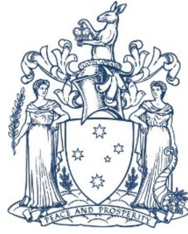

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2020 004422**

# FINDING INTO DEATH WITHOUT INQUEST

*Form 38 Rule 63(2)*

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

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| Findings of: | Coroner Simon McGregor |
| Deceased: | Dana John Walter |
| Date of birth: | 30 May 1952 |
| Date of death: | 11 August 2020 |
| Cause of death: | 1(a) Aspiration pneumonia<br>1(b) Cerebral palsy |
| Place of death: | Western Health, Sunshine Hospital, 176 Furlong Road, St Albans, Victoria, 3021 |

Key words: Disability accommodation services, dysphagia, aspiration, Sunshine Hospital, natural causes, Coroners Prevention Unit, Disability Services Commissioner, DSC, COVID

## INTRODUCTION

1. On 11 August 2020, Dana John Walter was 68 years old when he died at Sunshine Hospital in St Albans. At the time of his death, Dana lived at 15 Stoke Street, Deer Park, (**Stoke Street**) a Disability Accommodation Services residence with services provided by Home@Scope.[1]

2. Dana's medical history included cerebral palsy, epilepsy, intellectual disability, anxiety, reflux, dysphagia, severe asthma, nocturnal hypoxia, osteoporosis, folate deficiency, hypercholesteraemia, hypothyroidism, aspiration pneumonia, and senile purpura. Dana was bed bound and required a wheelchair for mobility.[2]

## THE CORONIAL INVESTIGATION

3. Dana'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. The death of a person in care or custody is a mandatory report to the Coroner even if the death appears to have been from natural causes.

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 an officer to be the Coroner's Investigator for the investigation of Dana'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.

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[1] Scope is a provider of disability support services throughout Australia. Home@Scope is a subsidiary of Scope that provides Supported Independent Living and Short Term Accommodation and Assistance services to facilities previously provided by the Victorian Government.

[2] Coronial Brief, statement of Dr John He dated 18 December 2020, page 2.

7. This finding draws on the totality of the coronial investigation into the death of Dana John Walter 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.[3]

8. In considering the issues associated with this finding, I have been mindful of Dana's basic human rights to dignity and wellbeing, as espoused in the Charter of Human Rights and Responsibilities Act 2006, in particular sections 8, 9 and 10.

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

### Circumstances in which the death occurred

9. Dana was an extrovert and enjoyed interacting with others. He also enjoyed visits from family and friends, singing, watching DVDs and was an avid subscriber to Readers Digest. Dana had a close relationship with his family and had contact with them two to three times a week. Dana's sister, Angela, made decisions on his behalf in relation to complex matters and was his medical treatment decision maker and financial administrator.[4]

10. Due to the severity of his dysphagia, Dana was at high risk of aspiration and choking while eating or drinking. He was given thickened fluids and up-to-date mealtime support and aspiration pneumonia health management plans were in place at the time of his death.[5]

11. Dana had been living at 15 Stroke Street in Deer Park since 2005. Before this, he was a resident of Kew Cottages until its closure. Due to his fragile condition, Dana was at a high risk of chest infections and had been hospitalised several times due to episodes of aspiration pneumonia however since moving to Deer Park staff noted a significant improvement in Dana's general health and wellbeing despite his complex health issues.[6]

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[3] 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.

[4] DSC Report, statement of Samantha Dooley dated 6 May 2021, pages 1-2.

[5] DSC Report, statement of Samantha Dooley dated 6 May 2021, page 2.

[6] Coronial Brief, statement of Kathryn Hare dated 19 February 2021, page 2.

12. Dana enjoyed relatively stable health until 23 July 2020 when he developed shortness of breath. His General Practitioner (**GP**), Dr John He, attended his residence at the behest of Dana's carer and diagnosed Dana with a severe asthma attack which was subsequently managed with salbutamol (Ventolin) and steroid therapy.[7]

13. On 24 July 2020, Dr He re-assessed Dana and requested that he be transferred to the Sunshine Hospital Emergency Department (**ED**) for severe asthma exacerbation. Dana was subsequently admitted to Sunshine Hospital, treated for aspiration pneumonia and was discharged back to his home on 8 August.[8]

14. On 11 August 2020, group home staff observed Dana was lethargic and an audible wheezing and crackling noise could be heard from his lungs.[9] Dr He conducted an urgent assessment of via telehealth of Dana in the context of a deteriorating respiratory status. Dr He noted that Dana appeared to be unwell, in respiratory distress, with audible noisy breathing. Concerned that Dana would deteriorate, Dr He directed Dana's carer to contact an ambulance immediately which attended and transported Dana back to Sunshine Hospital ED. [10]

15. On his arrival at the ED at 9.18am, Dana was found to be in acute respiratory distress, severely hypotensive, with significantly low oxygen saturations and metabolic derangement. He was commenced on the antibiotics piperacillin and tazobactam, intravenous fluids, deep-vein thrombotic prophylaxis, and hydrocortisone however Dana remained profoundly hypoxic with persistent hypoglycaemia despite treatment.[11]

