IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 0308

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Paul Lawrie
Deceased:	Colleen Mary Chapman
Date of birth:	22 March 1960
Date of death:	16 January 2020
Cause of death:	1(a) Myocardial infarction 1(b) Ischaemic heart disease Contributing factors: WHO Class IV obesity
Place of death:	1/22 Salmond Street, Deer Park, Victoria
Keywords:	In care, disability, obesity

INTRODUCTION

1. On 16 January 2020, Colleen Mary Chapman was 59 years old when she died at home. At the time of her death, Ms Chapman lived in a disability community residential unit at Deer Park.

2. Ms Chapman's mother passed away when she was a child and her father passed away in 2012. She is survived by a brother, although she had not been in contact with him for many years.

3. Ms Chapman lived at the community residential unit, which was managed by Home@Scope, for approximately 20 years. She was non-verbal and would communicate with others using hand gestures. She looked forward to attending her day programs from Monday to Friday where she would undertake various activities. She also enjoyed her fortnightly massages.

4. Her medical history included intellectual disability, epilepsy, asthma, osteoarthritis, and dysphagia and was prescribed various medications to assist with these conditions. Ms Chapman had been treated for a myocardial infarction at the end of December 2019 after which she was prescribed anticoagulation medication.

THE CORONIAL INVESTIGATION

5. Ms Chapman'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]

6. While Ms Chapman's death was reported to the Coroner, I note with concern that, as funding for disability services has shifted from the Department of Families, Fairness and Housing (**DFFH**) to the National Disability Insurance Scheme (**NDIS**), the definition of a person placed in custody or care in section 3(1) of the Act to include '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' no longer adequately captures the group of vulnerable people in receipt of disability services that the legislature had intended. Where the deaths of those people are from natural causes and not otherwise reportable, then, though this cohort is as vulnerable 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.

ever, their deaths and the circumstances in which they died – including the quality of their care – would not be subjected to coronial scrutiny.

7. 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.

8. 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.

9. Coroner Paresa Spanos initially had carriage of this investigation and Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Chapman's death. The Coroner's Investigator conducted inquiries on Coroner Spanos' behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

10. In August 2022, I took over carriage of this matter for the purposes of finalising this finding while Coroner Spanos was on long service leave.

11. This finding draws on the totality of the coronial investigation into Ms Chapman'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]

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

Identity of the deceased

12. On 16 January 2020, Colleen Mary Chapman, born 22 March 1960, was visually identified by her disability support worker, Kristy-Lee Hearn, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

14. Forensic Pathologist, Dr Yeliena Baber, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 27 January 2020 and provided a written report of her findings dated 7 July 2020.

15. The post-mortem examination revealed slight cardiomegaly, relatively recent myocardial infarction of the posteromedial left ventricle, moderate narrowing of all three major coronary arteries, bilateral small pleural effusions, and bilateral lung upper lobe adhesions.

16. Routine toxicological analysis of post-mortem samples detected carbamazepine,[3] citalopram,[4] dothiepin,[5] and paracetamol.[6] There was nothing in the toxicology which was contributory to Ms Chapman's death.

17. Dr Baber concluded that Ms Chapman's death was due to ischaemic heart disease. She explained that in this condition myocardial oxygen demand eventually becomes greater than the supply, resulting in irreversible ischaemia (heart attack) or a terminal cardiac arrhythmia. In this case there is evidence of a recent heart attack. Risk factors for coronary artery atherosclerosis include smoking, hypertension, diabetes mellitus, hyperlipidaemia, obesity, and a family history of the condition.

18. Dr Baber provided an opinion that the medical cause of death was *"1(a) Myocardial infarction"* secondary to *"1(b) Ischaemic heart disease"* with a contributing factor of WHO Class IV obesity. She concluded the death was due to natural causes.

19. I accept Dr Baber's opinion.

[3] Carbamazepine is an antiepileptic drug that produces its pharmacological effects by a use-dependent block of sodium channels to inhibit action potential initiation and propagation in the epileptic focus. Clinical indications include partial and tonic-clonic seizures, neuropathic pain and bipolar disorder.
[4] Citalopram and escitalopram are selective serotonin reuptake inhibitors (SSRIs) that increase serotonin neurotransmitter action in the synapse. Further, escitalopram has an additional allosteric effect at a separate allosteric binding site of the serotonin reuptake transporter. Citalopram is approved for major depression and panic disorders. Escitalopram is approved for the treatment of major depression, social anxiety disorders, panic disorder, generalised anxiety disorder and obsessive compulsive disorder.
[5] Dothiepin (dosulepin) is a tricyclic antidepressant.
[6] Paracetamol is an analgesic drug.

Circumstances in which the death occurred

20. On 16 January 2020, Ms Chapman awoke early and completed her usual morning routine of showering, eating breakfast, and taking her medication with assistance. She thereafter attended her usual day program.

21. Ms Chapman returned home at approximately 3.00m and had afternoon tea.

22. A short time later, Ms Chapman's disability support worker, Kristy-Lee Hearn, observed Ms Chapman standing at the door of her bedroom shaking. Ms Chapman subsequently collapsed. Ms Hearn contacted emergency services and administered cardiopulmonary resuscitation.

