IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2023 000439**

# FINDING INTO DEATH WITHOUT INQUEST

*Form 38 Rule 63(2)*

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

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| Findings of: | Coroner Simon McGregor |
| Deceased: | Kathryne Frances Callaghan |
| Date of birth: | 18 October 1971 |
| Date of death: | 23 January 2023 |
| Cause of death: | 1(a) Aspiration pneumonia in a woman with cerebral palsy and epilepsy |
| Place of death: | Wantirna Health, 251 Mountain Highway, Wantirna, Victoria, 3152 |
| Keywords: | In care, natural causes |

## INTRODUCTION

1. On 23 January 2023, Kathryne Frances Callaghan was 51 years old when she died at Eastern Health Wantirna. At the time of her death, Kathryne lived in specialist disability accommodation at 44 Crusoe Drive, Lysterfield, Victoria.

2. Kathryne was the youngest of six siblings born to parents Sylvia and Miles. Kathryne was diagnosed at a young age with an intellectual disability and cerebral palsy, and with epilepsy as a toddler. She was non-verbal and required support with all her daily living needs.[1]

3. As a child, Kathryne's family provided full-time care to her, with her mother assisting with her personal care and all daily activities, and Kathryne's father and siblings assisting with meals. Kathryne's brother Russell spoke of connecting with Kathryne through music and teaching her to sing along with songs.

4. When Kathryne was 18 years old, Sylvia was finding it more difficult to provide full-time care due to her own advancing age, and Kathryne moved into a care facility located in Mooroolbark, close to the family home.[2]

5. In 2004, Kathryne moved from Mooroolbark into a full-time care facility operated by the then Department of Health and Human Services at 44 Crusoe Drive, Lysterfield.[3] In 2019, Scope (Aust) Limited (**Scope**) took over at this address as the disability service provider[4] and continued to provide full-time care to Kathryne. Kathryne also attended Scope Lifestyle Options located 170 Boronia Road, Boronia between 9:00am and 3:00pm Monday to Friday.[5]

## THE CORONIAL INVESTIGATION

6. Kathryne's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in

[1] Coronial brief, statement of Russell Callaghan dated 26 September 2023; statement of Umesh Martha (undated).
[2] Coronial brief, statement of Russell Callaghan dated 26 September 2023.
[3] Ibid.
[4] Coronial brief, statement of Lukas Lobb dated 11 October 2023.
[5] Statement of Ebony Lillee, Scope (Aust) Limited, dated 15 November 2023; Coronial brief, statement of Umesh Martha (undated).

care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

7. 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.

8. 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.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Kathryne's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Kathryne Frances Callaghan 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.[6]

11. In considering the issues associated with this finding, I have been mindful of Kathryne's 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

[6] 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.

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

### Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

12. On 11 November 2022, Kathryne was diagnosed with COVID-19.[7] Scope staff arranged an appointment with a general practitioner, who prescribed paracetamol as needed and advised staff to monitor Kathryne and, if her condition worsened, to contact Rowville Health.[8]

13. On 13 November 2022, Kathryne's health deteriorated, with Kathryne suffering from shortness of breath and in an altered state of consciousness. Scope staff called for an ambulance and she was transported to Dandenong Hospital for assessment and treatment.[9]

14. Kathryne was admitted to Dandenong Hospital with COVID-19 and pneumonia, where she remained as an inpatient for the following five weeks. During this time Kathryne showed a significant deterioration in her condition and on 21 November 2022, she was put on a palliative care pathway after discussions with her family.[10]

15. Kathryne's health did stabilise over the following weeks, and she was removed from the palliative care pathway and returned to full ward management on 28 November 2022. On 20 December 2022, she was discharged from Dandenong Hospital and returned to full-time care at Scope.

16. On 24 December 2022, Kathryne's health declined, with recurrence of respiratory distress, poor oral intake, reduced conscious status, and a fever.[11] Scope staff called for an ambulance, and she was transported to Dandenong Hospital, which she was re-admitted with aspiration pneumonia.

