IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 004606

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Katrina Jarm
Date of birth:	28 November 1977
Date of death:	28 August 2019
Cause of death:	1(a) Aspiration pneumonia
Place of death:	The Northern Hospital, 185 Cooper Street, Epping, Victoria, 3076

INTRODUCTION

1. On 28 August 2019, Katrina Jarm was 41 years old when she died at the Northern Hospital (**The Northern**) as a result of aspiration pneumonia. At the time of her death, Ms Jarm lived in an Aruma Residential Care (**Aruma**) group home at 43 Winn Grove, Fawkner.

2. Ms Jarm had a number of medical conditions. She was diagnosed with an unidentified degenerative neurological disorder and was believed to have either Autism or Cerebral Palsy. Ms Jarm lived in supportive care for her entire adult life. Ms Jarm required full care, was wheelchair bound and non-verbal. She relied on support staff for all of her personal care needs. Ms Jarm also had epilepsy and a fatty liver. Despite her medical conditions, she enjoyed good health and a full and happy life.

THE CORONIAL INVESTIGATION

3. Ms Jarm'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.

4. Ms Jarm was "a person who immediately before death" was placed in care.[1] Section 52 (3A) of the *Coroners Act 2008* recognises the vulnerability of people who are in the care of the State by requiring that their deaths are reported to the coroner irrespective of the cause of death. A further safeguard is the mandatory requirement for an inquest as part of the coronial investigation. However, if the investigating Coroner is satisfied that the death is due to natural causes, they may choose to finalise the investigation without an inquest. In such a case, the Coroner must publish their finding.

5. 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.

6. 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

[1] Under section 3(1) of the *Coroners Act 2008*, a person placed in care includes a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health. Pursuant to section 4(2)(c) of the Act, the death of such a person is reportable irrespective of the cause of death.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. Victoria Police assigned First Constable Daniel Peisley to be the Coroner's Investigator for the investigation into Ms Jarm's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses, such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. The care provided to Ms Jarm by Aruma was also investigated by the Disability Services Commissioner (**DSC**), pursuant to section 128I of the *Disability Act 2006* (Vic). Their report was submitted to the Court and is an invaluable component of my investigation into the circumstances surrounding Ms Jarm's death.

9. Whilst I have reviewed all the evidence available to me regarding the circumstances of Ms Jarm's death, 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

Identity of the deceased

10. On 28 August 2019, Katrina Jarm, born 28 November 1977, was visually identified by her father Roger Jarm who signed a formal Statement of Identification to this effect.

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

Medical cause of death

12. Forensic Pathologist Dr Melanie Archer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 30 August 2019. Dr Archer also considered the Victoria Police Report of Death Form 83, the post-mortem computerised tomography (**CT**) scanning of the whole body conducted at VIFM, a medical deposition from Northern Hospital

[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.

and Ms Jarm's medical records before providing a written report of her findings dated 2 September 2019.

13. The post-mortem examination revealed patchy opacities in both lungs, in keeping with the history of pneumonia and acute respiratory distress syndrome. There was a thick calvarium with prognathism. Right distal humeral internal fixation was noted, in keeping with the history of surgery in February 2019 for a broken arm. There was longstanding right hip dislocation, and this was seen on the CT with surrounding callus formation. The CT also showed bilateral deformity of the feet and a fatty liver.

14. The external examination showed signs of medical intervention, deformity of the feet, and generalised wasting in keeping with the history of being wheelchair bound.

15. The external examination of the body did not show evidence of an injury of a type likely to have caused or contributed to death.

16. In the absence of a full post-mortem examination or autopsy, Dr Archer provided an opinion that the medical cause of Ms Jarm's death was 1(a) aspiration pneumonia.

17. I accept Dr Archer's opinion.

Circumstances in which the death occurred

18. On 24 and 25 August 2019, Ms Jarm was noted to have had a number of bowel movements. Otherwise, she appeared well and was eating and drinking as usual. On the afternoon of 25 August 2019, Ms Jarm was moaning and had shallow breathing. Ms Jarm's support worker contacted the Nurse on Call Service (**NOC**) for advice. The NOC recommended Ms Jarm's condition be monitored for any behavioural change or deterioration.

19. On the morning of 26 August 2019, Ms Jarm vomited and had a high temperature. The NOC advised staff to maintain Ms Jarm's fluid and to watch for any blood in her stool. The next day, Ms Jarm attended her general practitioner (**GP**) who observed shallow breathing. Later that afternoon, Ms Jarm continued to have difficulty breathing. The NOC was contacted and advised Ms Jarm should be put in the recovery position before transferring the call to emergency services.

