IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 005024

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Vikki Michelle Prenc
Date of birth:	20 April 1962
Date of death:	21 September 2021
Cause of death:	1(a) Asphyxial aspiration with upper airways obstruction by vomitus
Place of death:	Ballarat Base Hospital, 1 Drummond Street North, Ballarat Central, Victoria, 3350
Keywords:	Goals of Care; Ballarat Base Hospital; asphyxial aspiration;

INTRODUCTION

1. On 21 September 2021, Vikki Michelle Prenc was 59 years old when she died at the Ballarat Base Hospital. At the time, Ms Prenc lived alone in Ballarat Central and was supported daily by disability support workers from McCallum Disability Services (**McCallum**).

2. Ms Prenc was raised in the Ballarat area and was the eldest of four children to June and Nevio Prenc. She was born with spina bifida and, when she was six, was diagnosed with epilepsy. A ventriculo-peritoneal (**VP**) shunt[1] was inserted when she was a young child for hydrocephalus and an ileal conduit[2] was inserted in 1980.

3. As a result of her spina bifida, Ms Prenc relied on an electric wheelchair to move about. She had no sensation below her buttocks.

4. Ms Prenc did not have an intellectual disability. Despite her physical limitations, she performed exceptionally well at school. In her twenties, Ms Prenc commenced work at Pennyweight Park, and moved out of the family home and into an assisted living facility operated by McCallum. Ms Prenc lived across several homes in the Ballarat area, both on her own and with other residents, with the assistance of McCallum.

5. Ms Prenc enjoyed going to the gym regularly, swimming, horse riding and spending time with her family. She remained proudly independent throughout her life.

6. Since 2014, Ms Prenc was treated by General Practitioner (**GP**) Dr Azam Chowdhury of Medicaid Ballarat. Ms Prenc's medical history also included recurrent urinary tract infections/urosepsis, hypertension and hypothyroidism, and an ileal-colonic fistula with associated bilateral nephrostomies. Ms Prenc declined surgery to repair the fistula as it would involve major and invasive surgery.

7. At no stage did Ms Prenc complain of or present with symptoms of mental ill-health. According to Dr Chowdhury, she routinely presented in a euthymic mood.

8. At the time of her death, Ms Prenc received NDIS funding which provided for McCallum disability support workers to provided daily physical assistance. McCallum staff did not

[1] A ventriculoperitoneal shunt is a surgically implanted device that drain excess cerebrospinal fluid (hydrocephalus) from the brain into the abdominal cavity where it is reabsorbed

[2] An Ileal conduit is a type of urinary diversion away form a non-functioning bladder by the creation of a urostomy or 'Ileal Conduit'. This involves creating a stoma using a piece of small bowel which will be attached to the ureters and draining through the abdominal wall into an ostomy bag.

provide medical care, but instead provided physical supports under the direction of Ms Prenc's external medical practitioners including her GP.[3]

9. In 2021, Ms Prenc's physical health began to deteriorate. Since May 2021, she had six admissions to the Ballarat Base Hospital including following her final presentation on 13 September 2021. Each of these recent presentations related to complications from recurrent UTIs, including sepsis.

10. Both Ms Prenc's GP and McCallum stated they had no record or knowledge of Ms Prenc having a past history of difficulty swallowing or choking on food.

THE CORONIAL INVESTIGATION

11. Ms Prenc'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.

12. 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.

13. 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.

14. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Prenc'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.

15. This finding draws on the totality of the coronial investigation into the death of Vikki Michelle Prenc 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

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[3] Statement of Randal Newton-John, dated 10 March 2022, coronial brief.

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[4]

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

Identity of the deceased

16. On 21 September 2021, Vikki Michelle Prenc, born 20 April 1962, was visually identified by her carer, Jamie Tobin, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

18. Forensic Pathologist Dr Brian Beer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on Ms Prenc's body in the mortuary on 23 September 2021 and provided a written report of his findings dated 1 October 2021.

19. Examination of the post-mortem computerised tomography (**CT**) scan showed cerebral ventricular dilatation with ventricular-peritoneal shunt, upper airway obstruction and faecal loading.

20. In the absence of an autopsy, Dr Beer provided an opinion that the medical cause of death was *1 (a) asphyxial aspiration with upper airways obstruction by vomitus*.

21. I accept Dr Beer's opinion.

Circumstances in which the death occurred

22. On 13 September 2021, Ms Prenc was admitted to the Ballarat Base Hospital with confusion, slurred speech, and delirium caused by urinary sepsis, the result of a urinary tract infection (**UTI**). Ms Prenc had already been scheduled to undergo a planned bilateral nephrostomy to change her nephrostomy tubes the following day. The bilateral nephrostomy proceeded on 14 September 2021 as planned. The procedure was uncomplicated, and Ms Prenc was treated with intravenous anti-biotics to aid her recovery.

