IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006347

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Dorothy June McIntosh
Date of birth:	23 June 1967
Date of death:	4 November 2022
Cause of death:	1(a) Refractory seizures secondary to Lennox-Gastaut Syndrome (palliated)
Place of death:	Golf Links Road Rehabilitation Centre, 125 Golf Links Road, Frankston, Victoria, 3199
Keywords:	Supported Disability Accommodation (SDA), In care, Natural causes

INTRODUCTION

1. On 4 November 2022, Dorothy June McIntosh was 55 years old when she died in the Palliative Care Unit of the Golf Links Road Rehabilitation Centre, a facility operated by Peninsula Health. At the time of her death, Ms McIntosh lived in Supported Disability Accommodation (**SDA**) in Chelsea Heights that was managed by Scope (Aust) Limited (**Scope**), from whom she received National Disability Insurance Scheme (**NDIS**) funded and regulated support. She had resided at the facility for 11 years, which accommodated three other residents.

2. Ms McIntosh's medical history included Lennox-Gastaut Syndrome, intellectual disability, epilepsy, anxiety, depression, moderate dysphagia, constipation, and recurrent urinary tract infections (**UTIs**).

3. Care staff, which included seven permanent staff and agency staff as needed, were trained in epilepsy management specific to Ms McIntosh's care needs and were guided by health management plans developed and regularly reviewed by her treating clinicians. Staff accompanied her to appointments with her treating general practitioner (**GP**), Dr Victor Giang, and other specialist appointments.

4. Ms McIntosh was non-verbal but understood verbal communication. She communicated to care staff through body language, facial expressions and vocalisations, and staff considered she clearly communicated how she was feeling.

5. Ms McIntosh required the use of a wheelchair and shower chair with the assistance of care staff, each of which included a safety belt as a falls prevention measure during seizures. She was assessed as a high risk of falls and required a hoist, sling and the assistance of two staff members for all transfers. Ms McIntosh also required support for all activities of daily living including meals, personal care and continence management, medication administration, and behaviour support.

6. In the 12 months prior to her death, Ms McIntosh's declining health rendered her unable to attend Central Bayside services, which she previously attended three times a week for several years.

7. On 10 November 2021, Dr Giang completed a Comprehensive Health Assessment Plan (**CHAP**) for Ms McIntosh.

8. On 10 December 2021, Ms McIntosh commenced an inpatient admission at Frankston Hospital to investigate what care staff observed to be a significant decline in her condition. Staff noted that she was experiencing increased seizure activity, refusing to get out of bed, and becoming increasingly reluctant to eat, drink, or receive assistance with personal care needs. During her admission, treating clinicians were unable to identify a medical cause for Ms McIntosh's decline. She was ultimately discharged with a referral to the Victorian Dual Disability Service (**VDDS**).

9. On 18 January 2022, Ms McIntosh was reviewed by a VDDS clinician, who recommended that she engage with a community psychiatrist.

10. Following a medication change recommended by her neurologist in March 2022, care staff observed some improvements in Ms McIntosh's moods and oral intake, though she remained unable and unwilling to get out of bed.

11. In early May 2022, Ms McIntosh was admitted to Frankston Hospital for treatment of pneumonia and associated delirium.

12. In June 2022, Ms McIntosh's brother, Maxwell McIntosh, was consulted about documenting her end-of-life wishes in an Advanced Care Plan.

13. In July 2022, Ms McIntosh's anti-seizure medication was increased due to increased seizure activity. At around this time, staff observed a deterioration in her swallowing ability and she was reviewed by Dr Giang and a speech pathologist. She was also referred to the Melbourne Dental Clinic to assess whether dental pain was a factor in her reduced oral intake.

14. On 2 August 2022, Ms McIntosh was referred to Peninsula Home Hospice by Dr Giang. Throughout August 2022, she suffered increased seizure activity and underwent two hospital admissions.

