IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2022 2650

FINDING INTO DEATH WITHOUT INQUEST

Form 37 Rule 63(1)

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

Deceased:	Glenda Elaine Shapcott
Delivered on:	21 November 2022
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	21 November 2022
Findings of:	Coroner Paresa Antoniadis Spanos
Counsel assisting the coroner:	Grace Horzitski, Senior Coroner's Solicitor
Key words:	Disability, in care, SDA resident, SDA enrolled dwelling, fall, pneumonia, declining health, palliative care

INTRODUCTION

1. Glenda Elaine Shapcott was 65 years old when she passed away in hospital on 17 May 2022, following a deterioration in her health and an unwitnessed fall. At the time, Ms Shapcott resided at Kirinari House in Wangaratta.

2. Ms Shapcott was the fifth child in a sibship of six children. Initially, Ms Shapcott had no known medical conditions and appeared to be developing as expected until the age of 14 months when she began experiencing seizures. At age three years, she was reported to be having three or more grand mal seizures a week and likely multiple petit mal seizures. The grand mal seizures were well controlled with carbamazepine, however she continued to have frequent petit mal seizures throughout her childhood.

3. At age four years, Ms Shapcott began kindergarten at a school then known as the Peninsula Retarded Children's Association. She remained in the program until age seven years. She thereafter stayed at Kew Cottages intermittently for respite care before becoming a permanent resident at eight years of age. Ms Shapcott thereafter continued to reside in various supported living accommodations. In 1998, she moved to Kirinari House in Wangaratta, a group home for supported living, assisting people with disabilities with their daily living needs.

4. Ms Shapcott's medical history also included intellectual disability, type 2 diabetes mellitus (controlled), chronic hyponatraemia (stable and being monitored), and megaloblastic anaemia (no clear cause but generally stable). Ms Shapcott had been a heavy smoker of cigarettes, which she stopped in 2017.

5. Ms Shapcott's mother passed away in February 2022. Thereafter, her older sister, Linda Ritchie, became the main contact for her sister's care and medical needs and National Disability Insurance Scheme supports. Ms Ritchie noted her sister was able to understand conversation but was hesitant about being touched, such as for medical purposes, and could respond with violence. Her long-term general practitioner, Dr Alex Traill, confirmed that it was difficult to get Ms Shapcott to undergo tests, which prevented further investigation of her anaemia.

6. According to Bernadette Anderson, Service Deliver Manager at Kirinari Community Services, Ms Shapcott required support 24 hours a day, seven days a week. She required prompting and assistance with daily living, such as prompting to shower, go to bed, and complete personal care but could complete these tasks independently. She was mostly non-verbal but was able to use single words and short sentences to convey her wishes.

INVESTIGATION AND SOURCES OF EVIDENCE

7. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Shapcott'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. This finding draws on the totality of the coronial investigation into Ms Shapcott's death, including evidence contained in the coronial brief.

9. All of this material, together with the inquest transcript, will remain on the coronial file.[1] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

10. The purpose of a coronial investigation of a *reportable death*[2] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3]

11. Ms Shapcott's death clearly falls within the definition of reportable death, specifically section 4(2)(a) of the Act which includes (relevantly) a death that appears to have resulted, directly or indirectly, from an accident or injury.

Deaths of persons placed in care

12. 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.[4]

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[1] From the commencement of the ***Coroners Act 2008*** (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

[2] The term is exhaustively defined in section 4 of the Act. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

[3] Section 67(1).

[4] See section 4(2)(c) and the definition of 'person placed in custody or care' in section 3(1) of the Act.

13. Prior to the rollout of the National Disability Insurance Scheme, many supported living homes for people living with disabilities were managed by the then Department of Health and Human Services. By virtue of section 4(c), Ms Shapcott would have been considered to be a person who immediately before death was a person placed in care.[5] Section 52(2)(b) then requires a coroner to hold an inquest unless the death was due to natural causes.

14. When funding for disability services shifted from the now Department of Families, Fairness and Housing to the National Disability Insurance Scheme, 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 captured the group of vulnerable people in receipt of disability services that the legislature had intended. These people form a vulnerable cohort and their deaths and the circumstances in which they died – including the quality of their care – should be subjected to coronial scrutiny as the legislature intended. For this reason, I decided to hold an inquest into Ms Shapcott's death.

15. I note that on 11 October 2022, amendments to the Coroners Regulations 2019 came into effect. Regulation 7(1)(d) now provides that 'person placed in custody or care' now includes *"a person in Victoria who is an SDA resident residing in an SDA enrolled dwelling"*.[6] I note the National Disability Insurance Agency has confirmed for the Court that Ms Shapcott was an SDA resident residing in an SDA enrolled dwelling at the time of her death.

Cause of death and circumstances in which the death occurred

16. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death.

17. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently

[5] Section 3(1) relevantly provides that a 'person placed in custody or care' is a person under the control, care or custody of the Secretary to the Department f Huan Services or the Secretary to the Department of Health.

[6] 'SDA resident' has the same meaning as in the *Residential Tenancies Act 1997*: (a) a person who is an SDA recipient (i.e., an NDIS participant who is funded to reside in an SDA enrolled dwelling); or (b) a person who is a CoS supported accommodation client. 'SDA enrolled dwelling' also has the same meaning as in the *Residential Tenancies Act 1997:* (a) that provides long-term accommodation for one or more SDA residents; and that is enrolled as an SDA dwelling under the National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016 of the Commonwealth as in force from time to time or under other rules made under the *National Disability Insurance Scheme Act 2013* of the Commonwealth.

proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[7]

The coroner's prevention role

18. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[8]

19. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[9] These are effectively the vehicles by which the coroner's prevention role can be advanced.[10]

20. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[11]

IDENTITY OF THE DECEASED

21. Glenda Elaine Shapcott, born 23 March 1957, was visually identified by Tessa Church who had cared for Ms Shapcott in her supported living accommodation for six years. Ms Church signed a formal Statement of Identification to this effect on 18 May 2022.

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

MEDICAL CAUSE OF DEATH

23. Forensic Pathology Registrar, Dr Joanne Ho, supervised by Forensic Pathologist Dr Brian Beer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external

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[7] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[8] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[9] See sections 72(1), 67(3) and 72(2) regarding reports, comments, and recommendations respectively.

[10] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[11] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1).

inspection of Ms Shapcott's body in the mortuary on 20 May 2022 and provided a written report of her findings dated 6 June 2022.

24. The post-mortem external examination revealed a large bruise along the right hip. A post-mortem computed tomography (**CT**) scan showed there was no intracranial haemorrhage or skull fracture and was no pelvic or femoral trauma. There was a T8 vertebral compression fracture. There was soft tissue swelling and a haematoma around the right hip/thigh distribution. There was a distended gallbladder, small bilateral pleural effusions, and increased lung markings. There were also sternocostal calcifications.

25. Dr Ho provided an opinion that the medical cause of Ms Shapcott's death was *"1(a) Pneumonia and a right hip haematoma following a fall in a woman with multiple medical comorbidities"*.

26. I accept Dr Ho's opinion.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

27. In the months preceding her death, Ms Shapcott's health began to deteriorate gradually, and she experienced falls. According to Dr Traill, she experienced increasing lethargy, leg oedema, breathlessness, coughing, and low blood pressure. These symptoms were attributed to her anaemia and possible cardiac failure. Dr Traill discussed Ms Shapcott's medical management with Ms Ritchie in December 2021 and May 2022 and they agreed to take a palliative approach. This meant that Ms Shapcott would not be sent to hospital unless it was an emergency or staff could not manage her at Kirinari House. This was reflected in her Goals of Care. He also recommended beginning the process of getting an aged care assessment with a view to getting Ms Shapcott placed in residential aged care as her care needs were clearly escalating, however this did not come to fruition before her death.

28. Dr Traill described Ms Shapcott's condition as deteriorating rapidly from late April 2022 with worsening lethargy, breathlessness, anorexia, and refusal of care.

29. According to Ms Anderson, in the week before her death, Ms Shapcott was refusing to shower, refusing to eat, and her behaviour was increasingly difficult. Ms Shapcott had previously enjoyed her meals, so her decrease in appetite was a particularly noticeable behavioural change.

30. On 12 May 2022, care staff requested an ambulance for Ms Shapcott because she was consistently refusing to eat. After reviewing Ms Shapcott and speaking with her general practitioner, Dr Traill, it was decided not to take Ms Shapcott to hospital that day.

31. Dr Traill arrived at Kirinari House at 1.00pm to review Ms Shapcott. His notes record Ms Shapcott as being lethargic but responsive, afebrile, having moderate oedema of the legs, and a few fine basal crackles in her chest. She declined further examination. His assessment was that Ms Shapcott was progressively declining and he reinforced the palliative approach to her carers. Dr Traill also authored a letter to the effect that a decision had been made in consultation with Ms Ritchie that Ms Shapcott would be managed palliatively and she was not for resuscitation. She would only be transferred to hospital if she could not be managed at her residence.

32. Later that day at about 2.45pm, Ms Shapcott asked to go to the bathroom and was assisted to and from the bathroom. Ms Shapcott thereafter refused to sit back in her chair and kept walking. She was observed to be 'wobbly' before dropping to the ground slowly, which appeared to be a deliberate act rather than a mechanical fall. She was then unable to get back up and refused staff assistance. Another ambulance was subsequently called and attended at 3.15pm. Paramedics were unable to assess Ms Shapcott and reportedly declined to convey Ms Shapcott to hospital as she was being treated palliatively. Ms Shapcott remained on the floor. At about 5.00pm, a third ambulance was called and paramedics subsequently assisted Ms Shapcott back to her chair.

