IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 004764

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Tracey Lee Cooke
Date of birth:	29 June 1965
Date of death:	29 August 2020
Cause of death:	1(a) aspiration pneumonia
Place of death:	Footscray Hospital, 160 Gordon Street, Footscray, Victoria, 3011
Keywords:	Aspiration Pneumonia; Death in State Care; Disability Services Commissioner

INTRODUCTION

1. On 29 August 2020, Tracey Lee Cooke was 55 years old when she died at the Footscray Hospital from aspiration pneumonia. At the time of her death, Ms Cooke lived at a group home run by Home@Scope in Deer Park that had previously been operated by the Department of Health and Human Services. Ms Cooke had resided at the group home for 15 years prior to her death and lived with four other residents at the time of her death.

2. Ms Cooke suffered a brain injury as a child and had a severe intellectual disability as a result. She had also been diagnosed with Parkinson's disease, ataxia, epilepsy, dysphagia (difficulty swallowing) and vitamin D deficiency. Ms Cooke was treated for depression and anxiety which was associated with her Parkinson's disease.

3. Ms Cooke loved the colour pink. She enjoyed going to the local beauty salon, being outside in the garden, and music. Ms Cooke was regularly visited by her brother, Stephen Cooke and her sister in-law, Carol Cooke.

4. Ms Cooke had complex communication needs. She knew some words but primarily communicated with gestures and facial expressions. As her Parkinson's disease worsened, her ability to use words at all for communication lessened.[1]

THE CORONIAL INVESTIGATION

5. Ms Cooke's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Generally, reportable deaths are those deaths which are unexpected, unnatural or violent or result from accident or injury. However, in the case of a person such as Ms Cooke who was placed in care immediately before death, the death is reportable irrespective of the cause of death, even if it is a death from natural causes.[2]

6. 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.

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[1] Ms Cooke's background information contained in paragraphs 1-4 has been drawn from: Samantha Dooley, *Investigation into disability services provided by Home@Scope to Ms Tracey Cooke* [herby referred to as 'DSC Investigation'], 5 October 2021 pg 2.

[2] Section 4(2)(c) of the Act.

7. 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.

8. This finding draws on the totality of the coronial investigation into the death of Tracey Lee Cooke including evidence contained in the medical examiner's report prepared by Forensic Pathologist Dr Joanna Glengarry, the e-medical deposition from the Footscray Hospital and a letter from the Disability Services Commissioner summarising their investigation. 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]

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

Identity of the deceased

9. On 1 September 2020, Tracey Lee Cooke, born 29 June 1965, was visually identified by her sister-in-law, Carol Cooke, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

11. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 31 August 2020 and provided a written report of her findings on 3 September 2020.

12. The post-mortem examination did not reveal any evidence of an injury of a type likely to have caused or contributed to the death. Examination of the post-mortem CT scan did not show any acute intracranial abnormality.

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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.

13. Dr Glengarry provided an opinion that the medical cause of death was 1(a) *aspiration pneumonia.*

14. I accept Dr Glengarry's opinion.

Circumstances in which the death occurred

15. On 2 July 2020, Ms Cooke suffered a seizure which is reported to have lasted for approximately 10 minutes.[4] Ms Cooke was transported to the Sunshine Hospital and subsequently admitted. While in hospital, Ms Cooke was diagnosed with a urinary tract infection and an inflamed gallbladder. On 7 July 2020, surgery was performed to remove her gallbladder.

16. Ms Cooke was then transferred to the Footscray Hospital on 9 August 2020 for further surgery. She was placed on intravenous fluids and some intravenous medication.

17. On 22 August 2022, Ms Cooke was diagnosed with double aspiration pneumonia. It is stated in the e-medical deposition provide by Footscray Hospital that Ms Cooke had five documented episodes for aspiration pneumonia within the three months prior to her death.

18. On 25 August 2022, the decision was made by Ms Cooke's family and treating medical team to transfer Ms Cooke to the palliative ward for end-of-life care. Ms Cooke died at the Footscray Hospital at 1.00pm on 29 August 2022.

REVIEW BY THE DISABILITY SERVICES COMMISSIONER

19. On 3 August 2020 the Disability Services Commissioner (DSC) commenced an investigation pursuant to section 128I of the *Disability Act 2006* into disability services provided by Home@Scope to Ms Cooke.

20. In accordance with section 7(a) of the *Coroners Act 2008* ('the Act'), I placed my investigation on hold while the DSC undertook their investigation to avoid the unnecessary duplication of inquiries and investigations.

[4] DSC investigation pg 3.

21. On 8 September 2020, the DSC requested that Home@Scope conduct an internal review of the care and clinical management provided to Ms Cooke. Following this review, Home@Scope identified the following issues with the care provide to Ms Cooke:[5]

    a) Recognition and management of deteriorating health; and

    b) Incomplete record keeping, need to improve document templates and the functioning of house meetings during COVID-19.

22. Having identified these issues, Home@Scope provided the DSC with a plan of action as to how they intended to address the issues. The relevant planned actions included:

    a) Identifying residents who have specific health conditions and ensuring such health conditions are included in the residents' Health Support Needs Summary.

    b) Where required, develop specific health care plans for residents in conjunction with their families and treating health care practitioners.

    c) Review the use of resident treatment sheets and medication notes to ensure the correct template and medication notes documentation are being utilised.

23. The DSC requested a further updated from Home@Scope on 22 September 2021. The DSC was satisfied that the actions planned by Home@Scope to address the issues identified had been successfully implemented. Following the improvements, the DSC concluded no further action was required.

FINDINGS AND CONCLUSION

24. I acknowledge that Home@Scope has successfully implemented changes to their procedures following their own internal review and the investigation by the DSC. These improvements will lead to better outcomes for current and future Home@Scope residents. However, based on all the available evidence, I do not consider that if these changes been implemented prior to Ms Cooke's death, a different outcome for Ms Cooke would have been achieved.

25. For the purposes of section 52(3A) of the Act I consider Ms Cooke's death was due to natural causes.

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[5] DSC Investigation pg 3.

26. In the course of my investigation, I was unable to identify any prevention opportunities.

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

    a) the identity of the deceased was Tracey Lee Cooke, born 29 June 1965;

    b) the death occurred on 29 August 2020 at the Footscray Hospital, 160 Gordon Street, Footscray, Victoria, 3011, from aspiration pneumonia; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Ms Cooke'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:

Stephen Cooke, Senior Next of Kin

Disability Services Commissioner

Constable Bridget Magill, Coroner's Investigator

Signature:

Coroner Leveasque Peterson

Date : 06 October 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.