IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2012/2282

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of DAWN RUBY EDWARD

without holding an inquest:

find that the identity of the deceased was DAWN RUBY EDWARD

born 4 October 1939

and the death occurred on 16 June 2012

at 51 Armadale Street, Thornbury 3071

from:

1 (a) ASPIRATION OF GASTRIC CONTENTS IN A WOMAN WITH A FUNCTIONAL LARGE BOWEL OBSTRUCTION

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

1. Ms Dawn Ruby Edward was 72 years of age at the time of her death and lived at a disability support residence operated by the Department of Health and Human Services (DHHS) at 51 Armadale Street, Thornbury. Ms Edward had resided at this home for approximately 25 years with up to four other residents. She had an older sister who resided in an aged care facility. Her medical history included chronic Schizophrenia, depression, Type II Diabetes Mellitus, Eczema, Epileptic fit, hypertension, constipation and osteoarthritis. Ms Edward had sufficient interpersonal care skills and good communication skills.

2. At approximately 2.00pm on 16 June 2012, Ms Edward returned to her residence after a lunch outing. At approximately 3.00pm, she complained of feeling unwell. At approximately 3.30pm, Ms Edward was persuaded to use the toilet, following which she reported feeling better.

3. At approximately 4.30pm, Ms Edward reported feeling fine. At approximately 4.45pm, Ms Edward was located lying on the kitchen floor, stating that she could not get up. This was considered not unusual behaviour for Ms Edward. She was again taken to the toilet, and while walking in the hallway, she fell to the floor, also a common occurrence. Ms Edward was then assisted to bed. She refused dinner, also not an unusual event if the food offered was not to her taste.

4. At approximately 6.00pm, a decision was made to call for a doctor to attend and assess Ms Edward, despite Ms Edward not wanting this to occur. It was explained to her that she had to see either a doctor or paramedic. Disability Support Worker (DSW) Thee Prodromos contacted the locum doctor service, Melbourne Deputising Service,[1] at approximately 6.00pm.[2] The residence protocol was to wait for a doctor to attend or wait to be contacted by the locum service for an update, which usually occurred within a couple of hours.

5. Whilst waiting for the locum doctor to attend, Thee Prodromos checked on Ms Edward every 20-30 minutes, and left her bedroom door open so that she could be heard.

6. At approximately 7.30pm, Ms Edward called out. Thee Prodromos, who was apparently working alone at the residence after 7.00pm, attended her room and located her on the floor. She was assisted back into bed and placed on the bed in a way that attempted to prevent her rolling off. Regular checks on Ms Edward ensued, during which on two occasions Ms Edward reported feeling better. The locum doctor was still expected to attend at this stage.

7. At approximately 10.00pm, Thee Prodromos checked on Ms Edward, who was located wedged between the bed and bedside table on the floor. She was face down, and when lifted, vomit came from her mouth. Emergency Services were contacted and cardiopulmonary resuscitation

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[1] As it then was. The Melbourne Deputising Service has changed its trading name to the National Home Doctor Service. The locum service was for the Fairfield Medical Centre where Ms Edward attended as a patient.

[2] There is also evidence that the locum service was called at approximately 7.00pm; Statement of Ms Louise Stastnik dated 17 December 2014. A screen shot obtained from the locum service documents show the call as being received at 7.42pm.

(CPR) was commenced. The MFB and Paramedics attended shortly after but were unable to revive Ms Edward.

8. The locum service attended the residence at 10.47pm and there was no answer. The locum service made contact with the residence at 10.51pm and were informed that Ms Edward had died. These were apparently the only times the locum service had attempted to contact the residence.

INVESTIGATIONS

Forensic Pathology

9. Dr Malcolm Dodd, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed a post mortem examination on the body of Ms Edward, reviewed a post mortem CT scan and reviewed the Victorian Police Report of Death, Form 83. Anatomical findings included a quantity of gastric content within the distal trachea, and a markedly distended bowel. The distension pertained predominantly to the caecum where it measured up to 120mm in greatest transverse dimension. The distension extended up to the level of the hepatic flexure and to a lesser degree, extended into the transverse colon. The descending colon was of essentially normal dimension. There was no immediate evidence of torsion, volvulus or intussusceptions, however Dr Dodd noted a somewhat "S" shaped kink immediately above the caecum, but no evidence of mechanical obstruction. Examination of the bowel did not identify a definitive obstruction although it was noted that most of the distal part of the descending colon appeared somewhat narrow. There was no evidence of low lying rectal carcinoma or other luminal masses. Dr Dodd explained that an apparent obstruction without demonstrable mechanical strictures or masses is classified as a functional obstruction.

10. Dr Dodd considered that the gross distension of the bowel may have also splinted the diaphragm somewhat. Dr Dodd stated that the aspiration of the gastric contents into the major and minor airways is deemed to be related to an agonal event as no vital reaction to the foreign material was identified.

11. No significant naturally occurring disease or evidence of trauma was identified. Incidental findings included calcification of aortic valve, mild to moderate tripe vessel ischaemic coronary artery disease, mucocoele of gallbladder with cholelithiasis, multinodular colloid goitre and focal aged ischaemic changes of the left basal ganglia region of the brain.

12. Toxicological analysis of blood retrieved post mortem identified the presence of Amisulpride[3] at a concentration of 8.5mg/L. Dr Dodd noted fatalities had been recorded with blood concentrations of approximately 10mg/L. Dr Dodd concluded that the level of Amisulpride in this instance does not appear to have played a role in Ms Edward's death. Other medications were also identified, none of which exceeded the normal therapeutic usage. No alcohol was detected. Dr Dodd noted the standard biochemical analyses disclosed a mild renal impairment. Dr Dodd ascribed the cause of Ms Edward's death to natural causes, being aspiration of gastric contents in a woman with a functional large bowel obstruction.