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[4] 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.

23. A Goals of Care (**GOC**) document was completed on 14 September 2021 by locum medical registrar Dr Edmund Song. When the GOC was completed, Ms Prenc was still experiencing delirium and slurred speech and was deemed not competent to make decisions on her own behalf. The GOC recorded that Ms Prenc was not for resuscitation or intubation but was for active management. The reason documented for this limitation of care was her comorbidities.

24. On the evening of 17 September 2021, Ms Prenc had a small vomit. She was given the anti-nausea medication ondansetron intravenously, seemingly to good effect.

25. Ms Prenc remained stable throughout her admission and following the nephrostomy procedure. Her UTI showed clinical improvement and she was planned for discharge at 12.45pm on 21 September 2021.

26. At about 7.30am on the morning of her planned discharge, Ms Prenc was assisted by nurse Ms Lauren Harvey into an upright position to her eat breakfast. After breakfast, Ms Prenc vomited a small amount believed to be around 50-100ml. Otherwise, she did not complain of any symptoms of nausea or abdominal pain and reported feeling better after having vomited. Ms Prenc was given her medication which she tolerated with water.

27. At some time between 10 and 10.30am, Nurse Harvey checked on Ms Prenc. She remained upright and in bed and was having her morning tea, which consisted of milo and biscuits. The nurse stated she seemed alert and well.

28. When Nurse Harvey returned to Ms Prenc's room at about 11.00am, she found her unresponsive. A Medical Emergency Team (**MET**) call was made. The responding team found Ms Prenc in asystole[5] with no discernible signs of life. Resuscitation was not attempted in accordance with Ms Prenc's GOC documentation and she was verified deceased at 11.16am on 21 September 2021.

FAMILY CONCERNS AND CPU REVIEW

29. Following Ms Prenc's death, her sister Lisa contacted the Coroners Court of Victoria on behalf of her family raising concerns about the care Ms Prenc received proximate to her death. In summary, the family's concerns were:

    i. That Ms Prenc's medical management was beyond the capacity of McCallum staff.

[5] No detectable heart rhythm on an electrocardiogram (ECG)

ii. Ballarat Base Hospital staff did not adequately manage Ms Prenc's vomiting risk during her final admission.

iii. Ms Prenc's 'Not for Resuscitation' status documented in her GOC.

30. In light of these concerns, and as part of my investigation, I sought advice from the Coroners Prevention Unit (**CPU**) about the clinical management and care provided to Ms Prenc proximate to her death.

31. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided to the deceased by reviewing the medical records, and any concerns which have been raised.

32. As part of their review, the CPU were assisted by the coronial brief of evidence, the medical records from the Ballarat Base Hospital, the family's concerns, and the court file.

33. Some of the family's other concerns have been previously addressed in communication from the court and will not be incorporated into this finding. Only matters considered by the CPU to be of clinical significance given the cause of death will be addressed in this finding.

McCallum's medical management capacity

34. Ms Prenc's increased presentations requiring admission to hospital throughout 2021 were due to recurrent 'urosepsis' caused by her abnormal urinary tract. This was complicated by the development of an ileal-colonic fistula[6] which resulted in direct communication between Ms Prenc's bowel and her urinary tract. Unsurprisingly, this led to recurrent UTIs.

35. Bilateral nephrostomies tubes were inserted to divert urine away from where Ms Prenc's bowel and urinary tract intersected. Medical records indicate Ms Prenc declined the major surgery required to address these issues definitively.

36. The CPU identified that during her previous discharges from hospital to the care of McCallum staff, daily nursing visits were arranged. McCallum staff were advised to return Ms Prenc to hospital if they held concerns, which they did so several times. The CPU considered this appropriate in the circumstances.

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[6] Communication between the artificial bladder (ileal conduit) and the colon.

37. The CPU advised Ms Prenc's recurrent UTI were due to the underlying urinary tract anatomy and complications, and not due to a lack of adequate management or care. The next level of care up from what could be provided by McCallum would likely have been a residential aged care facility. As Ms Prenc advocated for her own medical needs and was competent to do so, any such escalation of care would have required Ms Prenc's consent.

38. In any event, the CPU considered the complications Ms Prenc encountered were not due to a lack of care by McCallum and likely would have occurred regardless of the setting.

39. The CPU did not identify any want of clinical management on the part of McCallum or its staff.

Response to vomiting on 21 September 2021.

