

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 / 5377

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Inquest into the Death of: JOANNE MARGARET BURGESS

Delivered On: 18 February 2014

Delivered At: Coroners Court of Victoria
Level 11, 222 Exhibition Street
Melbourne 3000

Hearing Dates: 18 February 2014

Findings of: PETER WHITE, CORONER

Police Coronial Support Unit Leading Senior Constable King Taylor

I, PETER WHITE, Coroner having investigated the death of JOANNE MARGARET BURGESS

AND having held an inquest in relation to this death on 18 February 2014
at Melbourne

find that the identity of the deceased was JOANNE MARGARET BURGESS
born on 24 September 1962
and the death occurred 16 December 2012
at Monash Hospital, Clayton, Victoria

from:

1 (a) ASPIRATION PNEUMONIA SECONDARY TO ASPIRATION OF PEG FEEDS

in the following circumstances:

1. Ms Joanne Margaret Burgess was a 50 year old woman who resided in a Department of Human Services facility at 55 Bulli Street in Moorabbin. She had an acquired brain injury from childhood after suffering meningitis, congenital birth anomalies and a history of epilepsy. She was confined to a wheelchair and was unable to speak. She was described by her carers as a very personable woman with a ready smile.
2. In July 2010, Ms Burgess required a PEG feed to be inserted as she could not ingest enough food to meet her nutritional requirements. The PEG operated well until early 2012 when Ms Burgess started to regurgitate her meals. In consultation with her general practitioner and a dietician it was decided that she should change from a gravity feed PEG to a metered machine to slow down the feed. She was placed on a regulated mechanical feed which was successful for a time but in mid 2012, she again had problems with regurgitation. She developed aspiration pneumonia and required multiple hospital admissions.
3. On 30 November 2012, she was admitted to the Monash Hospital with aspiration pneumonia. She was given antibiotics however further complications developed and the regurgitation continued. Due to her weakened condition she was not medically fit to undergo surgery to insert an alternate feeding tube. In consultation with Ms Burgess' family, she was palliated and passed away on 16 December 2012.
4. Doctor Michael Burke of the Victorian Institute of Forensic Medicine performed a post mortem inspection. The post mortem CT scan showed pleural effusions and increased lung markings with severe dilated porencephaly. Doctor Burke found the cause of death to be aspiration pneumonia secondary to aspiration of PEG feeds.

5. As Ms Burgess resided in a Department of Human Services Accommodation immediately prior to her death, she was classified as a person placed in care or custody under the *Coroners Act 2008* and as such, I was required under section 52(2) of the Act to hold an inquest.

Finding

I find that Joanne Margaret Burgess died as a result of aspiration pneumonia secondary to aspiration of PEG feeds. I am satisfied that Ms Burgess received an appropriate level of care at the facility and that her significant medical issues, including the care of her PEG feeds were managed appropriately.


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

Ms Margaret Burgess

Susan Van Dyke, Monash Health

Senior Constable Bret Heisey, Investigating Member, Victoria Police

Signature:



PETER WHITE
CORONER

Date: 18 February 2014

