IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 002653

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Ms WJ[1]
Date of birth:	5 August 1959
Date of death:	26 May 2019
Cause of death:	1(a) Sepsis in a woman with epilepsy, cerebral palsy and haemochromatosis
Place of death:	Kew, Victoria, 3101

[1] The finding has been de-identified in accordance with the family's wishes.

INTRODUCTION

1. On 26 May 2019, Ms WJ was 59 years old when she died at the Department of Health and Human Services[2] (**DHHS**) managed supported accommodation she lived at in Kew. Ms WJ had one sister and one brother. Her father passed away in 2020.

2. Ms WJ's sister described her as healthy for the first year or two of her life before she experienced seizures and developmental delay. Non-verbal, Ms WJ was mobile until her teen years before she became wheelchair bound and moved into supported accommodation.

3. Ms WJ had a medical history of cerebral palsy, C4-T2 vertebral fusion, epilepsy, intellectual disability, recurrent urinary tract infections (**UTI**), asthma, chronic constipation, iron deficiency anaemia and osteoporosis. She was reliant on others to perform her activities of daily living and required a smooth diet and thickened fluids.

4. She enjoyed music, going on outings and using tactile objects, particularly those in her activity box. Ms WJ's sister was her Medical Treatment Decision Maker and appeared to have had a long-standing and close involvement in the care of her sister's many chronic, severe health problems.

THE CORONIAL INVESTIGATION

5. Ms WJ'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 that are unexpected, unnatural or violent or result from accident or injury. However, in order to protect the vulnerable, the deaths of some people are reportable irrespective of the cause of death and even if the death is from natural causes and would otherwise not be reportable.[3]
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.

[2] Now the Department of Families, Fairness and Housing (**DFFS**).

[3] See sections 4(2)(c), (d) and (e) which define deaths as reportable based of the legal status of the person immediately before death. Also, the definition of "person placed in custody or care" in section 3 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 Ms WJ 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

Identity of the deceased

9. On 26 May 2019, Ms WJ, born 5 August 1959, was visually identified by her sister, who signed a formal Statement of Identification to this effect before a member of Victoria Police.

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

Medical cause of death

11. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 30 May 2019 and provided a written report of his findings dated 17 December 2019.

12. The post-mortem examination revealed evidence of sepsis with elevated inflammatory markers[5]. The bacterium *E. coli* was detected in several sites including in blood cultures and in lung, bronchial and bladder swabs. Another bacterium, *Proteus mirabilis* was also detected in lung and bladder swabs. Dr Bouwer explained that although the presence of this organism can represent post-mortem contamination, given it was detected in multiple sites, it is likely to be of clinical significance. There was no evidence of acute bronchopneumonia, so the most likely explanation for the presence of this organism is from a bladder infection (urosepsis).

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[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] Procalcitonin and C-reactive protein.

13. Dr Bouwer noted Ms WJ's clinical history of cerebral palsy. Neuropathological examination showed generalised white matter and cerebellar vermal atrophy in keeping with this diagnosis. There was no evidence of meningitis or encephalitis, nor were there any epileptogenic foci identified.

14. Other natural disease processes found include severe hepatic steatosis[6] and subnuclear vacuolation in the proximal tubular epithelium of the kidneys (Armanni-Ebstein lesions), which may be seen after prolonged periods of fasting or in Type 1 diabetes mellitus. However, post-mortem glucose was not elevated, which would exclude diabetic ketoacidosis as a potential cause of death. Post-mortem biochemistry showed evidence of mild dehydration.

15. There was no post-mortem evidence of violence or injury contributing to death.

16. Dr Bouwer considered it likely that Ms WJ's presenting symptoms were due to delirium from an underlying urinary tract infection.

17. Routine toxicological analysis of post-mortem samples detected an elevated level of acetone in the blood and vitreous humour. This is an endogenous substance that increases after a period of fasting. Anti-epileptic and antiemetic drugs were also detected consistent with their normal therapeutic use. No alcohol or other commonly encountered drugs or poisons were detected.

