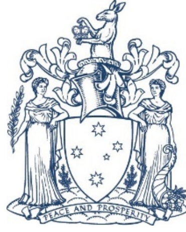

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 004129

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Angela Cuthbert

Delivered On:	19 July 2023
Delivered At:	Melbourne
Hearing Date:	19 July 2023
Findings of:	Coroner Simon McGregor
Counsel Assisting the Coroner	Fiona Ransom
Keywords	In care death, SDA resident, complications of dental surgery, pneumonia

INTRODUCTION

1. On 24 July 2022, Angela Cuthbert (**Angela**) was 59 years old when she died at The Alfred Hospital. Angela was a long-term resident of specialist disability accommodation at 225 McKinnon Road, McKinnon, operated by Scope (Aust) Ltd (**Scope**).

2. Angela was the youngest of three siblings born to parents Susan and Roderick. She was born with severe cerebral palsy with intellectual disability and required 24-hour care for her whole life. Although she was non-verbal, Angela was said to be very social and well-liked at her residence.[1] She was able to communicate using facial gestures, vocalisations and movements and make clear to her support staff when she was happy, upset or in pain. Angela enjoyed engaging with others and expressed her happiness and pleasure by laughing and squealing.[2]

3. Angela also suffered from severe dysphagia, had a high risk of choking and was at risk of developing pneumonia due to aspiration. Her food was modified, consistent with the International Dysphagia Diet Standardisation Initiative standards, and support staff supported Angela with pureed food and mildly thickened fluids. Due to her cerebral palsy and being wheelchair-bound, Angela often had physical ailments, including pressure sores, for which she was supported by an occupational therapist. Angela was also prescribed medication to treat chronic insomnia and anxiety at night.[3]

THE CORONIAL INVESTIGATION

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

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding

[1] Coronial Brief, statement of Andrew Cuthbert, p.12.
[2] Statement of Lisa Evans, Scope (Aust) Limited, dated 21 April 2023, p.3.
[3] Ibid., p.2.

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.

6. 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.

7. Victoria Police assigned Senior Constable Elise Nathan to be the Coroner's Investigator for the investigation of Angela's death. Senior Constable Nathan conducted inquiries on my behalf, including taking statements from witnesses – such as Angela's brother, Andrew Cuthbert, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Angela Cuthbert 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

9. In the year preceding her passing, Angela had been having trouble with her teeth.[5]

10. In early 2021, on referral by her general practitioner, Angela attended appointments with the Specialist Needs Dentistry clinic and Oral and Maxillofacial Surgery clinic of Dental

[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.

[5] Coronial Brief, statement of Andrew Cuthbert, p.13.

Health Services Victoria accompanied by support workers. Both clinics were of the view that removal of Angela's remaining 14 teeth under general anaesthetic was appropriate.[6]

11. In August/September 2021, Angela and a carer attended a telehealth appointment with the Royal Dental Hospital, who asked questions about Angela's physical condition and discussed recommended positioning during her procedure, taking into account her dysphagia.[7]

12. On 20 June 2022, Angela attended the Royal Dental Hospital to undergo the removal of her teeth under general anaesthetic. She was discharged the same day. The discharge plan provided to Angela's carers advised that she be given Panadol and Nurofen to assist with pain management, emphasised the importance of resting for three days following the procedure, and prescribed mouth washing care. The pro forma instruction sheet headed *Post Operative Care For Special Needs Patients Following Treatment Under General Anaesthesia* was not specific to patients who had undergone removal of all teeth (it advised regular tooth brushing), and was not modified to accommodate Angela's dysphagia, but her carers did their best to adhere to the plan with appropriate modifications.[8]

13. In the days following surgery, Angela appeared to her carers to be settled and in no pain.[9]

14. From 22 June to 5 July 2022, we have limited evidence as to Angela's condition, with only two entries in the client notes. Scope has acknowledged that there was inadequate recording-keeping in this period and that reliance on oral handovers between staff is insufficient from a record management perspective.[10]

15. On 5 July 2022, Angela's care workers noticed that her breathing seemed laboured and that she was wheezing. The locum service was called, and they advised 30 minute checks and to go to follow up with her general practitioner in the morning. Carers called an ambulance

