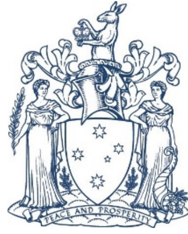

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 006712

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Amended pursuant to section 76 of the Coroners Act 2008

Findings of:	Coroner Darren J. Bracken
Deceased:	Stephen David Johnstone
Date of birth:	01 December 1956
Date of death:	09 December 2020
Cause of death:	1. (a) ASPIRATION PNEUMONIA 2. CEREBRAL PALSY
Place of death:	Peninsula Health, Frankston Hospital, 2 Hastings Road, Frankston, Victoria, 3199

INTRODUCTION

1. On 9 December 2020, Mr Stephen David Johnstone was 64 years old when he died in the Frankston Hospital. Mr At the time of his death Mr Johnstone had a moderate intellectual disability, cerebral palsy (spastic quadriplegia) and a hearing impairment. As a child he had contracted polio and this impacted on his physical abilities. Mr Johnstone also had cancer and oesophagitis; he experienced dysphagia, constipation, incontinence (faecal and urinary) and recurrent respiratory infections. Immediately before his death Mr Johnstone a lived at 18 Moorhead Avenue Mornington and was provided with disability services by the staff of Melba Support Services.

THE CORONIAL INVESTIGATION

2. Mr Johnstone'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. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

3. 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.

4. 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.

5. This finding draws on the totality of the coronial investigation into Mr Johnstone'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.[1]

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[1] 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

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

Post Mortem Examination

6. On 15 December 2020 Dr Paul Bedford, a specialist forensic pathologist practising at the Victorian Institute of Forensic Medicine performed a medical examination, an external examination of Mr Johnstone's body and provided a report dated 21 December 2021. In that report Dr Bedford opined that the cause of Mr Johnstone's death was 'aspiration pneumonia with a contributing factor of cerebral palsy and that his death was due to natural causes.

Circumstances in which the death occurred

7. Despite the challenges posed by his complex medical history Mr Johnstone was quite outgoing; he enjoyed being out in the community. He used a walking frame and a wheelchair to get around. He was close to his family and his brothers, who were his joint guardians and his medical treatment decision makers regularly visited him.

8. In the few weeks immediately prior to his death Mr Johnstone's health deteriorated and he experienced several episodes of vomiting and hiccups and was seen to be lethargic. On 28 November and 5 December 2020 staff providing assistance to Mr Johnstone arranged visits to his home by a locum doctor. Mr Johnstone also saw his regular general practitioner on 3 December 2020. As a result of his health continuing to deteriorate Mr Johnstone was transported to Frankston Hospital on 6 December 2020. One of Mr Johnstone's brothers discussed Mr Johnstone's condition and his prognosis with hospital doctors. Because it was believed that Mr Johnstone's condition would not improve a decision was made that all treatment would cease. Mr Johnstone died in hospital on 9 December 2020.

Disability Support Services – Melba Support Services

9. On 15 December 2020 the Disability Services Commissioner ("the Commissioner") commenced an investigation into Mr Johnstone's death which was concluded some time prior to 29 June 2021. By letter to the court dated 29 June 2021 the Commissioner ("the Commissioner's Letter") described that investigation as incorporating an investigation into disability services provided to Mr Johnston by Melba Support Services. The Commissioner's Letter set out what the investigation had ascertained and the various

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

sources of information which had been relied upon including the Melba Support Services review of the services that it had provided to Mr Johnstone ("the Melba Support Services Review").

10. The Commissioner's Letter set-out Mr Johnstone's personal and medical history together with the circumstances immediately (nearly two weeks) preceding his death.[2] The Commissioner canvassed the support services provided by Melba Support Services and discussed the content of the Melba Support Services Review.

11. The Commissioner's Letter made explicit reference to the commissioner making no adverse findings.[3]

Issue Identified by Melba Support Services Service Review

12. The Commissioner's letter referred to the Melba Support Servcies Review having identified a number of issues relating to the services it provided to Mr Johnstone:

    - Staff had not received formal training to support implimentation of Mr Johnstone's mealtime assistance plan.
    - A requested review of Mr Johnstone's falls risk had not been completed because of "*…COVID-19 and the OT's* availability.".
    - Mr Johnstone's end of life care plan was not in Melba Support Services records.

13. As a result of the investigation the Commissioner identified another issue, ie. that mealtime support was not consistently compliant with Mr Johnstone's mealtime support plan and sought Melba Support Services response. On 27 May 2021 Melba Support Services responded with an amended plan of action dealing with all the issues discovered by the investigation. On the basis of the improvements set out in the plan the Commissioner concluded that no further action was required.[4]

Relevant Legislative Provisions

1. Pursuant to section 4(2) *Coroners Act* (2008) ("the Act") Mr Johnstone's death was a 'reportable death' at least because he had been in care shortly before he died.

2. Pursuant to section 15 of the Act and bearing in mind that Mr Johnstone's death was a 'reportable death' I am obliged to investigate it.

[2] See paragraph 8 above.
[3] The Commissioner's Letter p.1.
[4] The Commissioner's Letter p.4.

3. Pursuant to section 17(1)(b) of the Act and bearing in mind Dr Bedford's opinions I am not required to continue my investigation.

14. The *Coroners Act* (2008) requires me to liaise with other investigative authorities, official bodies or statutory officers to avoid unnecessary duplication of inquiries and investigations and to expedite the investigation of deaths and fires.[5]

CONCLUSION

15. The Commissioner's Letter explicitly refers to the Commissioner having concluded the Investigation, made no findings and being satisfied based on Melba Support Services amended plan that no further action was required.

16. As at December 2020 Mr Johnstone had laboured under significant disabilities and conditions for a long time as a result of which he suffered ongoing serious debilitating illness.

Further investigation

17. I am satisfied, having considered all of the evidence before me, that no further investigation is required and pursuant to section 17(1)(b) of the Act I discontinue my investigation into Mr Johnstone's death.

MATTERS IN RELATION TO WHICH FINDINGS MUST, IF POSSIBLE, BE MADE PURSUANT TO SECTION 67 *CORONERS ACT* (2008)

18. Having investigated Mr Johnstone's death and pursuant to 67(1) of the *Coroners Act* (2008), I find that:

    a) The identity of the deceased is Stephen David Johnstone born 1 December 1956.

    b) Mr Johnstone's death occurred:

        i. On 9 December 2020 at the Frankston Hospital, 2 Hastings Road Frankston, Victoria.

        ii. as a result of Aspiration Pneumonia with cerebral palsy as a contributing factor and

        iii. in the circumstances set-out above.

[5] *Coroners Act* (2008) s.7.

PUBLICATION

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.

DISTRIBUTION

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

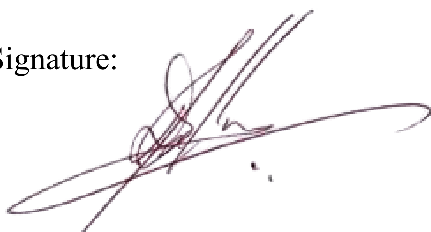
Mr William Johnstone

Victorian Disability Services Commissioner

The Proper Officer, Melba Support Services.

The Proper Officer, Frankston Hospital

Signature:



Darren J. Bracken

Coroner

Date : 28 February 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.