18. Dr Bouwer provided an opinion that Ms WJ's death was sue to natural causes, namely *1 (a)* Sepsis in a woman with epilepsy, cerebral palsy and haemochromatosis.

19. I accept Dr Bouwer's opinion.

Circumstances in which the death occurred

20. In the month preceding her death, Ms WJ had four presentations to hospital.

21. The first presentation was to St Vincent's Hospital on 30 April 2019 on a background of constipation of several week's duration, which had not responded to aperients. Ms WJ's oral intake had also diminished. Constipation was confirmed and other possible conditions excluded. Ms WJ was treated with fluids and increased aperients and discharged on 2 May 2019.

[6] Fat infiltration in the liver.

22. On 4 May 2019 Dr Bennie was concerned that Ms WJ's constipation had returned and referred her back to St Vincent's but as St Vincent's was extremely busy, she was transferred to the Austin Hospital. Again, Ms WJ was found to be constipated and treated as an inpatient between 4 and 7 May 2019.

23. Subsequent blood tests showed high iron levels and mildly abnormal liver function tests. Dr Bennie referred Ms WJ to the St Vincent's Emergency Department on 14 May 2019. A haematology registrar advised ceasing Ms WJ's supplemental iron, ordering further blood tests for haemochromatosis and to return for an outpatient review in three months.

24. Ms WJ remained plagued with constipation and returned to the St Vincent's ED on 20 May 2019. Fluids and aperients were given, and she was discharged back to her care home. Dr Mathew Kilmurray wrote that *"The ideal place of care for this patient, especially in the absence of emergent disease is unlikely to be an emergency department/hospital – in future suggest telephone advice or contacting our in-reach team – especially in light of recent referral to ED for high ferritin*".

25. The following day, Dr Bennie reviewed Ms WJ and made a referral to Epworth Palliative Care Services (**EPCS**). Ms WJ's sister was notified of the referral.

26. EPCS met with Dr Bennie and care staff on 23 May 2019 and discussed Ms WJ's general management. Although Ms WJ's sister was not present at the meeting, information was left at the desk for her and a meeting with EPCS to discuss her sister's care was scheduled for 27 May 2019. The next day a subcutaneous syringe driver administered 40mg of metoclopramide (an anti-nausea medication) and 2mg clonazepam (anti-seizure medication).

27. Ms WJ appeared comfortable on 25 May 2019 however the next morning, was found deceased in bed.

CORONERS PREVENTION UNIT REVIEW

28. Following receipt of concerns from Ms WJ's sister that her sister had fallen through the gaps of the medical system, I asked a member of the Health and Medical Investigation Team (**HMIT**) to review Ms WJ's medical care and management.[7] The HMIT considered two

[7] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

main issues. Firstly, the medical care provided to Ms WJ proximate to her death, and secondly, the end-of-life decision making, management and communication.

Medical care and management

29. The HMIT noted the post-mortem findings of *E. coli and P. mirabilis* in multiple sites and Dr Bouwer's conclusion that their presence indicated a likely bladder infection. At each of Ms WJ's four hospital presentations, the HMIT noted that she was afebrile with a normal white cell count, indicating she was not infectious at the time. Ms WJ's history of UTIs was noted several times (although urine dipstick results were not recorded). The HMIT commented that urinary catheterisation would have been required to obtain a diagnostic sample and in the absence of symptoms[8] and presence of an alternative diagnosis, her management appeared to have been reasonable. According to the HMIT, it is possible that the fatal urosepsis developed between 20 May and 26 May 2019.

30. In the HMIT's view, the investigations and medical care provided to Ms WJ in the month preceding her death, appeared to be reasonable, timely and appropriate. The diagnosis of constipation was supported by multiple investigations, treated appropriately, and alternative diagnoses considered. No significant deficiencies or opportunities for prevention were identified.

End of life management

31. In her correspondence, Ms WJ's sister felt that the hospital did not wish to conduct any further investigations and that staff were instructed not to bring Ms WJ back to hospital. The HMIT acknowledged that this belief was factually correct, but the rationale underpinning such a position is more complex.

32. It was clear that Ms WJ's sister was the person able to consent to medical procedures and emergency contact (even though a formal guardianship did not appear to have been in place).

