IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2022 005303

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Sarah Gebert, Coroner
Deceased:	Ms S[1]
Date of birth:	[redacted] 1959
Date of death:	[redacted] 2022
Cause of death:	1(a) Sepsis complicating cellulitis following skin cancer excision and skin graft procedure in a woman with multiple medical comorbidities (palliated)
Place of death:	Austin Hospital, 145 Studley Road, Heidelberg, Victoria
Key words:	In care, sepsis, cellulitis

[1] *At the direction of Coroner Sarah Gebert, the name of the deceased has been replaced with a pseudonym to protect her and her family's identities. Identifying details have also been redacted.*

INTRODUCTION

1. On [redacted] 2022, Ms S was 63 years old when she died in hospital following a procedure to remove cancer from her leg.

2. At the time of her death, Ms S lived in supported living accommodation in [redacted].

THE CORONIAL INVESTIGATION

3. Ms S'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. However, if a person satisfies the definition of a person placed in care immediately before the death, the death is reportable even if it appears to have been from natural causes.[1]

4. 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.

5. 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.

6. Victoria Police assigned Senior Constable Glenn Houghton to be the Coroner's Investigator for the investigation of Ms S'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.

7. This finding draws on the totality of the coronial investigation into Ms S'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]

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[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(1) of the Act.

[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

Background

8. Ms S was born with an intellectual disability. She grew up in [redacted] with sisters [redacted] and [redacted]. She initially attended a public primary school before transitioning to Bundoora Special Needs School where she finished her schooling.

9. At the age of 16 years, Ms S started attending [redacted] Training Centre (**the Centre**), which was established and funded by her parents, [redacted]. Other children with disabilities in the community also attended and their families assisted with funding.

10. Ms S loved attending the centre where she could participate in sports, craft, and music and socialise with her friends. [redacted] described her sister as having a very bright and outgoing personality.

11. In about 1987, Ms S's parents raised funding to build supported living accommodation at [redacted], so that people with the issues Ms S faced could live independently but also in a supportive environment. Ms S eventually settled and enjoyed living at the home.

12. [redacted], manager of the supported living accommodation, described Ms S as very friendly. She loved helping others, including staff and other residents.

13. Ms S's medical history included stage 4 chronic kidney disease, generalised epilepsy, type-2 diabetes mellitus, pancreatic pseudocyst, hypercholesterolaemia, gout, osteoporosis, hypertension, hyperlipidaemia, and gastro-oesophageal reflux. Ms S's diabetes and gout meant that any wounds or scratches she sustained were slow to heal and often became infected, requiring antibiotics.

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

Circumstances in which the death occurred

14. In March 2022, Ms S presented to her general practitioner, Dr Robert Chu at Sherbourne Road Medical Clinic, with a sore on her left shin. Dr Chu initially considered the sore to be dermatitis and prescribed appropriate treatment.

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

15. By August 2022, the sore remained, and Ms S's lower leg was noted to be swollen. Dr Chu determined the lesion to be suspicious. Believing it may be skin cancer, he took a punch sample biopsy with a 2-millimetre core from the lesion. A few days later, he noted that the left shin lesion and the surrounding skin was red, suggesting possible infection. He prescribed an oral antibiotic.

16. Several days later, Dr Chu noted that the sore was now a non-healing ulcer, 2.5 centimetres in diameter with surrounding redness, which suggested skin infection. The biopsy indicated hyperplastic Bowen's diseased (squamous cell carcinoma). Dr Chu initially planned to wait for the surrounding redness to settle before commencing Ms S on an anti-cancer cream. However, several days later he observed the lesion to be *"heaped up"* and he became concerned that the lesion was an invasive squamous cell carcinoma that required excision.

17. Dr Chu was experienced in the treatment of skin cancer and considered that Ms S would be subject to long waiting times for an outpatient hospital appointment and elective surgery. He subsequently conducted the procedure on 5 September 2022 at the clinic. By this time, there was no redness or swelling of the surrounding skin as Ms S had been on a three-week course of oral antibiotics. Dr Chu administered a local anaesthetic and excised the lesion, using a full thickness skin graft from the left triceps sin region. There were no complications. The left leg and left arm sites were dressed with non-adherent dressings and Ms S was instructed to keep her leg elevated. She was to return to the clinic for review in three days.

18. On 7 September 2022, Ms S complained of feeling unwell. She was taken to Austin Hospital for assessment of a presumed infection.

19. At hospital, Ms S presented with hypoactive delirium, subjective fevers, and lower limb pain in setting of lower limb skin cancer excision/graft procedure two days earlier. She was commenced on antibiotics. The plastic surgery team reviewed Ms S and considered the skin graft was infected, with no role for surgical debridement. Cellulitis from the left ankle to knee was noted.

20. During her admission, Ms S continued to decline despite intravenous antibiotics. She was transitioned to comfort care on [redacted] 2022. She sadly passed away at 3.00am on [redacted] 2022.

Identity of the deceased

21. On [redacted] 2022, Ms S, born [redacted] 1959, was visually identified by her nephew, [redacted].

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

Medical cause of death

23. Forensic Pathologist, Dr Heinrich, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on [redacted] 2022 and provided a written report of his findings dated [redacted] 2022.

24. The post-mortem examination revealed cerebral atrophy, marked peripheral oedema, no obvious osteomyelitis, contracted cystic kidneys, severe mitral valve calcification, coronary artery calcification, basal lung changes, and pleural effusions.

25. Dr Bouwer provided an opinion that the medical cause of death was *"1(a) Sepsis complicating cellulitis following skin cancer excision and skin graft procedure in a woman with multiple medical comorbidities (palliated)".* Dr Bouwer was of the opinion that Ms S's cause of death was due to natural causes.

26. I accept Dr Bouwer's's opinion.

FURTHER INVESTIGATION

Coroners Prevention Unit review

27. As part of my investigation and to assist my understanding as to whether Ms S's death was preventable, I obtained advice from the Coroner's Prevention Unit (**CPU**)[3] regarding the appropriateness of the medical care provided.

28. The CPU explained that Ms S suffered acute deterioration in the emergency department, which was thought to be septic with the likely source the recent operative wound. The CPU explained that Ms S was commenced on appropriate antibiotic in emergency department. However, Ms S responded poorly to treatment and continued to deteriorate, which included

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[3] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

a secondary myocardial injury (troponin rise). She was transitioned to palliative after family discussions.

29. The CPU considered that Dr Chu's management was appropriate. The CPU noted that skin lesion excision and grafting is reasonably undertaken by appropriately experienced general practitioners in their rooms. Preventative (prophylactic) antibiotic therapy is not normally utilised when performing skin lesion surgery on non-infected lesions. The organism in this case (pseudomonas) would not have been prevented by commonly utilised prophylactic antibiotics.

30. The CPU considered Ms S's medical care was reasonable and did not identify any prevention opportunities.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Ms S, born [redacted] 1959;

    (b) the death occurred on [redacted] 2022 at Austin Hospital, 145 Studley Road, Heidelberg, Victoria, from sepsis complicating cellulitis following skin cancer excision and skin graft procedure in a woman with multiple medical comorbidities (palliated); and

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

I convey my sincere condolences to Ms S'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:

[redacted], senior next of kin

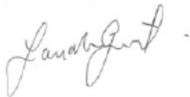
Austin Health

Dr Robert Chu

IDV Disability Services Provider

Senior Constable Glenn Houghton, Victoria Police, Coroner's Investigator

Signature:



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Coroner Sarah Gebert

Date: 26 October 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.