IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 001105

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Fiona Lebner
Date of birth:	26 December 1962
Date of death:	26 February 2020
Cause of death:	1(a) Combined features of moderately stenosed right coronary ostium, aortic valve regurgitation with dilated aortic root, mitral valve prolapse and mitral valve regurgitation, dilated cardiomegaly clinical and heart failure <u>Contributing factors</u> Chronic descending thoracic aortic dissecting aneurysm and abdominal aortic aneurysm
Place of death:	24 Vision Street, Chadstone, Victoria
Key words:	Intellectual disability, in care, natural causes, cardiac disease

INTRODUCTION

1. On 26 February 2020, Fiona Lebner was 57 years old when she was found deceased in her bedroom. At the time, Ms Lebner lived in a group home in Vision Street managed by Life Without Barriers.

2. Ms Lebner had lived at the group home for about 13 years and had been in care for approximately 30 years. The group home at Vision Street was previously managed by the Department of Health and Human Services (as it was then named) and management was transferred to Life Without Barriers on 31 March 2019.

3. Ms Lebner's immediate and extended family lived in Queensland. She visited them several times a year and frequently spoke to them via Skype. Ms Lebner enjoyed singing, shopping, and going out for lunch. She had several friends who she saw on a weekly basis at her day service.

THE CORONIAL INVESTIGATION

4. Ms Lebner's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). 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]

5. While Ms Lebner'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 ever, their deaths and the circumstances in which they died – including the quality of their care – would not be subject to coronial scrutiny.

[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.

6. 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.

7. 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.

8. This finding draws on the totality of the coronial investigation into Ms Lebner's death. 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

9. On 26 February 2020, Fiona Lebner, born 26 December 1962, was visually identified by her disability carer, Kylie Anne Peele, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

11. Forensic Pathologist, Dr Brian Beer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 2 March 2020 and provided a written report of his findings dated 26 June 2020.

12. The post-mortem examination revealed a combination of heart disease conditions, which have most probably caused a sudden fatal cardiac arrhythmia event. The heart abnormalities included a moderately stenosed right coronary ostium, aortic valve regurgitation with dilated

[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.

aortic root, mitral valve prolapse and mitral valve regurgitation, dilated cardiomegaly clinical and heart failure. Dr Beer explained that in lay terms, this means Ms Lebner had a heart attack.

13. There was a chronic thoracic descending aortic dissecting aneurysm and an infrarenal abdominal aortic aneurysm which had been clinically recognised with no evidence of rupture as the cause of death.

14. Routine toxicological analysis of post-mortem samples detected valproic acid,[3] metoprolol,[4] citalopram,[5] and aripiprazole[6] but no alcohol or other commonly encountered drugs or poisons.

15. Dr Beer provided an opinion that the medical cause of death was *"1(a) Combined features of moderately stenosed right coronary ostium, aortic valve regurgitation with dilated aortic root, mitral valve prolapse, and mitral valve regurgitation, dilated cardiomegaly clinical and heart failure"*. Contributing factors were chronic descending thoracic aortic dissecting aneurysm and abdominal aortic aneurysm. Dr Beer considered Ms Lebner died from natural causes.

16. I accept Dr Beer's opinion.

Circumstances in which the death occurred

17. According to her general practitioner, Dr Elvera Stow at Mount Waverly Clinic, Ms Lebner had a severe idiopathic intellectual disability with very limited communication skills. She also had known cardiac and peripheral vascular disease.

18. In January 2018, Ms Lebner presented with peripheral oedema and was noted to have a heart murmur. An echocardiogram showed moderate aortic regurgitation, with dilated ascending aorta, mitral prolapse, and moderate mitral regurgitation. An abdominal ultrasound undertaken at about the same time was suspicious of abdominal aorta aneurysm (**AAA**).

19. Ms Lebner was referred to Dr James Sapontis, cardiologist at Monash Heart, who recommend ongoing monitoring of the heart and treatment of hypertension and peripheral oedema with perindopril and frusemide.

[3] Valproic acid is primarily used for the treatment of epilepsy, but also clinically indicated as adjunct therapy in mania and schizophrenia where other therapy is inadequate.
[4] Metoprolol tartrate is an anti-hypertensive drug.
[5] Citalopram is indicated for major depression and panic disorders. Escitalopram is indicated for the treatment of major depression, social anxiety disorders, panic disorder, generalised anxiety disorder, and obsessive-compulsive disorder.
[6] Aripiprazole is an antipsychotic drug.

