television as he was sleeping.[9] Awoken by the staff, Mr Palmer was asked how he was feeling, which he replied, "much better now".

20. At 10.00pm, the sleepover support staff checked on Mr Palmer and noted he was breathing heavily while asleep.

21. At approximately 1.00am on 24 February 2018, support staff observed Mr Palmer was asleep, and noted his breathing was not as heavy compared to the previous check.

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[8] The available evidence indicates that Mr Palmer's medications were ordinarily administered at 8.00am, 12.00pm and 6.00pm

[9] According to the Operation Manager, the sleepover shifts typically commence at 10.00pm and end at 6.00am, with the support worker sleeping overnight in the main office of the group home unless additional assistance is required from the residents.

22. In the early hours of 24 February 2018, the sleepover support staff heard Mr Palmer walk past the office area to use the toilet. The staff did not recall hearing Mr Palmer calling out or coughing.

23. At approximately 7.45am, the sleepover support staff went to check on Mr Palmer and found him lying face down on the floor, unresponsive. Assisted by the morning support staff, they immediately commenced resuscitation on Mr Palmer and contacted emergency services.

24. Ambulance Victoria paramedics, followed by Victoria Police, attended the home shortly after. Mr Palmer was unable to be assisted and was declared deceased.

25. Following Mr Palmer's death, police officers commenced an investigation at the home and found no suspicious circumstances.

Identity of the deceased

26. On 24 February 2018, Jonathan Travis Palmer, born 17 January 1982, was visually identified by his mother, Janeen Keath.

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

Medical cause of death

28. On 27 February 2018, Senior Forensic Pathologist Dr Victoria Christabel Mary Francis from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Jonathan Travis Palmer. In preparing her report, Dr Francis reviewed a post-mortem CT scan and referred to the preliminary examination report, Victoria Police Report of Death (**Form 83**), and medical records from Echuca Regional Health and Rich River Health Group. Dr Francis provided a written report of her findings dated 8 August 2018.

29. At autopsy, Dr Francis noted evidence of acute bronchopneumonia and bronchitis in both lungs.

30. Neuropathology examination of the brain revealed the evidence of bilateral hippocampal sclerosis and mild ventriculomegaly.

31. Post-mortem biochemistry analysis revealed a minimally elevated C-reactive protein (**CRP**). Dr Francis explained that CRP is a molecule that increases in the bloodstream in response to inflammation, particularly, infections, which might reduce an individual's seizure threshold.

32. Dr Francis also noted the increased risk of sudden unexpected death in people with epilepsy. While the mechanism of death of sudden unexpected death in epilepsy is not clearly understood, Dr Francis commented that it is thought to be due to respiratory depression and/or cardiac arrhythmia and usually occurs after a seizure.

33. Toxicology analysis of post-mortem samples revealed the presence of risperidone[10], and its metabolite hydroxyrisperidone, amisulpride[11], valproic acid[12] and lamotrigine[13] at levels consistent with therapeutic use. Ethanol (alcohol) was not detected.

34. Dr Francis concluded that Mr Palmer's death was due to natural causes and ascribed the medical cause of death to: "1(a) bronchopneumonia in a man with epilepsy".

DISABILITY SERVICES COMMISSIONER INVESTIGATION

35. Upon completion of its independent investigation into the disability services provided by DHHS, the Commissioner provided the Court with an Investigation Report[14].

36. As foreshadowed, the investigative jurisdiction of the DSC differs from the Coroners Court's jurisdiction. The DSC's jurisdiction provides an important oversight of a particularly vulnerable group of persons in the care of disability services. The purpose of the DSC's investigation was to identify issues in the services being provided to Mr Palmer and to consider any action that the service provider should take in response to any issues identified with the aim of improving service delivery.

37. As part of its investigation, the DSC considered documents relating to Mr Palmer's care and DHHS' response to DSC questions relating to its service provision.