20. When Ambulance Victoria (AV) paramedics responded a short time later, they noted Ms Jarm had low blood pressure, low oxygen levels and low blood sugar and that her left lung was not clear. She was taken to the Northern Hospital Emergency Department. A chest x-ray showed

moderate consolidation in mid and lower zones on both sides. Her blood tests showed marked neutropenia and a high C-reactive protein.

21. Ms Jarm was given antibiotics, fluids and supplemental oxygen. Despite treatment, her condition continued to deteriorate, and it was thought that she was experiencing severe aspiration pneumonia. The treating team discussed Ms Jarm's prognosis and treatment options with her father who agreed that she should be subject to a Not For Resuscitation order.

22. Intensive Care Consultants considered Ms Jarm had developed acute respiratory distress syndrome (**ARDS**) which carries a very high mortality rate. It was considered medically inappropriate to proceed with intubation. Ms Jarm was provided support and comfort care to manage her symptoms until she passed away at about 3:30am on 28 August 2019.

FAMILY CONCERNS

23. In January 2019, Ms Jarm fractured her right humerus bone and required surgical repair in February 2019. The injury was investigated by the Ethical Standards Department of the Department of Health and Human Services. However, the cause of the injury remained unclear. Roger Jarm, Katrina's father, raised concerns that he was never told what had occurred or how Ms Jarm came to be injured.

24. I have considered the concerns raised by Mr Jarm and note that they are discussed in the DSC report detailed below. As this injury was neither temporally nor causally related to Ms Jarm's death and therefore falls outside the reasonable scope of a coronial investigation of her death, I have not investigated it beyond noting Mr Jarm's concerns and the DSC report.

REPORT OF THE DISABILITY SERVICES COMMISSIONER

25. The care provided to Ms Jarm by Aruma was investigated by the DSC, pursuant to section 128I of the *Disability Act 2006* (Vic) and provided to the Court in accordance with standing administrative arrangements between the DSC and the Court. I note that the report provided addresses incidents and complaints relating to other residents at 43 Winn Grove, Fawkner, as well as Ms Jarm.

26. The DSC advised that a number of incident reports and complaints had been received regarding the group home at 43 Winn Grove, Fawkner, between August 2018 and February 2020. One of these incident reports related to Ms Jarm's fractured humerus.

27. The DSC made the following findings:

a) Undocumented and unauthorised restrictive interventions were applied to Ms Jarm, in contravention of the requirements of the Act;

b) Positive behaviour support strategies were not provided to Ms Jarm and the other residents of 43 Winn Grove;

c) Reasonable steps were not taken to meet the mealtime and health care needs of Ms Jarm and other residents;

d) A person-centred approach was not maintained in the support provided to Ms Jarm and other residents; and

e) A poor staff culture at the home impacted the quality of care provided.

28. I note that there was no deficiency in care found which is causally relevant to Ms Jarm's death. However, the issues identified by the DSC did impact the quality of the care provided to Ms Jarm and the other residents at 43 Winn Grove, Fawkner.

29. I further note that the deficiencies which were identified largely relate to the period when the Department of Health and Human Services was managing the group home at 43 Winn Grove, Fawkner, and that Aruma only took over management of the group home on 18 August 2019, some ten days prior to Ms Jarm's death.

30. DSC have advised that the investigation was closed on 23 November 2020 after receiving a satisfactory response from Aruma to the Notice to Take Action.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Katrina Jarm, born 28 November 1977;

b) the death occurred on 28 August 2019 at The Northern Hospital, 185 Cooper Street, Epping, Victoria, 3076;

c) the cause of Ms Jarm's death was aspiration pneumonia; and

d) the death occurred in the circumstances described above.

32. I acknowledge the DSC's findings relating to the service and care provided to Ms Jarm and the other residents of Aruma. Whilst I consider the findings of this investigation to be concerning, I do not consider them to be causally related to Ms Jarm's death.

33. The weight of available evidence does not support a finding that there was any want of care on the part of the staff of Aruma or any want of any clinical management and care on the part of the staff of the Northern Hospital that caused or contributed to Ms Jarm's death.

34. Nor does the weight of available evidence support a finding that Ms Jarm's death was preventable.

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:

Roger Jarm, Senior Next of Kin

Jackie Petrov – Legal Coordinator, The Northern Hospital

First Constable Daniel Peisley, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date: 13 April 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.