IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2019 1474**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**PHILLIP BYRNE, CORONER**
Deceased:	**LORRAINE SIMMONS**
Date of birth:	**21 OCTOBER 1937**
Date of death:	**23 MARCH 2019**
Cause of death:	**I (a) ASPIRATION PNEUMONIA IN AN ELDERLY LADY**
Place of death:	**AUSTIN HOSPITAL, 145 STUDLEY ROAD, HEIDELBERG, VICTORIA, 3084**

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 1474

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***

I, PHILLIP BYRNE, Coroner having investigated the death of LORRAINE SIMMONS
without holding an inquest:
find that the identity of the deceased was LORRAINE SIMMONS
born on 21 October 1937
and the death occurred on 23 March 2019
at Austin Hospital, 145 Studley Road, Heidelberg, Victoria, 3084

from:

1 (a) ASPIRATION PNEUMONIA IN AN ELDERLY LADY

Pursuant to section 67(1) of the **Coroners Act 2008** I make findings with respect to **the following circumstances**:

Background

1. Ms Lorraine Simmons, 81 years old at the time of her death, resided in a Department of Health and Human Services (DHHS) (now the Department of Families, Fairness and Housing) (DFFH) managed Supported Residential Service at 50-52 Crispe Street, Reservoir.
2. Ms Simmons was born with phenylketonuria, resulting in a moderate intellectual disability. Ms Simmons also had an eating and swallowing disorder. She did not communicate verbally and used a wheelchair for mobility.
3. Ms Simmons required support for all daily activities and had a 'Personal Care Dictionary'. This outlined how Ms Simmons communicated by use of sounds and actions and what response staff should give. She required support with decision making including decisions related to medical treatment.
4. In the 12 months before her death, she had multiple hospital admissions relating to aspiration pneumonia.

5. At the time of her death, Ms Simmons was in the care of the Secretary of DHHS.

Circumstances of the death

6. On 15 March 2019, Ms Simmons was discharged from the Austin Hospital following her most recent episode of aspiration pneumonia, to receive ongoing palliative care at her residential facility. Carers at the facility were directed by doctors to administer sedatives and pain relief to Ms Simmons as required.

7. On 22 March 2019, Ms Simmons was readmitted to the Austin Hospital as her carers were unable to support her due to the unavailability of a registered nurse at the facility. She presented with pain, shortness of breath and persistent agitation. Biochemistry results confirmed a further worsening of Ms Simmons' aspiration pneumonia. Her condition continued to deteriorate, and she died at 12.25pm on 23 March 2019.

Report to the Coroner and post-mortem examination

8. The matter was appropriately referred to the Coroner as Ms Simmons was "in care" at the time of her death.

9. In initial contact with the Coronial Admissions and Enquiries (CA&E) office, the Senior Next of Kin, Ms Simmons' brother, Mr Neville Simmons, advised that the family would not object to an autopsy if the Coroner considered one necessary, and further advised that the family had no concerns with the care provided.

10. Having considered the circumstances and having conferred with a forensic pathologist, I directed an external only post-mortem examination and ancillary tests. An external examination was performed by Forensic Pathologist Dr Yeliena Baber of the Victorian Institute of Forensic Medicine. Dr Baber advised that the immediate cause of Ms Simmons' death was:

    I (a) Aspiration pneumonia in an elderly lady

11. Dr Baber further advised that Ms Simmons' death was due to natural causes.

Further investigation

12. I was advised that the Disability Services Commissioner (the Commissioner) proposed to undertake a Disability Death Review of the DHHS management of Ms Simmons. The Court made the totality of the coronial material available to the Commissioner to facilitate their review. Noting that a fundamental objective of the *Coroners Act 2008* (Vic), section 7(a), is to avoid unnecessary duplication of inquiries and investigations, I determined to leave further investigation of Ms Simmons' death in abeyance.

13. Pursuant to the *Coroners Act 2008* (Vic), as Ms Simmons' death was due to natural causes, I am not required to hold a mandatory inquest, but must complete a finding which is required to be put on the Court's website.

14. On 15 April 2019, the Court advised Mr Neville Simmons of the Commissioner's proposed review and further advised I would leave my investigation in abeyance and notify him if there were any further developments. Subsequently, I was advised by our Disability Death Review Case Investigator that the Commissioner did not object to me proceeding to finalise my investigation.

The Commissioner's Investigation Report

15. On 1 May 2020, I was in receipt of a copy of the Investigation Report from the Commissioner into the disability services provided by to Ms Simmons by DHHS.

16. The Commissioner assessed the services provided to Ms Simmons in relation to the relevant legislation and practice guidance, including but not limited to the DHHS Residential Services Practice Manual.

17. The Commissioner made a number of findings in the report against DHHS. These included that DHHS had failed to provide Ms Simmons with appropriate mealtime assistance. The Commissioner issued DHHS with a Notice to Take Action pursuant to the *Disability Services Act 2006.*

18. The report outlines that an assessment conducted by a speech pathologist in January 2019 noted that 'Ms Simmons was at very high risk of aspiration and that she was continuing to be fed 'at risk''. Group home staff had previously rejected the option of percutaneous endoscopic gastrostomy (PEG) feeding, as they believed Ms Simmons would not tolerate this. I accept that was a reasonable position to take.

19. In January 2019, Ms Simmons mealtime assistance requirements were modified by a hospital speech pathologist from mildly thick fluids provided via a cup to being given by a spoon. Ms Simmons expressed frustration with this assistance method. Her speech pathologist recommended the use of a 'Provale' cup for independent drinking, however there was no evidence that this occurred.