Investigation outcome

38. After its investigation, the DSC identified several issues pertaining to Mr Palmer's care.

Management of Mr Palmer's deteriorating health

39. The DSC considered the observations made by support staff on 23 February 2018 illustrated their acknowledgement of a change and deterioration from Mr Palmer's usual health status. Notably, the DSC noted that the symptoms that he exhibited were consistent with the triggers

[10] Risperidone is an atypical antipsychotic and is a selective monoaminergic antagonist with a high affinity for serotoninergic 5HT2-receptors and dopaminergic D2-receptors, prescribed for schizophrenia and some behavioural disorders (delusions, aggression).
[11] Amisulpride is a benzamide neuroleptic used in the treatment of acute and chronic schizophrenia.
[12] Valproic acid (as sodium valproate) is a carboxylic acid used therapeutically as an anticonvulsant, treatment for manic depression or in some instances for neurogenic pain.
[13] Lamotrigine is a substituted asymmetric triazine compound used as an anticonvulsant.
[14] Dated 10 October 2019.

for seizure activity outlined in his Epilepsy Management Plan (**EMP**). While it is not clear from Mr Palmer's progress note whether staff had considered the possibility that his symptoms had indicated an increased risk of seizures, the DSC considered it reasonable for support staff to seek appropriate medical attention and advice for his running nose and persistent coughing.

40. Furthermore, the DSC outlined that although support staff recorded in detail Mr Palmer's subsequent health condition, the progress notes did not include any information about the decisions, action and support provided to him. Notably, there was no evidence of any documentation of advice by the clinic staff concerning the standards and frequency of monitoring.

41. In terms of the frequency of monitoring, the DSC noted Mr Palmer's condition was not monitored between approximately 1.00am and 7.45am on 24 February 2018, even though support staff had been concerned about his condition and had a plan to present him to ED if he did not improve.

42. In view of Mr Palmer's state of health at the time and the known triggers of his seizure activity, DSC found that support staff at the home had failed to act appropriately to manage his deteriorating health. Specifically, the DHHS' Residential Services Practice Manual (**RSPM**) provides that staff are responsible for completing residents' progress notes, details of the support provided, and decisions made in relation to the support on every shift.

Record keeping

43. According to the RSPM which outlines the roles and responsibilities of disability services support staff working in residential services, support staff are required to ensure comprehensive documentation of the care provided to residents.

44. In terms of managing deteriorating health, the RSPM specifically provides that staff must ensure all relevant information provided by the medical practitioner or NURSE-ON-CALL is clearly documented. In the event that a medical practitioner requests a resident be monitored, staff are also required to obtain clear instructions about the necessary level and type of monitoring and follow the additional medical advice provided.

45. During the course of the investigation into the care provided to Mr Palmer, it was identified that support staff failed to maintain accurate and complete records. There were also no records that detailed his health status between 10.00pm on 23 February 2018 and 7.00am on 24 February 2018.

DSC's Findings

46. Given the above consideration, the DSC made the following Findings[15]:

Finding 1: DHHS failed to adequately manage Mr Palmer's deteriorating health on the evening of 23 February 2018.

Finding 2: DHHS did not maintain adequate records and client notes, as per its legislative and policy obligations.

Notice to Take Action

47. Given the issues of concern identified by the DSC investigation, the DSC issued a *Notice to Take Action* to DHHS to work with its future service provider, Aruma.[16]

48. On 10 October 2019, the Notice was formally issued to DHHS with four recommendations made to DHHS to address the issues as identified in its investigation report.[17]

49. Recommendation 1 advised DHHS that all support staff at the home be made aware of the findings of the DSC and the recommendations made.

50. Recommendation 2 advised DHHS to ensure that all support staff at the home are trained on how to manage a resident's deteriorating health as per the RSPM guidelines on managing deteriorating health.

51. Recommendation 3 advised DHHS must undertake an audit of the resident files the home in ensuring resident files and shift report documentation is contemporaneous and accurate.

52. Recommendation 4 advised DHHS to provide training to all support staff at the home to ensure all staff are trained in records procedures that relate to their work, including support staff compliance with completing records on every shift, record keeping requirements as per the *Disability Act 2006* and the *Privacy and Data Protection Act 2014*.

FURTHER INVESTIGATION

53. Following the completion of the DSC's investigation, I considered there remained some unaddressed concerns in relation to remedial actions taken to prevent similar deaths. Accordingly, I sought further information from DHHS in relation to the details of support

[15] CF, DSC Investigation Report.