THE CORONIAL INVESTIGATION

15. Ms McIntosh's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Ms McIntosh's death was reportable as she was a person placed "*in care*" under section 4(2)(c) of the Act.[1] This category of deaths are reportable to ensure independent scrutiny of the circumstances given the vulnerability of the

[1] She was an SDA resident residing in an SDA enrolled dwelling before the time of her death; Reg 7(1)(d), *Coroners Regulations 2019*.

deceased and the level of level of power and control exercised by those who care for them. If such deaths occur as a result of natural causes, a coronial investigation must take place, but the holding of an inquest is not mandatory.

16. 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.

17. 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.

18. This finding draws on the totality of the coronial investigation into the death of Ms McIntosh, including evidence contained in her medical records, information from the NDIS and Scope, and a medical deposition completed by Peninsula Health, Mount Eliza Rehabilitation. While 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

19. Throughout September 2022, Ms McIntosh had four hospital admissions for increasing seizure activity. She was assessed by Peninsula Home Hospice, who noted her functional decline and increased distress and impulsivity. Ms McIntosh is recorded as receiving sponge baths in bed due to her aggression and associated manual handling risk with hoist transfers. She commenced music therapy at around this time, during which she appeared calm and engaged.

[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.

20. Following a neurology review in September/October 2022, a Goals of Care Plan was developed in collaboration with Ms McIntosh's treating palliative care team, her brother, and Scope care staff. Several protocols were developed in the form of a seizure management plan, which set out the treatment pathways for Ms McIntosh if her seizures did not improve following administration of certain anti-seizure medication. On the advice of her treating palliative care doctor, Ambulance Victoria agreed to attend and administer subcutaneous anti-seizure medications if required.

21. On 1 November 2022, Ms McIntosh was admitted to the Palliative Care Unit of the Golf Links Road Rehabilitation Centre due to increasingly uncontrolled seizures as a result of her continued refusal of medications. On admission, she continued to refuse oral medications and she was assessed as unsafe for oral intake due to her reduced conscious state.

22. On the morning of 4 November 2022, Ms McIntosh's midazolam infusion was increased due to ongoing seizures, however there was little improvement and she subsequently passed away at 10.45am.

Identity of the deceased

23. On 4 November 2022, Dorothy June McIntosh, born 23 June 1967, was visually identified by her brother, Maxwell McIntosh.

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

Medical cause of death

25. Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine (**VIFM**) examined Ms McIntosh on 7 November 2022 and provided a written report of her findings dated 9 November 2022.

26. Dr Zhou reviewed a post-mortem computed tomography (**CT**) scan, which revealed cerebral oedema and focal coronary artery calcification. There was no evidence of any acute skeletal trauma, nor any external injuries, that would have caused or contributed to death.

27. Dr Zhou provided an opinion that the medical cause of death was 1(a) Refractory seizures secondary to Lennox-Gastaut Syndrome (palliated). She considered that Ms McIntosh's death was due to natural causes.

28. I accept Dr Zhou's opinion.

CONCLUSION

29. Having carefully considered the available evidence, I am satisfied that Scope staff were attentive to her changing needs as her condition gradually deteriorated throughout the 12 months prior to her death. I am therefore satisfied that the care Ms McIntosh received in the period proximate to her death was reasonable and appropriate.

30. As noted above, Ms McIntosh's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before her death, she was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Ms McIntosh died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an Inquest into her death.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Dorothy June McIntosh, born 23 June 1967;

    b) the death occurred on 4 November 2022 at Golf Links Road Rehabilitation Centre, 125 Golf Links Road, Frankston, Victoria, 3199, from refractory seizures secondary to Lennox-Gastaut Syndrome (palliated); and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Ms McIntosh'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:

Maxwell McIntosh, Senior Next of Kin

National Disability Insurance Scheme Quality and Safeguards Commission

Leading Senior Constable Kellie Williams, Coroner's Investigator

Signature:

Coroner David Ryan

Date :08 September 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.