DHHS's opportunity to response

20. In May 2020, I asked that my coroner's solicitor write to DHHS to inform them of my intention to adopt the Commissioner's conclusion DHHS had failed to provide Ms Simmons

with appropriate mealtime assistance and finalise the coronial investigation 'on the papers' by way of a Finding without Inquest.

21. In July 2020, I received a letter under the hand of Ms Carley Northcott, Director, National Disability Insurance Scheme (NDIS), Service Delivery, Disability and NDIS Branch, DHHS. The department liaised with the relevant senior staff of Aruma to gather information to inform its response.

Actions taken following the Commissioner's Report

22. Ms Northcott outlined the department's response:

"*In response to the Commissioner's Final Report and Notices to Take Action the department worked closely with Aruma, the new service provider to 50-52 Crispe St, Reservoir to implement the quality improvement actions. In response to the mealtime assistance finding, the following actions were undertaken.*

- *A staff meeting was held on 3 June 2019 to review and discuss the findings of the Commissioner's investigation. The House Supervisor led a discussion with staff about the learning from the report and how the findings and recommendations could continue to improve services for all residents at the Crispe Street group home.*
- *A training session was delivered by a speech pathologist from Premium Health on 3 June 2020 to educate all house staff and familiar causals with regards to aspiration pneumonia, including the signs, symptoms, risk factors, and support requirements (including texture modification and preparation requirements) for people who have swallowing difficulties.*
- *The six current residents who are at risk of aspiration pneumonia or experience swallowing difficulties have current Mealtime Assistance Plans in place, developed by a speech pathologist. All plans were reviewed and updated by May 2020 and will continue to be reviewed as resident dysphagia requirements change*."

System wide improvements

23. Ms Northcott also outlined system wide improvements as follows:

"*Since 2017-18 Victorian Government funding of $3.5 million has been provided to assist in the provision of training and the development of learning and development programs for disability support workers to enhance their capabilities and confidence as part of the transition to the NDIS. Further funding is being provided to develop specialist training in positive behaviour support planning in 2020.*

Prior to the transition to the NDIS, Victoria worked with the Commonwealth to develop a mandatory worker orientation module 'Quality, Safety and You' to assist all NDIS workers to better support people with disability and explain the obligations of workers under the NDIS Code of Conduct. The NDIS Code of Conduct includes requirements to take all reasonable steps to prevent and respond to all instances of violence, exploitation, abuse and neglect of people with disability.

The Victorian Government is working with the Commonwealth Government and other States and Territories to develop a National NDIS Workplace Plan which will include a focus on maintaining capability and quality of service.

The department continues to respond to the system-wide recommendations coming from the Commissioner's death investigations. In 2020 this includes work on swallowing and choking risk, falls prevention, responding to deteriorating health and supporting residents in hospital".

Safe mealtimes

"*The department has commenced a project to deliver an e-learning module in safe mealtime management suitable for disability support workers. The aim of the project is to increase the knowledge and skills of disability workers in this area including aspiration pneumonia, management of dysphagia and choking. The aim is to provide comprehensive and expert training to staff on this issue. Once completed (estimated time March 2021) this e-learning package will be made available to the transfer providers. The department will also consider ways to make this more widely available to the disability services sector.*

The department has joined the Commissioner's Mealtime Support Advisory Groups. These groups bring together service providers, Speech Pathology Australia, Dieticians Association of Australia, the department, Deakin University and the NDIS Commission with the aim of identifying current resources and addressing gaps in mealtime management resources/guidelines.

The department has provided input to the Commissioner on their safe mealtime's poster. Once this poster is finalised, it will be distributed to the transfer providers for display in their group homes to increase awareness of swallowing and choking risks and the importance of following a resident's mealtime management plans.

The department is assessing recently released online safe mealtime training to determine if this can be made more widely available to transfer service providers in the short term while other training is developed.

It is also noted that the NDIS Quality and Safeguard Commission is funding a project to develop resources for staff on safe mealtime practices. The department is liaising with the Commission to learn more about these resources and how they can be made available to disability support workers in group homes".

Conclusion

24. Having carefully considered all of the available evidence, I am satisfied that there is sufficient information to finalise my investigation by way of this finding without inquest.

25. I acknowledge the steps undertaken by the department in implementing quality improvement actions at 50-52 Crispe Street, Reservoir and the systemwide improvements undertaken in relation to mealtime assistance to promote safe mealtime management.

Finding

26. I formally find that on 23 March 2019 at Austin Hospital, Ms Simmons died from aspiration pneumonia in the setting of her advanced age and that the death was due to natural causes.

27. I direct that this finding be published on the Coroners Court of Victoria website pursuant to section 73(1B) of the *Coroners Act 2008* (Vic).

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

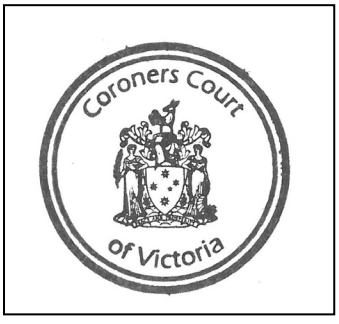
    Mr Neville Simmons, Senior Next of Kin;

    Mrs Pauline Chapman, Austin Health;

    Office of the Disability Services Commissioner; and

    Constable Lauren Wilson, Coroner's Investigator, Victoria Police.

Signature:



PHILLIP BYRNE
CORONER

Date: 5 July 2021