IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 3161

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

*Amended pursuant to section 76 of the **Coroners Act 2008***

INQUEST INTO THE DEATH OF DIANNE LINFORD

Delivered on:	4 May 2023
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing date:	4 May 2023
Findings of:	Coroner John Olle
Assisting the Coroner:	Ms Prudence Davie, Coroner's Solicitor Coroners Court of Victoria
Representation	Mr Peter Ryan, Monash Health
Keywords	Death in care, mandatory inquest

BACKGROUND

1. On 2 July 2018, Dianne Linford (Dianne) was aged 63 when she died. At the time of her death, Dianne resided in Department of Health and Human Services (**DHHS**) shared supported accommodation in Moorabbin.
2. Dianne lived with a profound disability, which was a result of an infant encephalitis infection and cerebral palsy. Dianne's other medical conditions included epilepsy, constipation and incontinence.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Dianne's death constitutes a reportable death pursuant to section 4 of the Coroners Act 2008 (Vic) (**the Act**), as Dianne ordinarily resided in Victoria, and she was a person placed in the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health.

4. Pursuant to section 52(2)(b) of the Act, it is mandatory for a coroner to hold an inquest if the death occurred in Victoria and the deceased was immediately before the death a person placed in custody or care.

5. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[1] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[2]

6. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[4] or to determine disciplinary matters.

---

[1] *Coroners Act 2008* (Vic) s 89(4).
[2] *Coroners Act 2008* (Vic) preamble and s 67.
[3] *Keown v Khan* (1999) 1 VR 69.
[4] *Coroners Act 2008* (Vic) s 69(1).

7. The expression cause of death' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

8. For coronial purposes, the phrase 'circumstances in which the death occurred'[5] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

9. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's 'prevention' role.

10. Coroners are also empowered:

    a. To report to the Attorney-general on a death;[6]

    b. To comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[7] and

    c. To make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.[8]

11. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.9 In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[10] The effect of this and similar authorities is that coroners should

[5] *Coroners Act 2008* (Vic) s 67(1)(c).
[6] *Coroners Act 2008* (Vic) s 72(1).
[7] *Coroners Act 2008* (Vic) s 67(3).
[8] *Coroners Act 2008* (Vic) s 72(2).
[9] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[10] (1938) 60 CLR 336.

not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

12. Victoria Police appointed Senior Constable Andrew Cox to be the Coroner's Investigator. Senior Constable Cox compiled a Coronial Brief on my behalf.

13. The Disability Services Commissioner also submitted a report outlining Dianne's time in care.

14. This finding draws on the totality of the material gathered throughout the coronial investigation into the death of Dianne. That is, the investigation and inquest brief and the statements, reports and any documents obtained throughout the course of my investigation. All of this material will remain on the coronial file. In this finding, I do not purport to summarise all of the evidence but refer only in such detail as is warranted by its forensic significance.

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

Identity of the deceased, pursuant to section 67(1)(a) of the Act

15. On 2 July 2018, Dianne Linford, born 8 September 1954, was visually identified by her mother, Patricia Miles.

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

Medical cause of death, pursuant to section 67(1)(b) of the Act

17. Forensic pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 4 July 2018 and provided a written report of his findings dated 20 May 2019. Dr Young also reviewed the Victoria Police Report of Death (Form 83), the Coroners Court of Victoria e-Medical Deposition Form, notes from Monash Health and the computed tomography (**CT**) scan.

18. Dr Young provided an opinion that the medical cause of death was 1 (a) complications following sedation for percutaneous endoscopic gastrostomy (PEG) tube insertion (procedure abandoned) in a woman with congenital polymicrogyria.

19. I accept and adopt Dr Young's opinion.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

20. On 12 March 2018, Dianne was out shopping with her carer when the wheelchair she was in toppled forward on an uneven pavement. Dianne fell forward onto her face, causing her front incisor teeth to loosen. Dianne was taken to the Monash Health Emergency Department (**ED**).

21. On 13 March 2018, a dentist at Monash Health reviewed Dianne and arranged, via the emergency booking system, for a dental extraction under a general anaesthetic. Severe mouth ulcers, along with gingivitis, were evident. There was concern that Dianne had swallowed other teeth, which were observed to be missing from her mouth. Overnight in the ED, Dianne vomited twice and was tachycardic.[11]

22. A chest X-ray that had been taken on 13 March 2018 excluded teeth aspiration but diagnosed aspiration pneumonia and an enlarged heart. Antibiotics were commenced to treat aspiration pneumonia. A further X-ray on 14 March 2018 was unchanged.

23. A dental extraction was booked on 15 March 2018, but later postponed allowing time for an improvement in Dianne's nutritional status. Dietetics were consulted and involved in providing nutritional advice.

24. On 22 March 2018, Dianne was discharged from Monash Health. She was discharged with a diet consisting of thickened feeds, along with a topical mouth gel for her ulcers. The need for long-term feeding via a percutaneous endoscopic gastrostomy (**PEG**) tube was also discussed.

25. On 12 June 2018, Dianne's general practitioner (**GP**) Dr Garland referred Dianne back to Monash Health for the treatment of dehydration, caused by her reduced oral intake which was thought to be related to mouth ulcers.

[11] Dianne was flushed, diaphoretic, with a temperature of 37.7 degrees Celsius, with a heart rate of 138 beats per minute.

26. On 13 June 2018, Dianne was taken by Ambulance to the Monash Health ED as she was refusing to eat or drink. Dianne presented with severe mouth ulcers and poor dentition, and the dental team planned for teeth extraction with general anaesthesia on 15 June 2018, however this procedure was abandoned due to persistent tachycardia.

27. On 27 June 2018, Dianne was scheduled to have a PEG tube inserted, but the procedure was abandoned due to hypoxia during sedation, requiring intubation and transfer to the Intensive Care Unit (**ICU**) for respiratory support. Dianne was extubated on the same day and returned to the ward. Again, aspiration pneumonia developed and was treated by antibiotics.

28. On 2 July 2018, following discussions with Dianne's family, the decision was made to transition Dianne into palliative care. She died that morning at 11:50 am.

FINDINGS AND CONCLUSION

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

    a. The identity of the deceased was Dianne Linford, born 8 September 1954;

    b. The death occurred on 2 July 2018 at the Monash Medical Centre, from 1 (a) complications following sedation for percutaneous endoscopic gastrostomy (PEG) tube insertion (procedure abandoned) in a woman with congenital polymicrogyria; and

    c. The death occurred in the circumstances described above.

I convey my sincere condolences to Dianne'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:

Senior Next of Kin

Colleen Carey, Department of Families, Fairness and Housing

Laura Colaviazza, Monash Health

Signature:

Coroner John Olle

Date: 06 June 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 inquest. 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.