[16] Carley Northcott, Director of National Disability Insurance Scheme advised that the group home at 2 Towle Court, Echuca was transferred from the Department Health and Human Services to Aruma, a community service organisation on 21 July 2019.

provided to Mr Palmer, namely, strategies and staff training employed by the DHHS in managing a resident's deteriorating health.

54. By email dated 25 May 2020, Carley Northcott, Director of National Disability Insurance Scheme (**NDIS**) Delivery, on behalf the DHHS responded to my enquiries.

DHHS' response

Services provided to Mr Palmer

55. Ms Northcott informed me that Mr Palmer's records before his move to the group home consisted mainly of information on his functional status rather than his health or medical history. Earlier records between 1995 and 1998 provided a limited indication of health and medical issues and recorded Mr Palmer's health status as follows:

> *"Jonathan is generally in good health, wears glasses all the time for depth perception. Jonathan is epileptic and is currently on Epilum and is on 450mg twice a day. Also has Haloperidol drops 12 twice a day for behaviour intervention methods program"*.

56. Ms Northcott noted that in addition to the above details, Mr Palmer's records indicated that he was prone to severe croup, and he was to be seen by his medical practitioner if he had a croup.

57. Ms Northcott acknowledged that some assessments conducted by Mr Palmer's GP, Dr Adrian Waldron had identified Mr Palmer's risk of seizure. When asked about the overall health evaluation conducted by support staff at the home, Ms Northcott outlined that the supporting role of support staff was limited to escalating any health concerns they identify to a health professional when a resident's health appears to be deteriorating.

58. Ms Northcott emphasised that support staff were not trained to provide assessments of medical issues to the level of a health professional. In Mr Palmer's circumstances, the role of support staff extended as far as to monitor changes in his behaviour or apparent signs of illness, such as his food intake, mood, gait and energy level.

59. Ms Northcott informed me that in May 2017, a Specific Health Management Plan (**SHMP**) for pain was developed for Mr Palmer and was approved by Dr Waldron.

60. An EMP was also arranged by Dr Waldron in the same month. The EMP prescribed that staff *"must directly monitor [Mr Palmer] for 10 mins post seizure, and after that check at a 5 mins interval for a further 15 mins whilst he recovered"*. The plan indicated further that support staff were to escalate Mr Palmer's condition by calling an ambulance if his seizure persisted for three to four minutes.

61. Moreover, Ms Northcott informed me that the home had worked with Mr Palmer's health professionals to manage his weight and dysphagia in light of his recent weight loss and difficulty with swallowing.

Training in relation to managing deteriorating health

62. Ms Northcott advised that she could not locate documentation in relation to any training provided to support staff on how to manage residents' deteriorating health.

63. Despite that, Ms Northcott informed me that the DHHS did conduct an audit program, Promoting Better Practice (**PBP**), to all departmental-managed group homes, including the Towle Court group home. As part of the PBP program, the home supervisor attended a three-day training course in October 2013 on promoting quality and improving outcomes for residents. The PBP program also reviewed practices in group homes in accordance with requirements contained in the RSPM.

Subsequent actions

64. Ms Northcott advised that the DHHS did not conduct an internal investigation into Mr Palmer's death. However, the Department did work actively with Aruma to respond to the DSC's *Notice to Take Action*.

65. Of note, the DHHS has worked with Aruma to deliver a training session to support staff in managing deteriorating health. The training session emphasised on the importance of early intervention and sharing a resident's health information with the nurse-on-call after an appointment.

66. In addition to implementing the DSC's recommendations, Ms Northcott advised that DHHS had actively responded to the DSC advice to the Secretary of DHHS and reviewed its RSPM to ensure the guidelines in relation to managing deteriorating health align with the DSC advice.

67. As part of its continuing work to address and implement strategies to raise awareness amongst support staff in responding to deteriorating health, DHHS also co-operated with the DSC in developing a poster on recognising and responding to a resident's deteriorating health that is suitable for display in all group homes.