33. No formal advanced care plan appeared to be in place at Ms WJ's supported accommodation. The HMIT commented that a discussion to write such a document would

[8] Typically, a characteristic odour in Ms WJ's case.

have been valuable during Ms WJ's final month and its absence would generally be considered an omission.

34. While Ms WJ was an inpatient at The Austin on 6 May 2019, a Goals of Care form was completed, which stated that she was for curative or restorative care within limits to be managed on the ward but was not for cardiopulmonary resuscitation or intubation. This was a medical decision[9] and according to the HMIT, probably indicated that physicians thought that aggressive or invasive procedures were either inappropriate or futile in the context of Ms WJ's underlying conditions and chance of recovery. The HMIT considered this approach to be appropriate on the basis that there is no obligation to provide futile or non-beneficial care. It was not apparent if Ms WJ's sister was informed of these discussions, but they commented it would be good practice to do so.

35. Although no Goals of Care were apparent in medical records from St Vincent's, the medical notes imply a similar opinion that medical interventions should be minimised. Accordingly, the HMIT considered that Dr Bennie's referral to palliative care on 23 May 2019 was reasonable.

<u>The language used around end-of-life management</u>

36. The HMIT commented that the term 'palliative care' carries a defined meaning within the community and is strongly associated with death and dying. However, the definition itself is not so constrained at least form a clinician's perspective. Although the major focus of palliative care is care of the dying, strictly speaking, the area of expertise of palliative care clinicians is in symptom management (as opposed to curative therapy), regardless of the patient's proximity to death.

37. The treatment that was provided to Ms WJ (converting anticonvulsant and antiemetic administration to a subcutaneous infusion), was a simple, practical and low risk intervention of significant potential benefit. It was not related to an expectation of imminent death and would be difficult to reasonably object to.

38. The HMIT acknowledged that it was unfortunate that Ms WJ died of natural causes before the planned meeting with EPCS where presumably, her management would have been discussed more fully with Ms WJ's sister and plans made for her future management.

[9] As opposed to one made by Ms WJ or her sister.

DISABILITY SERVICES COMMISSIONER REVIEW

39. On 10 September 2019 the Disability Services Commissioner (**DSC**) commenced an investigation pursuant to section 128l of the *Disability Act 2006* into Ms WJ's death.

40. The Commissioner advised Ms WJ's sister that they intended to investigate. She expressed concerns similar to those submitted to the Coroners Court, namely that her sister "*fell through the gaps*" in relation to the medical care she received proximate to her death and that essentially, her disability meant that she did not receive the same standard of care that would be furnished elsewhere, such as in aged care.

41. The DSC made several findings, two of which had relevance to the coronial investigation and aligned with the opinion of the HMIT. Namely, that the group home did not adequately document the change in Ms WJ's support requirements with the commencement of palliative care. The second finding was that the group-home staff did not fulfil their obligation to maintain contemporaneous and accurate records relating to Ms WJ.

42. They planned to issue a Notice to Take Action to DFFH to work with the new supported accommodation provider to undertake a quality audit to ensure that health documentation for all residents is accurate and up to date. Among other things, the group home were to ensure there was clear documentation in relation to arrangements for medical decision making and end of life care.

43. DFFH responded to the DSC's report and indicated they had commenced working with the group home to implement service improvements.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Ms WJ, born 5 August 1959;

    b) the death occurred on 26 May 2019 at Kew, Victoria, 3101, from Sepsis in a woman with epilepsy, cerebral palsy and haemochromatosis and was due to natural causes; and

    c) the death occurred in the circumstances described above.

45. The weight of available evidence supports a finding that, while documentation and planning for Ms WJ could have been improved, the clinical management and care provided was

reasonable and appropriate and there was no want of clinical management or care on the part of her carers or clinicians involved that caused or contributed to death.

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

Ms WJ's sister, Senior Next of Kin

Donna Filippich, St Vincent's Health,

Pauline Chapman, Austin Health

The Proper Officer, Disability Services Commissioner

Signature:

Coroner Paresa Antoniadis Spanos

Date: 25 March 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.