IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 005649

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Danielle Elizabeth Peters
Date of birth:	18 November 1981
Date of death:	1 October 2022
Cause of death:	1(a) SEPSIS SECONDARY TO URETERITIS, PYELONEPHRITIS AND ASPIRATION PNEUMONIA 2 CEREBRAL PALSY
Place of death:	Frankston Hospital, 2 Hastings Road, Frankston, Victoria, 3199
Keywords:	In care, disability, cerebral palsy, sepsis, natural causes

INTRODUCTION

1. On 1 October 2022, Danielle Elizabeth Peters was 40 years old when she died at Frankston Hospital. At the time of her death, Ms Peters lived in specialist disability accommodation in Frankston South, Victoria.

THE CORONIAL INVESTIGATION

2. Ms Peters' 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 due to natural causes.

3. Since 2019, funding for disability services in Victoria has shifted from the Department of Families, Fairness and Housing to the National Disability Insurance Scheme. This shift meant that the definition of person placed in custody or care in section 3(1) of the Act, which included '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', was no longer sufficient to capture the group of vulnerable persons in receipt of disability services.

4. The *Coroners Regulations 2019* (Vic) (**the Regulations**) were amended on 11 October 2022 to create a new category of persons considered to be 'in care' pursuant to Regulation 7, namely a 'person in Victoria who is an SDA[1] resident residing in an SDA enrolled dwelling'.

5. Whilst Ms Peters was not 'in care' within the meaning of the Act at the time of her death on 1 October 2022, she was an SDA resident residing in an SDA-enrolled dwelling and the Regulations were amended only 10 days later. If her death had occurred on or after 11 October 2022, she would be a person 'in care' for the purposes of the Act with additional requirements attaching to the coronial process. These include the need for an inquest unless the coroner considers the death was due to natural causes and a requirement that the findings are published.

6. In the circumstances, I have considered it appropriate for the coronial process to proceed as though Ms Peters was a person 'in care' at the time of her death.

[1] Specialist Disability Accommodation

7. 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.

8. 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.

9. This finding draws on the totality of the coronial investigation into the death of Ms Peters. 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

Circumstances in which the death occurred.

10. Ms Peters' medical history included cerebral palsy, autism, and schizoaffective disorder. She lived in specialist disability accommodation and was noted by her treating clinicians to be normally bedbound.

11. In early September 2022, Ms Peters had an unwitnessed fall which resulted in her sustaining a fracture of the neck of her left femur. She was admitted to Frankston Hospital for surgical correction of the fracture. Ms Peters recovered well after this treatment and she was discharged home on 9 September 2022.

12. On 23 September 2022, Ms Peters was admitted to Frankston Hospital with sepsis related to aspiration pneumonia and pyelonephritis.[3] I note that Ms Peters had been admitted to hospital on several previous occasions with aspiration pneumonia.

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[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.

[3] Long term suprapubic catheter due to cerebral palsy.

13. Ms Peters was treated with intravenous antibiotics and other supportive treatments, including blood transfusions and albumin. Despite the efforts of her treating clinicians, Ms Peters' condition deteriorated. She required increasing oxygen supplementation due to worsening bilateral pleural effusions resulting in significant hypoxia and acidosis. After consultation with her family, Ms Peters was transferred to palliative care and she passed away at Frankston Hospital on 1 October 2022.

Identity of the deceased

14. On 1 October 2022, Danielle Elizabeth Peters, born 18 November 1981, was visually identified by her sister.

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

Medical cause of death

16. A Medical Certificate of Cause of Death was completed by Dr Hui of Peninsula Health which documented Ms Peters' cause of death as '1(a) Sepsis secondary to ureteritis and pyelonephritis, 1(b) Aspiration pneumonia and, 2 Cerebral Palsy'.

17. Forensic Pathologist, Dr Yeliena Baber from the Victorian Institute of Forensic Medicine, conducted an examination on 4 October 2022 and provided a written report of her findings dated 23 December 2022.

18. The post-mortem examination showed findings in keeping with the clinical history. A post-mortem computed tomography (CT) scan showed some cerebral oedema, no injuries of the head or cervical spine, pitting oedema of both lower limbs, metal work to the left indwelling urinary catheter, a subcutaneous pump in the right anterior abdominal wall, a small amount of peritoneal fluid, bilateral large pleural effusions, and a small pericardial effusion. There were also bilateral increased lung markings which Dr Baber noted were most likely due to pneumonia.

19. Dr Baber provided an opinion that the medical cause of death was '1 (a) sepsis secondary to ureteritis, pyelonephritis and aspiration pneumonia with a contributing factor of cerebral palsy.'

20. I accept Dr Baber's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Danielle Elizabeth Peters, born 18 November 1981;

    b) the death occurred on 1 October 2022 at Frankston Hospital, 2 Hastings Road, Frankston, Victoria, 3199, from sepsis secondary to ureteritis, pyelonephritis and aspiration pneumonia with a contributing factor of cerebral palsy; and

    c) the death occurred in the circumstances described above.

22. I am satisfied that the care and medical treatment received by Ms Peters was appropriate.

I convey my sincere condolences to Ms Peters' family.

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:

Neil Peters, Senior Next of Kin

Amber Salter, Peninsula Health

Danielle Kelley, National Disability Insurance Scheme Quality and Safeguards Commission

Senior Constable Edan Luff, Coroner's Investigator

Signature:

Coroner Paul Lawrie

Date : 29 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.