IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 5939

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Jacqui Hawkins
Deceased:	Simone Grigg
Date of birth:	24 August 1983
Date of death:	24 November 2017
Cause of death:	I(a) Pneumonia in a woman with intellectual disability and asthma
Place of death:	Bendigo Hospital, 100 Barnard Street, Bendigo, Victoria, 3550

SUMMARY

1. Simone Grigg was 34 years old when she died. Ms Grigg was a resident at a Department of Health and Human Services (**DHHS**) Shared Supported accommodation in Eaglehawk. She had lived in DHHS care since turning 18 years old. She regularly attended Amicus Disability Services (**Amicus**) five days a week in Bendigo.

2. Ms Grigg had an intellectual disability and autism. She was diagnosed with epilepsy and asthma, however she had not had a recorded seizure for a number of years. Ms Grigg was non-verbal and communicated through use of simple sign language techniques, gestures, facial expressions and vocalisations. She enjoyed bus trips, outings, listening to music, playing with her beanie toys, longs walks with staff and looking through catalogues. Ann-Maree Davis, the Chief Executive Officer of Amicus described Ms Grigg to have a great sense of humour, be lively, energetic and an active person who was likeable and determined.

3. Ms Grigg died on 24 November 2017 at the Bendigo Hospital.

4. Ms Grigg's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008.*

THE PURPOSE OF A CORONIAL INVESTIGATION

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame or determine criminal or civil liability.[1]

6. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[2] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[3]

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1 In the coronial jurisdiction facts must be established on the balance of probabilities 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.

2 *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.

3 *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

7. In writing this Finding, I do not purport to summarise all the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

8. On Tuesday 21 November 2017 staff at her group home administered Ms Grigg with medication for symptoms of hay fever. Amicus staff noted she appeared unwell when they attended to pick her up. At approximately 12pm a carer noticed Ms Grigg was pale and short of breath. Amicus staff contacted DHHS and a decision was made to return Ms Grigg to her residential care facility. Upon arrival her condition deteriorated and an ambulance was called.

9. At approximately 1.43pm Ambulance paramedics arrived and assessed Ms Grigg. She was transported to Bendigo Hospital in acute respiratory distress. Once she arrived at hospital, she was sedated and administered a breathing tube, which improved her oxygen levels. She was administered antibiotics and moved to the Intensive Care Unit (ICU).

10. On 22 November 2017 at some time in the morning Ms Grigg's oxygen levels dropped to dangerously low levels, which required manual ventilation. She was treated with a presumed chest infection. The next day her oxygen levels dropped dramatically again and she was administered manual ventilation. At approximately 12.20pm Dr Jan Yeung conducted a bronchoscopy to see if there were any blockages in her lungs – but was unable to locate any. At 2pm the family were advised to come and see Ms Grigg due to her poor prognosis. After family discussions, she was palliated.

11. Ms Grigg passed away on 24 November 2017 at 12.50pm in the presence of her family.

IDENTITY OF THE DECEASED

12. Ms Grigg was visually identified by her mother, Lorna Grigg on 24 November 2017. Identity was not in issue and required no further investigation.

MEDICAL CAUSE OF DEATH

13. On 27 November 2017, Dr Gregory Young, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed an external examination on the body of Ms Grigg and reviewed the Form 83 Victoria Police Report of Death, the e-medical deposition and the post mortem computed tomography (**CT**) scan.

14. The external examination showed some bruises on the right forearm and left thigh, but there were no unexpected signs of trauma. A post mortem CT scan showed bibasal lung

consolidation. No other significant pathology was identified. The CT scan was consistent with lower respiratory tract infection (pneumonia) causing death.

15. Dr Young provided an opinion that the medical cause of death was I(a) *pneumonia in a woman with intellectual disability and asthma* and was due to natural causes. I accept and adopt this as the cause of death.

DISABILITY SERVICES COMMISSIONER

16. The Disability Services Commissioner (**DSC**) has oversight of certain deaths of persons with disability who are receiving disability supports at the time of their death, including Ms Grigg.

