IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 5588

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Simon McGregor, Coroner
Deceased:	Pamela Mary Bell
Date of birth:	16 August 1955
Date of death:	5 November 2018
Cause of death:	**1(a) Aspiration of gastric contents and acute renal failure complicating intestinal pseudo-obstruction and urinary retention, in a woman with hyponatraemia**
Place of death:	Goulburn Valley Health Graham Street, Shepparton, Victoria

HIS HONOUR:

THE CORONIAL INVESTIGATION

1. Pamela Mary Bell was a 63-year-old woman who lived in shared accommodation supported by the Department of Health and Human Services at the time of her death.

2. Ms Bell's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as she appeared to be a '*person placed in custody or care*'.[1]

3. 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.

4. 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.

5. The Coroner's Investigator, Detective Senior Constable Shaun-Maree Brock, prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist, a treating clinician and the investigating officer.

6. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

7. I have based this finding on these materials. In the coronial jurisdiction facts must be established on the balance of probabilities.[2] 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.

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[1] *Coroners Act 2008* s 4..

[2] This is 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.

8. In considering the issues associated with this finding, I have been mindful of Ms Bell'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. Ms Bell lived in shared accommodation for people with disabilities which was managed by the Department of Health and Human Services. She had a supportive family and had been particularly supported by her brother Barry Bell and her sister-in-law Joyce Bell.[3]

10. Ms Bell had an intellectual disability and had reportedly been deprived of oxygen during her birth. In 1958 she was diagnosed with epilepsy, and she was treated for this throughout her life. At the time of her death, she was prescribed the anticonvulsant carbamazepine.[4]

11. She suffered from chronic hyponatraemia (low sodium levels), which is a known side effect of carbamazepine.[5]

12. In June 2018 Ms Bell had an incident of paralysis of the left side of her body with a facial droop on the right side. She recovered control of her left side, but the facial droop remained. Medical staff determined that the symptoms might have been caused by absence seizures, although they could not entirely rule out the possibility of a stroke.[6]

13. Around October 2018 Ms Bell moved from her shared accommodation at Glenda Anne Court in Mooroopna to a different shared home at Craigmuir Drive. Toward the end of the month, Ms Bell was reportedly '*off her food*' and not feeling well. According to her brother Barry, she loved her food so when she refused food it was clear she was sick.[7]

14. On 30 October 2018 she was taken to Goulburn Valley Health with acute hyponatraemia and an acute confusional state. Staff there ceased her carbamazepine and replaced it with other antiepileptic drugs.[8]

15. Ms Bell was given a fluid-restricted diet and her hyponatraemia initially improved, but it soon worsened again and her medication was changed again.[9]

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3 Statement of Barry Bell dated 4 November 2019, Coronial Brief; Goulburn Valley Health Medical Records.
4 Statement of Barry Bell dated 4 November 2019, Coronial Brief; Goulburn Valley Health Medical Records.
5 Statement of Dr Sean Ng Kwet Chi Ng Ying Kin dated 2 December 2019, Coronial Brief.
6 Goulburn Valley Health Medical Records, Discharge Summary dated 22 June 2018.
7 Statement of Barry Bell dated 4 November 2019, Coronial Brief.
8 Statement of Dr Sean Ng Kwet Chi Ng Ying Kin dated 2 December 2019, Coronial Brief.

16. On 5 November 2018 Ms Bell began refusing care and food. She began to vomit small amounts of brownish fluid. Goulburn Valley Health staff informed Ms Bell's family that if she continued to deteriorate there was little they could do.[10]

17. At around 12.15pm Ms Bell had what appeared to be a possible seizure and began gasping. Shortly after that she stopped breathing and there was '*coffee ground fluid*' in her throat.[11]

18. Ms Bell passed away at 12.40pm, before medical staff could determine the cause of her deterioration.[12]

Identity of the deceased

19. On 5 November 2018, Barry Bell visually identified Pamela Mary Bell, born 16 August 1955.

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

Medical cause of death

21. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine **(VIFM)**, conducted an autopsy on Ms Bell and provided a written report of his findings. Post mortem examination revealed aspirated gastric contents in the lungs, and markedly distended stomach, small bowel and large bowel. However, no mechanical cause for intestinal obstruction was found.