23. Responding Ambulance Victoria paramedics arrived at 3.35pm and found Ms Chapman to be in cardiac arrest. They provided treatment and two further MICA paramedics arrived a short time later to assist.

24. Sadly, Ms Chapman could not be revived and was verified deceased at 4.15pm.

DISABILITY SERVICES COMMISSIONER INVESTIGATION

25. On 31 January 2020, the Disability Services Commissioner commenced an investigation under section 128I of the *Disability Act 2006*, into disability services provided by Home@Scope to Ms Chapman.

Home@Scope internal review

26. The Commissioner requested that Home@Scope conduct their own review of the disability services provided to Ms Chapman at the time of her death.

27. Relevantly, Home@Scope identified the following issues:

    (a) the mealtime management plan was not updated; and

    (b) the Specific Health Management Plans should be updated on a yearly basis or as care needs change.

28. As part of their service review, Home@Scope provided the Commissioner with a plan of action, which identified how each issue or concern will be addressed. Actions included:

(a) education to ensure Specific Health Plans are updated annually or as care needs change;

(b) education to ensure staff advocate for NDIS plans to fund required disability specific allied health supports including meal management plan reviews/updates; and

(c) house meeting to be booked to reiterate the importance of following up the recommendations of a health professional, and education to ensure Specific Health Plans are updated annually or as care needs change.

29. In May 2021, Home@Scope provided an update to the Commissioner regarding the implementation of their service improvements. These included that a further extraordinary team meeting/educational session was held on 16 September 2020, which included topics such as Specific Health Management Plans, including development and review requirements and advocacy for NDIS funded supports.

30. Upon assessing Home@Scope's review and evidence of the implementation of service improvements, the Commissioner determined that no further action is required with regard to Ms Chapman's case.

Commissioner's investigation

31. I note that the forensic pathologist identified obesity as a contributing factor in the cause of Ms Chapman's death.

32. Relevantly, the Commissioner's own investigation found that Ms Chapman did not have a weight management plan in place. The Commissioner identified an opportunity for service improvement in relation to dietary support and healthy eating. It was noted that although Ms Chapman was morbidly obese, she was provided with unhealthy foods on many occasions. The Commissioner considered that Ms Chapman should have been encouraged to make healthy food choices, which would have promoted her health and wellbeing, and assisted in addressing her weight management issues.

33. The Commissioner therefore requested that Home@Scope ensure that dietician appointments were arranged for any residents diagnosed as obese and for the development of weight management plans where required. Further, that group home staff are suitably skilled to support residents with healthy eating.

34. Home@Scope subsequently agreed to support customers to make healthy eating choices and maintain their overall health and wellbeing. In addition, Home@Scope advised they were working to ensure all customers have an up-to-date Annual Health Review and that any resident identified as obese will be supported to access appropriate health supports.

35. Home@Scope further advised that the organisational plan for 2022 included the development of several evidence-based resources to support customers' health and wellbeing, such as Scope's Supporting Healthy Eating Guide and Scope's Supporting Physical Activity Guide. The plan will also include the promotion of existing specialist resources, such as the Heart Foundation Action Plans.

Update as to implementation

36. In June 2022, Home@Scope was provided with an opportunity to update the Court as to the implementation of any further policies or activities.

37. Home@Scope subsequently advised the following:

    (a) that all customers have up-to-date annual health assessments;

    (b) if a customer is identified to have a weight management concern, referral is made to a Dietitian and/or Nutritionist and a nutritional diet designed to support a customer to lose weight as required is implemented and adhered;

    (c) customers are supported to participate in menu planning at their residence with an embedded focus on healthy eating choices;

    (d) Weight Management Charts are in place to support the monitoring of weight fluctuation and regular review of progress occurs;

    (e) customers who have mobility concerns that may impact on their capacity to lose weight are referred to a Physiotherapist or Occupational Therapist and an exercise program is developed and implemented to support them to be physically active;

    (f) the Clinical Practice team has been expanded to enable additional capacity for support in the areas of Clinical and Allied Health support and attend Case Conferences as required to support planning for customers who have complex health needs. Home@Scope has access to Scope employed Therapists, Dietitians, and Specialist Dysphagia professionals as an additional resource of support.

(g) following Home@Scope's transition to the NDIS, the Clinical Practice Reference Group has developed a suite of documents, tools, and resources to further enhance the support provided for customers with complex health needs; and

(h) Home@Scope utilises the Measurement, Analysis and Reporting System to complete an internal audit of customers' Specific Health Management Plans to ensure the documents are current.

37. I am satisfied that Home@Scope has recognised weight management as an important issue in the lives of their clients and taken steps to prioritise this as a health issue.

FINDINGS AND CONCLUSION

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

(a) the identity of the deceased was Colleen Mary Chapman, born 22 March 1960;

(b) the death occurred on 16 January 2020 at 1/22 Salmond Street, Deer Park, Victoria;

(c) the cause of Ms Chapman's death was myocardial infarction secondary to ischaemic heart disease with a contributing factor of WHO Class IV obesity; and

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

I convey my sincere condolences to Ms Chapman's friends 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:

State Trustees

Home@Scope Pty Ltd

Disability Services Commissioner

Acting Sergeant Quasar Hayes, Victoria Police, Coroner's Investigator

Signature:

Coroner Paul Lawrie

Date: 27 September 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.