IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 6348

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Sarah Gebert, Coroner
Deceased:	MA
Date of birth:	22 May 1972
Date of death:	22 November 2020
Cause of death:	1(a) *Pleural Effusion with Lung Infection*. Contributing Factors: *Acquired Brain Injury*
Place of death:	Wimmera Base Hospital, 83 Baillie Street, Horsham, Victoria
Other matters	*Person placed in custody or care*, *natural causes*

INTRODUCTION

1. MA, born on 22 May 1972, was 48 years of age at the time of her death. She was survived by her older siblings [redacted] [redacted] and [redacted]. MA parents [redacted] and [redacted] predeceased her.

2. MA lived in a supported accommodation group home in Horsham, managed by Melba Support Services, since 2006. She required 24 hour a day full time care and was supported by Disability Development Service Officers. She had suffered a hypoxic brain injury as a result of a swimming accident when she was a teenager.

3. MA was very social and loved to be around people. She enjoyed listening to music, watching TV and talking books. She also enjoyed painting, being told jokes and having poetry read to her.

4. MA had an acquired brain injury, a profound intellectual disability and quadriplegia. Her physical disabilities caused her to develop a windswept posture, resulting in muscle deterioration and spasticity. These physical changes caused MA considerable pain and discomfort for which she required ongoing pain management.

5. MA had a number of medical conditions including constipation, an ear disease, dysphagia, incontinence, pressure sores and a suspected mental illness. Due to her dysphagia, MA was at high risk of aspiration and choking. As a result, she was provided with minced blended meals orally, while fluids were administered through a percutaneous endoscopic gastrostomy (**PEG**) feeding tube. An up-to-date mealtime support plan and PEG care plan was in place at the time of her death.

6. MA had complex communication needs and was only able to communicate using three distinct words, vocalisations and facial expressions. A comprehensive communication assessment was undertaken and a communication dictionary was developed by a speech pathologist to support MA's capacity to communicate.

7. MA was restricted by her physical disabilities, and she used a wheelchair for mobility purposes. Due to a history of painful, irregular menstrual periods and difficulties in maintaining hygiene and skin integrity, a chemical routine to suppress menstruation was put in place. A behaviour support plan for menstrual suppression was developed and was current at the time of her death.

8. The Office of the Public Advocate (**OPA**) was her medical treatment decision maker.

9. In the early hours of 22 November 2020, MA passed away at the Wimmera Base Hospital having been admitted on 8 November 2020.

THE CORONIAL INVESTIGATION

10. MA's death was reported to the coroner as she was considered to be *a person placed in custody or care* under section 3(1) of the *Coroners Act 2008* **(the Act)** and so fell within the definition of a reportable death under the Act.

11. 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.

12. 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.

13. Victoria Police assigned Senior Constable Anthony Zivkovic (**SC Zivkovic**) to be the Coroner's Investigator for the investigation into MA's death. SC Zivkovic conducted inquiries on my behalf, including taking statements from witnesses and submitting a coronial brief of evidence. The brief includes statements from MA's sister, Melba Support Services employees including Dean Welsh (Operations Manager for the Wimmera Central Highland – Supported Independent Living Program) and Antony Dunn (Melba Support Services Manager), her General Practitioner (**GP**) Dr David Wilson from Lister House Medical Clinic, treating clinicians from the Wimmera Base Hospital and the forensic pathologist who examined her.

14. MA's medical records were also obtained from the Wimmera Health Care Group.

15. As advice was received from the pathologist that MA's death was due to natural causes[1], a mandatory inquest was not required.[2]

[1] Paragraph 25.
[2] S52(3A) of the Act.

Disability Services Commissioner

16. I also considered the advice regarding the *Investigation into disability services provided by Melba Support Services to Ms MA* prepared by the Disability Services Commissioner (**DSC**) which was provided to the Court. The DSC investigation was conducted under the auspices of the *Disability Act 2006* with a different scope to that of a coronial investigation (although it can overlap). Consistent with the Act, a coroner should liaise with other investigative bodies to avoid unnecessary duplication and expedite investigations.[3]

17. This finding draws on the totality of the coronial investigation into MA's death, 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.[4]

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

Circumstances in which the death occurred

18. On 7 November 2020, group home staff observed that MA had laboured breathing. Soon after, her GP, Dr Wilson was called and he attended the group home to examine her. Dr Wilson advised that MA should be taken immediately to Wimmera Base Hospital. Tests subsequently conducted at the Hospital revealed that she had a build-up of fluid on the left lung.

19. Later that day, MA was returned to her group home with a GP follow-up plan and further tests scheduled for 9 November 2020. However, MA's health continued to deteriorate overnight and the following morning, being 8 November 2020, she was taken back to hospital and admitted. Over the next five days, MA received medical treatment to which she did not respond, and her health deteriorated. Following a discussion between the hospital and OPA, it was agreed that MA be moved to a palliative pathway with comfort care measures.

20. Eight days following her admission to palliative care, MA passed away on 22 November 2020.

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[3] S.7 of the Act.

[4] 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.

Identity of the Deceased

21. On 22 November 2020, Dean Welsh visually identified MA born 22 May 1972, who he had known for 16 years

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

Medical cause of death

23. Specialist Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 23 November 2020 and provided a written report of his findings dated 27 November 2020.

24. Dr Bedford provided an opinion that the medical cause of death was 1(a) *Pleural Effusion with Lung Infection*. Contributing Factors: *Acquired Brain Injury*.

25. Dr Bedford stated that on the information available to him, he was of the opinion that MA's death was due to *natural causes*.

26. I accept Dr Bedford's opinion.

FINDINGS AND CONCLUSIONS

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

    (a) the identity of the Deceased was MA, born 22 May 1972;

    (b) the death occurred on 22 November 2020 at Wimmera Base Hospital, 83 Baillie Street, Horsham, Victoria from 1(a) *Pleural Effusion with Lung Infection*. Contributing Factors: *Acquired Brain Injury*; and

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

28. I convey my sincere condolences to MA's family for their loss.

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

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

    [redacted], senior next of kin

    Senior Constable Anthony Zivkovic, Victoria Police, Coroner's Investigator

Signature:

SARAH GEBERT

Date: 30 November 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.