33. On 13 May 2022, Ms Shapcott was mobile, but staff observed that she did not appear to be her usual self. That night, she slept in her recliner chair, which was unusual.

34. Around midnight, a staff member heard Ms Shapcott moving in her recliner chair. When staff checked, they noted that Ms Shapcott had been incontinent of urine. She was asked if she would like to go to the bathroom but refused. A towel was placed underneath her legs, but Ms Shapcott did not allow any other care and then went back to sleep.

35. At about 6.30am that morning, 14 May 2022, the staff member found Ms Shapcott on the floor. It was unknown how long she had been on the floor or how she had got there. While Ms Shapcott did not appear to be in any pain, emergency services were contacted, and an ambulance arrived at approximately 8.15am and conveyed her to hospital.

36. Ms Shapcott arrived at Northeast Health/Wangaratta Hospital at about 9.50am and was reviewed in the emergency department. According to Dr Mitchell Brown, Ms Shapcott was

highly resistive to care and was only able to have a motion degraded CT brain scan, which did not demonstrate an acute injury, bleed, stroke, or mass effect. No further imaging was undertaken as Ms Shapcott became extremely distressed and aggressive including when pathology and observations were attempted. However, it was noted that Ms Shapcott had right hip pain and was unable to mobilise on her right leg. Further investigation of these issues could not be completed.

37. On 15 May 2022, clinicians contacted Ms Ritchie to discuss Ms Shapcott's medical management. Ms Ritchie had explained that her sister had previously required sedation for simple procedures, including injections. The treating team considered sedation would place Ms Shapcott at greater harm when weighed against the potential benefit. Given there were no signs of clinical deterioration or significant discomfort, there was no plan for further investigations without Ms Shapcott's cooperation. Ms Shapcott continued to demonstrate distress and refused nursing care and oral intake.

38. On 16 May 2022, Dr Brown reviewed Ms Shapcott. There were no clinical signs that pointed to neck of femur fracture (such as leg shortening, external rotation, or significant pain). Dr Brown and Ms Ritchie discussed the need for further imaging to exclude acute fracture, infection, or bleeding. Dr Brown explained that further imaging would have prognostic value and provide an expected trajectory given Ms Shapcott's ongoing inability to mobilise. Ms Ritchie agreed to sedation with anaesthetic support for the purposes of further investigation. The anaesthetic team was then contacted, and they planned to review Ms Shapcott once she had been allocated a time for her right hip CT scan.

39. Overnight, Ms Shapcott continued to be resistive to nursing care with ongoing aggression and distress. She refused all medication, personal care, and observations.

40. On the morning of 17 May 2022, Ms Shapcott allowed staff to take her observations and she was noted to be less agitated and distressed. A sacral pressure injury without signs of acute infection was noted.

41. At 8.40am, nursing staff observed Ms Shapcott to be well. Fifteen minutes later, Ms Shapcott was found unresponsive, and a MET (Medical Emergency Team) call was made. In keeping with her Goals of Care, no cardiopulmonary resuscitation was provided.

42. Ms Shapcott passed away at 9.00am that morning. Dr Brown noted there was no clear precipitant prior to her acute unresponsiveness and sudden death.

FINDINGS AND CONCLUSION

43. The applicable standard of proof for coronial findings is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications. [12]

44. Having applied the applicable standard of proof to the available evidence, I find that:

    (a) the identity of the deceased was Glenda Elaine Shapcott, born 23 March 1957;

    (b) the death occurred on 17 May 2022 at Northeast Health Wangaratta, 35 – 47 Green Street, Wangaratta, Victoria;

    (c) the medical cause of Ms Shapcott's death was pneumonia and a right hip haematoma following a fall in a woman with multiple medical comorbidities;

    (d) the death occurred in the circumstances described above; and

    (e) the available evidence does not support a finding that there was any want of clinical management or care on the part of those involved in caring for Ms Shapcott that may have caused or contributed to Ms Shapcott's death.

45. I convey my sincere condolences to Ms Shapcott's family for their loss.

PUBLICATION OF FINDING

46. Section 73(1) of the Act provides that unless otherwise ordered by a coroner, the findings comments and recommendations made following an inquest must be published on the Internet in accordance with the rules. I make no such order and therefore this finding is to be published in its totality.

[12] *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…".*

DISTRIBUTION OF FINDING

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

Linda Ritchie, senior next of kin

The Manager, Kirinari House, Wangaratta

Dr Alex Traill, Ovens Medical Group

Constable Joshua Stafford, Victoria Police, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date: 21 November 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 inquest. 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.