[6] Statement of Lisa Evans, Scope (Aust) Limited, dated 21 April 2023, p.5, and exhibited records.
[7] Ibid., p.6.
[8] Statement of Lisa Evans, Scope (Aust) Limited, dated 21 April 2023, p.7; Dental Health Services Victoria Day Surgery Unit Patient Discharge Information & Checklist dated 20 June 2022.
[9] Scope Client Notes dated 20 June 2022.
[10] Statement of Lisa Evans, Scope (Aust) Limited, dated 21 April 2023, p.9.

early the next morning, but attending paramedics determined that she was suitable to stay home, to be followed up by the locum service.[11]

16. On 6 July 2022, Angela attended an appointment with her general practitioner, who noted that she was 'well' and not febrile.[12]

17. On the morning of 13 July 2022, Angela attended her regular Daily and Lifestyle Options (DLO) program, Morning Melodies, a music program noted to be her favourite outing of the week. Support workers who attended with her noticed that Angela did not eat as much that day, but that she otherwise enjoyed the program. In the early afternoon, support workers noticed swelling under Angela's chin going from left jawline to right jawline and that she was presenting as distressed, with a slight temperature. An ambulance was called and Angela was conveyed to The Alfred Hospital to undergo further investigation.[13]

18. Computed tomography (**CT**) scans revealed a number of abscesses with extensive fluid collections on the floor of Angela's mouth. These were surgically incised and drained on 14 July 2022, and Angela was admitted to the Intensive Care Unit for post-operative care. Despite treatment with intravenous antibiotics, Angela developed pneumonia, causing respiratory distress, and her condition deteriorated.[14]

19. On 21 July 2022, after consultation with her family, Angela was transitioned to comfort care and she passed away on 24 July 2022.[15]

Identity of the deceased

20. On 24 July 2022, Angela Cuthbert, born 26 May 1963, was visually identified by her mother, Susan Rocco.

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

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[11] Statement of Lisa Evans, Scope (Aust) Limited, dated 21 April 2023, p.9; McKinnon Road Diary Extract, 5 July 2022.
[12] Health Management Form dated 6 July 2022, McKinnon Hill Medical Centre.
[13] Statement of Lisa Evans, Scope (Aust) Limited, dated 21 April 2023, p.11; RiskMan Incident Report 74150, dated 13 July 2022
[14] Medical IP Progress Note, 18 July 2022, Alfred Health medical records.
[15] Progress notes, 21 July 2022, Alfred Health medical records.

Medical cause of death

22. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine conducted an external examination on 27 July 2022 and provided a written report of his findings dated 9 August 2022.

23. Dr de Boer's findings on external examination were consistent with Angela's medical history.

24. A post-mortem CT scan revealed consolidation of the lower lobe of the left lung, a single air pocket in the soft tissues surrounding the left side of the mandible with no overt abscesses, osteoporosis, porcelain gallbladder and no intracranial haemorrhage.

25. Dr de Boer provided an opinion that the medical cause of death was 1(a) complications of abscesses following dental extraction, in a woman with cerebral palsy.

26. I accept Dr de Boer's opinion.

FINDINGS AND CONCLUSION

27. Angela resided at her specialist disability accommodation at McKinnon Road, McKinnon for 30 years prior to her passing. By all accounts she was happy there, and her family have expressed their satisfaction that she was well cared for.

28. Having carefully reviewed the available evidence, I too am satisfied that the care provided to Angela by Scope was reasonable and appropriate, and that the disability support workers were attentive to Angela's needs and quality of life. I find that it is reasonable to conclude that Angela's death was from natural causes and was not preventable.

29. I, Coroner Simon McGregor, having investigated the death of Angela Cuthbert, and having held an inquest in relation to this death on 19 July 2023 at Melbourne, find that:

    a) the identity of the deceased was Angela Cuthbert, born 26 May 1963;

b) the death occurred on 24 July 2022 at The Alfred 55 Commercial Road, Melbourne, Victoria, 3004, from complications of abscesses following dental extraction, in a woman with cerebral palsy; and

c) the death occurred in the circumstances described above.

I order that this finding be published on the Internet.

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

Susan Rocco, Senior Next of Kin

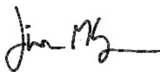
Roderick Cuthbert, Senior Next of Kin

Wendy Grant, Patient Safety Manager, Alfred Health

Werner Bischof, Director of Clinical Governance, Dental Health Services Victoria

Senior Constable Elise Nathan, Coroner's Investigator

Signature:



Date: 19 July 2023

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 inquest. 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.