16. Discussions were held between clinical staff at Sunshine Hospital and Dana's family who decided that the best course of action would be for Dana to receive symptomatic care only. Dana passed away peacefully at 8.07pm.[12]

**Identity of the deceased**

17. On 13 August 2020, Dana John Walter, born 30 May 1952, was visually identified by his brother-in-law, Noel Sherry.

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

[7] Coronial Brief, statement of Dr John He dated 18 December 2020, page 1.
[8] Coronial Brief, statement of Dr John He dated 18 December 2020, page 1.
[9] DSC Report, statement of Samantha Dooley dated 6 May 2021, page 2.
[10] Coronial Brief, statement of Dr John He dated 18 December 2020, pages 1-2.
[11] Sunshine Hospital Medical E-Deposition dated 12 August 2020, page 1.
[12] DSC Report, statement of Samantha Dooley dated 6 May 2021, page 2.

**Medical cause of death**

19. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 17 August 2020 and provided a written report of his findings dated 18 August 2020.

20. The post-mortem examination revealed findings in keeping with the clinical history.

21. Examination of the post-mortem computed tomography scan (**CT**) scan demonstrated a large right sided cerebral hypodensity, atrophic, dilated ventricles, no skull fractures or intracranial haemorrhage. There were bilateral increased lung markings and possible pleural effusions consistent with history of aspiration. A dilated bowel was noted but no fluid levels and no free gas or fluid.

22. Toxicological analysis was not indicated.

23. Dr Beer provided an opinion that the medical cause of death was 1 (a) aspiration pneumonia and was due to natural causes.

24. I accept Dr Beer's opinion.

## FAMILY CONCERNS

25. On 18 March 2022, Dana's siblings wrote to the court to express several concerns, including fears that Dana's anxiety and respiratory distress were unduly exacerbated by his transfer to Sunshine Hospital without adequate reassurance from staff or patient-specific documentation detailing his individual care needs, as well as an apparent lack of adequately trained staff familiar with Dana's individual needs at his care facility following his return on 8 August.

## REVIEW OF CARE

### CPU review

26. To assist with my investigation into Dana's death and to address the concerns communicated to the court by Dana's family, I requested that the Coroners Prevention Unit (**CPU**) [13] conduct a review of the care provided to Dana during his time at Stoke Street.

[13] 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

27. The CPU noted that individuals with a history of aspiration pneumonia are at a constant risk of further episodes of aspiration. Prevention strategies (such as thickened fluids) may decrease the chance of reoccurrence but can never fully prevent them – much like a mobility frame cannot completely eliminate the chance of an individual having a fall. Like each fall, every episode of aspiration pneumonia leaves the individual weaker and increases their susceptibility to succumbing to the next episode.

28. With regards to the decision to transfer Dana to hospital, it was noted that Dr He was appropriately contacted by Stoke Street staff, and then assessed him on both occasions prior to the decision being made to transfer Dana to hospital. The CPU investigator noted that staff (and doctors) consider whether an individual requires care that cannot be adequately provided at their residence whilst balancing their desire to remain in a familiar environment.

DSC review

29. On 14 August 2020, the Disability Services Commissioner (**DSC**) commenced an investigation under section 128I of the *Disability Act 2006* (Vic), into the services provided to Dana. A review was conducted by Home@Scope and was provided to the DSC for assessment. The investigation did not identify any issues relating to the services provided to Dana by Home@Scope during his time at the Deer Park residence.

## FINDINGS AND CONCLUSION

30. Disability care is often very fragmented, especially during the COVID-19 pandemic where nursing homes and care facilities relied on agency staff to "fill the gaps" left by staff being furloughed due to the pandemic. The ongoing situation frequently resulted in staff providing care who were unfamiliar with residents' individual needs. Whilst I agree that this approach suboptimal, given the surrounding circumstances, it is a product of nursing homes and care facilities "doing the best they can" in very challenging times.

31. After careful review of the evidence, including the DSC report which I note did not identify any deficiencies in Dana's care, it is reasonable to conclude that the care that he received was reasonable and appropriate given the circumstances and his history of recurrent aspiration.

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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.

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

   a) the identity of the deceased was Dana John Walter, born 30 May 1952;

   b) the death occurred on 11 August 2020 at Western Health, Sunshine Hospital, 176 Furlong Road, St Albans, Victoria, 3021, from aspiration pneumonia; and

   c) the death occurred in the circumstances described above.

I convey my sincere condolences to Dana'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:

Susanne Sherry, Senior Next of Kin

Dr John He

Samantha Dooley, Disability Services Commissioner

Senior Constable Liam Barry, Victoria Police, Coroner's Investigator

Signature:

**CORONER SIMON McGREGOR**

**CORONER**

Date: 16 June 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 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.