40. Ms Prenc had one isolated vomiting episode on 17 September 2021 which settled when she was administered ondansetron. The CPU noted that Ms Prenc's observations between 19 and 21 September 2021 were normal, and she made no complaints of abdominal or other pain.

41. Furthermore, Ms Prenc did not have a known history of choking according to her GP and the statement from McCallum. A speech pathology assessment conducted during a previous admission for sepsis on 8 August 2021 concluded that there was mild oropharyngeal dysphagia (swallowing difficulty).

42. On the morning of 21 September 2021, Ms Prenc had a small vomit after breakfast. She told nursing staff she felt better afterwards and was then able to tolerate her morning medications and morning tea. A medical review had been requested by nursing staff, but Ms Prenc had not been seen by a doctor prior to her death.

43. The CPU advised that the nursing response to Ms Prenc's vomiting episode on 21 September 2021 was appropriate. The vomiting episode was a single small vomit (50-100mls), Ms Prenc's observations were normal, and she reported feeling better. The CPU advised that although it would have been ideal for a medical review to have occurred, vomiting is a very common occurrence in hospitalized patients, and it would not be an urgent priority for medical staff in the circumstances.

44. The CPU noted that at times that Ms Prenc was not in hospital, she did not have nursing supervision while she ate, and it does not appear there was any indication for this level of care

at home. Moreover, when Ms Prenc passed away she was not actively eating and there is no record of her experiencing a choking episode on the morning of 21 September 2021.

Goals of Care and Do Not Resuscitate

45. The GOC document was completed around the time of Ms Prenc's admission on 14 September 2021. The GOC established that Ms Prenc was not for resuscitation or intubation but was for active management.

46. Ms Prenc initially presented to the Ballarat Base Hospital with confusion and delirium. The CPU identified that Ms Prenc's delirium did not resolve until 15 September 2021 at the earliest. Therefore, at the time of completion of the GOC document, Ms Prenc was still experiencing delirium and the CPU advised she could not have been considered competent to make informed decisions about GOC at this time.

47. Moreover, there is no evidence that Ms Prenc had an advanced care directive consistent with the GOC "not to resuscitate or intubate". There was also no recent GOC document in the Ballarat Base Hospital records from any recent admission consistent with an intention not to resuscitate or intubate. A previous nursing handover chart completed on 6 August 2021 indicates that a GOC summary was completed at level of care 'A.' Such a level indicates there was <u>no limitation</u> of medical treatment, that is, that she was for resuscitation.

48. There is no evidence in the medical records that Ms Prenc had a Medical Power of Attorney, or that her family was contacted with respect to her GOC. This was corroborated by the evidence of the family who stated they were not contacted and, if they had been, would have informed the hospital that Ms Prenc's GOC included resuscitation and intubation.

49. The CPU advised the GOC appears to have been completed without consultation with Ms Prenc's family at a time when she herself could not have made an informed choice due to a temporary cognitive impairment caused by delirium. The CPU further advised that Ms Prenc's acute condition, whilst serious, was not untreatable and a recovery was expected at least in the short term. Her comorbidities were largely a lifelong disability with which Ms Prenc appears to have lived with in a positive manner. Whilst permanent, her comorbidities were not progressive or necessarily lethal.

50. The CPU shares the family's concerns around the establishment of the GOC for Ms Prenc.

FURTHER INVESTIGATION

51. Following the CPU's advice, I directed a statement be obtained from Dr Song who prepared Ms Prenc's GOC documentation, and a statement from Grampians Health in relation to their policies regarding the creation of GOCs.

Ballarat Policy

52. Dr Rosemarie Eyre, Medical Administration Registrar provided a statement to the court detailing the procedures at Grampians Health for establishing GOC for a patient.

53. Dr Eyre advised that Grampians Health policy states GOC decisions must be discussed with the patient and/or their Medical Treatment Decision Maker (**MTDM**) and family where appropriate. If the GOC includes a decision to limit treatment, it needs to be discussed and authorized by a consultant. Dr Eyre confirmed there was no documentation that any such discussions took place in relation to Ms Prenc's GOC.

54. In the event that a person does not have capacity to have an informed discussion about GOC, a previous Advanced Care Directive and/or Refusal of Treatment Certificate should be considered. Dr Eyre confirmed there was neither an Advanced Care Directive nor Refusal of Treatment Certificate on file for Ms Prenc.

55. Grampians Health policy states that GOC should be reviewed when there is a significant change in the patient's medical condition or expected prognosis. This includes a patient who was temporarily incapable of having an informed GOC discussion, who has since recovered, and is now able to participate in such a discussion. This was the case for Ms Prenc once she overcame her delirium.