17. On 26 December 2022, Kathryne was diagnosed with an acute chronic oropharyngeal dysphagia and began a fluid diet. Kathryne also began intravenous Tazocin treatment for pneumonia.[12]

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[7] Coronial brief, statement of Lukas Lobb dated 11 October 2023.
[8] Statement of Ebony Lillee, Scope (Aust) Limited, dated 15 November 2023.
[9] Coronial brief, Ambulance Victoria electronic patient care record, 13 November 2022; statement of Lukas Lobb dated 11 October 2023.
[10] Coronial Brief, Monash Health discharge summary, 13 November 2022 admission; Statement of Dr Zoya Shivanand, Monash Health, dated 20 November 2023.
[11] Statement of Dr Zoya Shivanand, Monash Health, dated 20 November 2023.
[12] Coronial Brief, Monash Health discharge summary, 13 November 2022 admission; Medical deposition of Dr Eleanor Pryor, Rowville Health, dated 23 January 2023.

18. Over the next few weeks, Ms Callaghan continued to have minimal or no oral intake, due to a combination of low conscious state and inability to swallow, or refusal of attempted feeding by nursing staff, resulting in dependence on intravenous maintenance of fluid and electrolytes.[13]

19. On 4 January 2023, chest x-rays identified a collapse of Kathryne's right lung and an abrupt truncation of the right main bronchus, large airway obstruction from foreign material, aspiration mucous and a collapse/consolidation of the left lower lobe region.[14]

20. On 17 January 2023, a second family meeting occurred with medical staff. This included Kathryne's brother Russell, her sister Adelle, sister-in-law Cheryl and a Scope Staff member. A decision was made to transition Kathryne to comfort care.[15]

21. On 18 January 2023, Kathryne was transported to Wantirna Health Palliative Ward for end-of-life care.[16]

22. On 23 January 2023 at 11:00am, Kathryne passed away.[17]

**Identity of the deceased, pursuant to section 67(1)(a) of the Act**

23. On 23 January 2023, Kathryne Frances Callaghan, born 18 October 1971, was visually identified by her brother, Russell Callaghan.

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

**Medical cause of death, pursuant to section 67(1)(b) of the Act**

25. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine conducted an external examination on 26 January 2023 and provided a written report of her findings dated 21 March 2023.

26. The post-mortem examination revealed no evidence of any injuries that could have cause or contributed to death.

[13] Ibid.
[14] Medical deposition of Dr Eleanor Pryor, Rowville Health, dated 23 January 2023.
[15] Coronial brief, statement of Russell Callaghan dated 26 September 2023; Statement of Dr Zoya Shivanand, Monash Health, dated 20 November 2023.
[16] Medical deposition of Dr Eleanor Pryor, Rowville Health, dated 23 January 2023.
[17] Statement of Grace Walpole, Eastern Health Wantirna, dated 26 October 2023.

27. The post-mortem computed tomography (**CT**) scan showed areas of bibasal consolidation,[18] with patchy bronchiectasis[19] and a bilateral pleural effusion.[20]

28. Dr Archer provided an opinion that the medical cause of death was 1(a) aspiration pneumonia in a woman with cerebral palsy and epilepsy.

29. I accept Dr Archer's opinion.

## FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Kathryne Frances Callaghan, born 18 October 1971;

    b) the death occurred on 23 January 2023 at Wantirna Health, 251 Mountain Highway, Wantirna, Victoria, 3152, from aspiration pneumonia in a woman with cerebral palsy and epilepsy; and

    c) the death occurred in the circumstances described above.

31. Because Kathryne was residing in Specialist Disability Accommodation at the time of her passing, her death is considered to be 'in care' as defined by section 3 of the Act and *prima facie* subject to a mandatory inquest. Having considered all of the evidence, I am, however, satisfied by the available evidence that Kathryne's death was due to natural causes and, pursuant to section 52(3A) of the Act, have therefore determined not to hold an inquest.

I convey my sincere condolences to Kathryne'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.

[18] Lung consolidation on both sides, when the air in the small airways of the lungs is replaced with a fluid, solid, or other material.
[19] A condition where the walls of the airways (bronchi) widen and are thickened from inflammation and infection.
[20] Accumulation of fluid in the pleural space in both lungs.

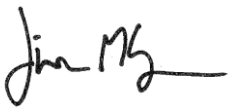
I direct that a copy of this finding be provided to the following:

**Sylvia Callaghan, Senior Next of Kin**

**Yvette Kozielski, Eastern Health**

**First Constable James Anderson, Coroner's Investigator**

Signature:




Coroner Simon McGregor

Date : 19 February 2024

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.