17. On 10 May 2019, Anthony Kolmus, Deputy Commissioner of DSC wrote to the court to advise that the DSC had finalised its investigation following the death of Ms Grigg. The DSC investigation identified the following concerns with the adequacy of the provision of disability services to Ms Grigg.

18. In relation to Amicus:

- Failure to seek urgent medical attention.

19. In relation to DHHS:

- Inadequate management of deteriorating health.
- Undocumented and unauthorised use of restrictive practices.
- Failure to update Ms Grigg's Behaviour Support Plan.
- Inadequate incident reporting.
- Inadequate behaviour support strategies.
- Inadequate documentation and implementation of Ms Grigg's goals.
- Failure to provide a clear communication assessment with corresponding communication aids.
- Inadequate documentation and monitoring of health concerns and medical recommendations.
- Failure to seek medical consent from Ms Grigg's family.

20. The DSC issued Notice to Take Action under the *Disability Act 2006* (Vic) to DHHS and Amicus to address identified issues. Given the concerns raised by the DSC, I requested a statement from DHHS and Amicus to advise what measures have been implemented since Ms Grigg's death.

21. DHHS advised that after Ms Grigg's death DHHS transferred their management to Possability, a community service organisation. DHHS worked with Possability to develop an Improvement Plan, including the following actions:

- In May 2019, an audit was undertaken in relation to the supports provided to residents at the Eaglehawk accommodation service. This included the use and recording of restrictive practices (where applicable), Behaviour Support Plans, communication assessments and documentation of client goals.
- In May and June 2019, staff were provided with training on appropriate use of restrictive practices, management of deteriorating health, promoting positive behaviour and incident reporting requirements.
- Processes have been implemented for the review of client goals through the Key Worker Reports, which are reviewed and completed on a monthly basis,
- All non-critical logs are recorded electronically and submitted to the House Supervisor and Operations manager for review and action.
- The implementation of a formalised process of communicating with day program providers with the introduction of a handover sheet that includes health presentation and medical updates.

22. The Residential Services Practice Manual was also updated in August 2018 in relation to consent to medical treatment and provided to Possability.

23. Ms Davis from Amicus reported that they were not provided with timely, adequate and accurate medical/health information regarding Ms Grigg. She advised that Amicus staff were advised that Ms Grigg was drowsy due to a change of medication. This made it "*extremely difficult for Amicus staff to accurately identify [Ms Grigg's] deteriorating health and accordingly, make an informed decision as to the care or medical assistance she required*." Amicus were also not told that Ms Grigg had been given hay fever medication – which could have masked early signs of distress.

24. Ms Davis advised that once Amicus staff became concerned with Ms Grigg's deteriorating health, they contacted DHHS staff to inform them that they would meet at the hospital,

however DHHS staff advised them to take Ms Grigg back to the home. As part of their response to the DSC Notice to Take Action Amicus developed an Identifying and Managing Deteriorating Health Policy for which staff received training.

25. Amicus has also introduced a Centralised Pathways service and process to oversee and support a participant's journey with Amicus. This will ensure all relevant and up-to-date health plans and information are gathered from relevant stakeholders. Amicus has developed a High Intensity Support Manual/ Practice guide to ensure complex health supports are identified and delivered safely. Amicus has also implemented a Competency framework to ensure their staff are skilled. Amicus also require their staff to maintain first aid training as a condition of employment.

26. Having considered the evidence I am satisfied that no further investigation is required.

FINDINGS

27. Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

    (a) the identity of the deceased was Simone Grigg, born on 24 August 1983;
    (b) Ms Grigg died on 24 November 2017 from I(a) *pneumonia in a woman with intellectual disability and asthma*; and
    (c) in the circumstances described above.

28. I wish to express my sincere condolences to Ms Grigg's family. I acknowledge the grief and devastation that you have endured as a result of your loss.

29. Pursuant to section 73(1) of the Coroners Act, I order that this finding be published on the internet.

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

The family of Ms Grigg;

Disability Services Commissioner;

DHHS;

Amicus; and

Information recipients.

Signature:

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JACQUI HAWKINS
Coroner
Date: 13 July 2021