56. Dr Eyre conceded that there was no evidence that Ms Prenc's GOC were reviewed in light of her recovery from delirium, or that she was ever informed that her GOC were not for resuscitation or intubation.

Dr Edmund Song

57. Dr Song stated that the decision to alter Ms Prenc's GOC was related to her history of recurrent urinary tract infections and previous denial of surgery to address her ileal-colonic fistula. Dr Song stated he considered prognosis poor and that she had a low likelihood of survival if she were to fall into cardiac arrest and require resuscitation.

58. Dr Song conceded that he was unable to discuss Ms Prenc's GOC at the time she was admitted given her delirium. He further conceded that her did not have any discussions with her family or a MTDM.

59. Dr Song maintained that he was under the impression that Ms Prenc's GOC would soon be re-visited once her delirium had subsided but conceded that his "*decision not to involve family in the goals of care decision, and to document that involvement, was flawed*." He also took the opportunity of providing a statement to the court to apologise to the Prenc family for his failure to consult them prior to establishing Ms Prenc's GOC.[7]

FINDINGS AND CONCLUSION

60. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the Briginshaw gloss or explications.[8]

61. Moreover, the effect of the authorities is that Coroners should not make adverse comments or findings against individuals or institutions, unless the evidence provides a comfortable level of satisfaction that they departed materially from the standards of their profession and in so doing, caused or contributed to the death.

62. It is axiomatic that the material departure from applicable standards be assessed without the benefit of hindsight, on the basis of what was known or should reasonably have been known at the time, and not from the privileged position of hindsight. Patterns or trajectories that may be appreciated at a later time or may even obvious once the tragic outcome has come to pass are to be eschewed in favour of a fair assessment made.

63. The implementation of Ms Prenc's GOC on 14 September 2021 occurred at a time when she was incapable of making an informed choice due to delirium. Neither her family, nor an appropriate MTDM, were consulted at any stage about her GOC. As a result, Ms Prenc was subject to a GOC that stipulated she was not for resuscitation or intubation. The evidence suggests such conditions were contrary to Ms Prenc and her family's wishes and true goals of care.

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[7] Statement of Dr Edmund Song, dated 6 April 2023.

[8] Briginshaw v Briginshaw (1938) 60 C.L.R. 336 especially at 362-363. *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…".*

64. After her recovery from delirium, clinical staff ought to have been re-visited Ms Prenc's GOC now that she was competent to participate in such discussions. The failure to re-visit Ms Prenc's GOC was a breach of Grampians Health own procedure and represents a missed opportunity to remedy the GOC incorrectly completed by Dr Song.

65. Dr Song's handling of Ms Prenc's GOC fell well below the standard of care expected of him as a doctor. There was no legitimate basis for Dr Song to implement the GOC in the manner that he did. By doing so, Dr Song clearly breached the procedures in place at Grampians Health which later led to potentially lifesaving treatment being withheld for Ms Prenc.

66. I acknowledge and commend the candour in Dr Song's statement in which he conceded that his actions on 14 September 2021 fell well below the standard of care expected of him as a doctor. It is apparent that Dr Song sincerely regrets his handling of Ms Prenc's GOC.

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

    i. the identity of the deceased was Vikki Michelle Prenc, born 20 April 1962;

    ii. the death occurred on 21 September 2021 at Ballarat Base Hospital (Ballarat Health Services) 1 Drummond Street North, Ballarat Central, Victoria, 3350;

    iii. the cause of Ms Prenc's death was asphyxial aspiration with upper airways obstruction by vomitus; and

    iv. the death occurred in the circumstances described above.

68. When Ms Prenc was discovered unresponsive by nursing staff on 21 September 2021, resuscitation was not attempted in accordance with the GOC documented for her. I am satisfied the cause of Ms Prenc's cardiac arrest resulted from an episode of choking on vomit which is generally considered a reversible cause.

69. Had CPR been attempted, Ms Prenc's outcome may well have been different. However, due to the inherent fallibility of CPR, and the potential length of her down time, the available evidence does not support a finding that Ms Prenc would *probably* have survived the arrest if CPR had been attempted.

70. Apart from the handling of Ms Prenc's GOC, the available evidence does not support a finding that there was any want of clinical management or care on the part of Ballarat Base Hospital staff or McCallum carers that caused or contributed to Ms Prenc's death.

I convey my sincere condolences to Ms Prenc'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:

June & Nevio Prenc, senior next of kin

Lisa Prenc

Grampians Health

Dr Edmund Song c/o Kennedys Law

Sergeant Christopher Taylor, Victoria Police, Coroner's Investigator

Signature:

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Coroner Paresa Antoniadis Spanos

Date : 24 November 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 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.