13. Ms Edward's death was reported to the Coroners Court of Victoria, as it was considered a "reportable death", as defined in section 4 the *Coroners Act 2008* (the Act), as her death was "unexpected". Although Ms Edwards was a "person placed...in care" as it is defined in the Act, because her death was attributed by Dr Dodd in his report to natural causes, an inquest was not held into Ms Edward's death pursuant to section 52(3A) of the Act.

Police Investigation

14. The circumstances of Ms Edward's death have been the subject of investigation by Victoria Police on my behalf. The Police investigation did not identify any evidence of third party involvement.

15. Police obtained statements from DHHS House Manager (and Acting Operations Manager for Disability Accommodation Services) Ms Lina Corelli, Operations Manager for Disability Accommodation Services Ms Louise Stastnik, DSW Thee Prodromos, an MFB worker and an attending Paramedic.

16. The MFB Patient Care Record indicated a call was received at 10.10pm. The MFB arrived at the residence less than five minutes later. The ambulance records also indicate a call was received at 10.10pm, and that the ambulance arrived at the residence at 10.16pm.

17. Ms Corelli explained that staff at the residence undergo a two-day induction package plus 'shadow shifts' prior to working unsupervised. All staff are annually trained in First Aid and CPR. Each resident has an individual health plan, and annual health checks performed by their

[3] Amisulpride is an antipsychotic medication used for the treatment of schizophrenia.

local General Practitioners. Ms Edward had a routine plan relevant to her bowel health, focusing on hydration and preventing constipation. There were no alerts relating to her health.

18. Ms Corelli noted that the locum service contacted for Ms Edward on 16 June 2012 was supplied by her Medical Centre (Alphington Medical Centre).

19. Ms Corelli provided evidence of the process that was to be followed in the event of a resident becoming unwell. Ms Corelli explained that the only change to processes is that currently, staff contact 'Nurse On-call' for advice instead of the locum physician. This had changed in approximately August 2014.

20. Coroner's Investigator Senior Constable (S/C) Hall received a request dated 22 August 2012 on my behalf to prepare and submit a coronial brief of evidence. Senior Sergeant (S/S) Jenny Brumby of the Police Coronial Support Unit (PCSU) contacted the Officer in Charge of the relevant police station on 20 August 2014, requesting an explanation for the considerable delay in submitting the coronial brief of evidence.

21. By correspondence dated 13 October 2014, S/S Ian Fidler explained how this situation occurred. Although S/S Fidler acknowledged that S/C Hall performed a large amount of upgrading at different units over the previous two years, he similarly acknowledged that no satisfactory excuse can be made for the inattention to this file.

22. S/S Fidler stated that the Northcote station management acknowledge improvement can be made in the practice of managing coronial briefs of evidence. As such, they have instructed unsworn staff not to add any update to station books unless there is clear evidence that the update has been approved by a Supervisor/Sergeant. This practice has been implemented immediately. All members have been informed of this practice. The Standard Operating Procedures will be updated to clarify this practice. Further, Supervisors have been instructed to actively manage the complication of coronial briefs of evidence to ensure these are completed in a timely manner. This 'active' management is to be reflected in the reporting on monthly correspondence team reports submitted by Sergeants.

FACTORS CAUSING OR CONTRIBUTING TO DEATH

23. The evidence supports a conclusion that Ms Edward died on 16 June 2012 and that the cause of her death was aspiration of gastric contents in a woman with a functional large bowel

obstruction. There was no evidence to suggest any other cause or contribution to her death. Ms Edward died from natural causes.

FINDING

I accept and adopt the medical cause of death as identified by Dr Malcolm Dodd and find that Mr Dawn Ruby Edward died from natural causes, being aspiration of gastric contents in a woman with a functional large bowel obstruction.

Although there was a significant delay identified of approximately four hours between a locum General Practitioner being contacted and Ms Edward being located, I do not consider there is substantial evidence that this delay in itself caused or contributed to Ms Edward's demise. I further accept that Ms Edward was closely monitored during this four hour period, had reported feeling better, and that most of her behaviours during this time, such as refusing dinner, fell within Ms Edward's usual behaviour patterns, and were therefore not reasons necessarily to escalate the situation. I accept that the Disability Support Worker acted in accordance with the relevant policies and procedures in place at the time. I accordingly find that the care Ms Edward received at her residence operated by the Department of Health and Human Services was reasonable and appropriate in the circumstances.

As Ms Edward was in care within the meaning of the *Coroners Act 2008*, this Finding will be published on the Internet in accordance with section 73(1B) of the Act.

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

Ms Valerie Wilmot

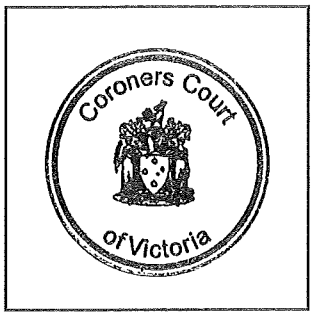
Mr Shane Beaumont, Disability Services, Department of Health and Human Services

Alphington Medical Centre

Sergeant Steven Hall

Senior Sergeant Ian Fidler

Signature:



AUDREY JAMIESON
CORONER
Date: **13 July 2015**