22. Dr Young commented that '*an intestinal pseudo-obstruction occurs when there is an apparent blockage of the small and/or large intestine, for which no anatomical cause is apparent. Causes may include some medications, previous abdominal surgery, infection, or muscle or nerve diseases. Complications of pseudo-obstruction include metabolic and fluid imbalances, and pressure effects on the diaphragm leading to aspiration of gastric contents from the stomach to the lungs.*'

23. He noted that fluid shifts from pseudo-obstruction can lead to renal failure, as shown by elevated urea and creatinine. Ms Bell's post mortem urea and creatinine levels were elevated compared to ante mortem results from 3 November 2018, indicating an acute process.

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[9] E-medical deposition of Dr Sean Ng Kwet Chi Ng Ying Kin dated 5 November 2018, Coronial Brief.
[10] Statement of Dr Sean Ng Kwet Chi Ng Ying Kin dated 2 December 2019, Coronial Brief.
[11] E-medical deposition of Dr Sean Ng Kwet Chi Ng Ying Kin dated 5 November 2018, Coronial Brief.
[12] E-medical deposition of Dr Sean Ng Kwet Chi Ng Ying Kin dated 5 November 2018, Coronial Brief.

24. Dr Young's autopsy also revealed gastric stress ulcers, which would explain the '*coffee ground*' fluid which was observed shortly before her death. These stress ulcers are non-specific and can indicate stress from any cause.

25. There was no post mortem evidence of any injuries which may have caused or contributed to death.

26. Dr Young concluded that a reasonable cause of death was:

> **1(a) Aspiration of gastric contents and acute renal failure complicating intestinal pseudo-obstruction and urinary retention, in a woman with hyponatraemia**

FAMILY CONCERNS

27. Shortly after Ms Bell's death, but before her cause of death was clear, her brother noted that Ms Bell had been assaulted around a year before her death by a fellow resident. He enquired whether there was any indication that an assault may have been involved in her death.

28. Based on Dr Young's report, I am satisfied that Ms Bell's death was due to natural causes and that no assault or other injury contributed to it.

DISABILITY SERVICES COMMISSIONER INVESTIGATION

29. Following Ms Bell's death, the Disability Services Commissioner (**DSC**) investigated the care she received in the time leading up to her death. This investigation noted issues with the care provided.

30. I have been provided a copy of the DSC's report, which includes actions to be taken by the Department of Families, Fairness and Housing (**DFFH**) and by the disability services provider Aruma.

31. I am satisfied that the DSC's investigation has appropriately addressed the issues and that DFFH and Aruma will take appropriate measures to remedy them.

32. I do not consider, to the requisite degree of satisfaction under the *Briginshaw* standard, that any of these identified issues were causally related to Ms Bell's death. As such, and as section 7 of the *Coroners Act 2008* requires me to avoid unnecessary duplication of inquiries and investigations, I do not consider it appropriate for me to further investigate these matters or make findings in relation to them.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Pamela Mary Bell, born 16 August 1955;

    (b) the death occurred on 5 November 2018 at Goulburn Valley Health, Graham Street, Shepparton, Victoria from aspiration of gastric contents and acute renal failure complicating intestinal pseudo-obstruction and urinary retention, in a woman with hyponatraemia and;

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

34. I convey my sincere condolences to Ms Bell's family for their loss.

Pursuant to section 73(1B) of the *Coroners Act 2008*, I direct that a copy of this finding be published on the Internet.

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

Barry Bell, Senior Next of Kin.

Detective Senior Constable Shaun-Maree Brock, Coroner's Investigator

Signature:

SIMON McGREGOR

CORONER

Date: 19 July 2021

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