20. Ms Lebner was also referred to the Monash Health Vascular Surgery Clinic for assessment of the AAA. A further ultrasound in June 2018 identified a dissection of the AAA and she was sent to the Monash Health emergency department. The vascular and emergency doctors spoke to Ms Lebner's family about treatment options. It was subsequently decided that Ms Lebner should not be put through the trauma of major surgery as she would be unable to cope.

21. According to the *Victoria Police Report of Death for the Coroner* (VP Form 83) completed by First Constable Tuckerman, on 25 February 2020 Ms Lebner had been at home all day with her carers and the other occupant. I note however that material from the Disability Services Commissioner states that Ms Lebner attended her usual day service that day and returned to the group home in the evening.

22. From approximately 4.00pm, Ms Lebner watched television and appeared in good health. She had dinner at about 6.00pm during which she ate well and appeared her usual self. She then watched television again until approximately 8.30pm. Again, she appeared to be in good spirits at this time and was taking photos with her carer to send to family members.

23. Ms Lebner's carer then assisted her to use the bathroom before changing into her pyjamas and getting into bed.

24. At approximately 9:30pm, Ms Lebner was observed singing to herself which she usually did. At about this time, her carer assisted her to go to the bathroom again after which she returned to bed.

25. Ms Lebner's carer then went back to her room and was awake until about 11.00pm with no further issues or any contact from Ms Lebner or other occupants of the house.

26. The carer awoke at 4:40am the next day and started her shift at 5:00am. At this time, she went into Ms Lebner's room and found her lying on the floor next to her bed. The carer looked for a pulse but could not find one and stated that Ms Lebner felt cold to the touch. The carer immediately called emergency services.

27. Victoria Police members were the first responders and found Ms Lebner deceased on the floor with some bleeding from her mouth.

DISABILITY SERVICES COMMISSIONER INVESTIGATION

28. In January 2021, the Disability Services Commissioner advised that an investigation under section 128I of the *Disability Act 2006* into disability services provided by Life Without Barriers to Ms Lebner had been concluded.

29. During her investigation, the Commissioner requested that Life Without Barriers undertake a review of their service provision to Ms Lebner. Life Without Barriers subsequently identified the following issues relating to the services provided to Ms Lebner:

    (a) there should be quality improvement to support standardised hospital discharge planning within Victorian Disability Accommodation Supports (**VDAS**) services; and

    (b) the level of awareness amongst staff around what constitutes a life-limiting condition should be enhanced.

30. Life Without Barriers provided a plan that identified how each issue would be addressed. Actions included conducting a workshop on hospital discharge planning to determine best practice and agree upon a standard process across VDAS and developing a Palliative Care Plan for clients with life-limiting conditions. The education sessions were subsequently held in October 2020, and it was identified that none of the occupants at Vision Street required palliative care plans. Life Without Barriers was also due to start using a Disability Pathway, which provides guidelines on end-of-life planning, between March and May 2021.

31. The Commissioner subsequently assessed Life Without Barrier's review of service provision including their plan for service improvements to address identified issues. The Commissioner determined that no further action was required with regard to Ms Lebner's case and there were no adverse findings about the services provided by Life Without Barriers.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Fiona Lebner, born 26 December 1962;

    (b) the death occurred on 26 February 2020 at 24 Vision Street, Chadstone, Victoria;

    (c) the cause of Ms Lebner's death was combined features of moderately stenosed right coronary ostium, aortic valve regurgitation with dilated aortic root, mitral valve

prolapse and mitral valve regurgitation, dilated cardiomegaly clinical and heart failure with contributing factors of chronic descending thoracic aortic dissecting aneurysm and abdominal aortic aneurysm; and

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

I convey my sincere condolences to Ms Lebner'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:

Max and Phyllis Lebner, Senior Next of Kin
Disability Services Commissioner
Monash Health
Senior Constable Allison Ramselaar, Victoria Police, reporting member

Signature:

Coroner Paresa Antoniadis Spanos

Date : 05 October 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.