68. Ms Northcott conceded that the record-keeping at the home in some instances was poor. She advised that the DHHS had, since the issue of the *Notice to Take Action*, worked with Aruma in implementing actions to improve recording keeping, particularly documenting residents' health needs.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

2. My investigation highlights the inherent difficulties faced by those with complex care needs as well as those who are not medically equipped to care for them. The Department of Health and Human Services failed at several points, to provide necessary training to disability support staff in supporting the specific significant aspects of Mr Palmer's disability. These represent a missed opportunity that contributed to Mr Palmer's premature death.

3. I acknowledge the Department of Health and Human Services had made an effort to work with Mr Palmer's general practitioner to develop an Epilepsy Management Plan to manage his epilepsy, however, the insufficient training provided to disability support staff on recognising and understanding the importance of the triggers as detailed in the plan completely defeated the inherent purpose of the plan. This further highlights the importance of accurately documenting and relaying important health related information amongst all support staff members.

4. I also acknowledge the Department of Health and Human Services had conceded its failures in providing disability services to Mr Palmer. I am satisfied that appropriate preventative and restorative measures have been implemented since his death. These include system-wide improvements and internal audits resulting in the re-enforcement of emphasis on the importance of early intervention.

5. I commend the superseding department and agency of the Department of Health and Human Services, the Department of Families, Fairness and Housing's initiatives to collaborate with the Disability Services Commissioner in continuing educating and raising awareness of early intervention amongst disability support staff, including the implementation of a poster that aims at providing information about what action a support staff should take once any signs or symptoms have been identified.[18]

[18] See further at the Disability Services Commissioner website at https://www.odsc.vic.gov.au/2022/02/21/deteriotinghealthposter/.

6. Having also considered the circumstances of Mr Palmer's death against the background of the Commonwealth and Victorian governmental initiatives in providing a selection of resources to support workplace learning and training for disability staff as part of their *Bilateral Agreement*[19] on the National Disability Insurance Scheme, I have determined not to make any formal recommendations.

7. In this regard, I have considered and noted a series of Practice Alerts, including Practice Alerts specifically on epilepsy management available as part of staff training resources.[20]

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Jonathan Travis Palmer, born 17 January 1982;

b) the death occurred on 24 February 2018 at 2 Towle Court, Echuca, Victoria, 3564;

c) I accept and adopt the medical cause of death ascribed by Dr Victoria Christabel Francis, and I find that Jonathan Travis Palmer, a man with a medical history of epilepsy, died from bronchopneumonia.

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

PUBLICATION AND DISTRIBUTION OF FINDING

Pursuant to section 73(1B) of the Act, a Finding made following an investigation of death of a deceased who was, immediately before the death, a person placed in care that the death was due to natural causes must be published on the Internet. I order that this Finding be published on the Coroners Court of Victoria website in accordance with the Act.

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[19] Federation.gov.au, *Bilateral Agreement between the Commonwealth and Victoria on the National Disability Insurance Scheme* (webpage, 17 June 2019) <https://federation.gov.au/about/agreements/bilateral-agreement-between-commonwealth-and-victoria-national-disability>.

[20] NDIS Quality and Safeguards Commission, Practice Alerts. Practice Alerts are short research summaries that provide important information on best –practice, safe and quality service delivery to people with disability. They were developed in response to the *Scoping review of causes and contributors to deaths of people with disability in Australia*.New resources have been developed to complement the Practice Alert series including short animations, quick reference guides and easy reads, providing this valuable information in alternative and easily accessible formats for NDIS providers and workers. See further at https://www.ndiscommission.gov.au/workerresources#paragraph-id-4010.

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

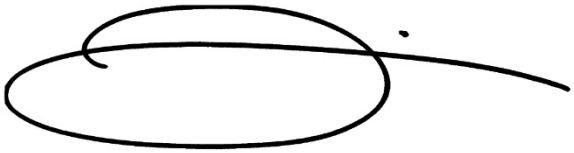
Mr Donald Palmer, Senior Next of Kin

Ms Janeen Keath, Senior Next of Kin

Disability Services Commissioner

The Honourable Lizzie Blandthorn, MP, Minister for Disability, Ageing and Carers

Signature:



AUDREY JAMIESON

CORONER

Date: 14 April 2023

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.