IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 0966

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 LYNETTE DAWN SMITH

without holding an inquest pursuant to section 52(3A) of the *Coroners Act 2008*:
find that the identity of the deceased was LYNETTE DAWN SMITH
born 17 April 1951
and the death occurred on 2 March 2016
at Wantirna Health, 251 Mountain Highway Wantirna Victoria 3152
from:

1 (a) COMPLICATIONS OF CACHEXIA AND ASPIRATION PNEUMONIA ON A BACKGROUND OF CEREBRAL PALSY

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

1. Lynette Dawn Smith was 64 years of age at the time of her death. Ms Smith suffered from cerebral palsy; she used a wheelchair and was non-verbal. Ms Smith originally resided with her family, but in approximately 1990, she transitioned to state funded disability care. She resided at a care facility in Blackburn South and was a client of Scope, a disability service provider funded by the Department of Health and Human Services (DHHS).

2. On 21 February 2016, Ms Smith was admitted to Box Hill Hospital with decreased oral intake and presumed aspiration pneumonia. She had initially been treated at her care facility, but had refused oral antibiotics. Ms Smith was trialled on intravenous antibiotics, before being switched to augmentin duo forte syrup, however, Ms Smith failed to improve. Percutaneous endoscopic gastrostomy (PEG) feeding was considered by dieticians and gastroenterology teams, but it was determined that it would not improve Ms Smith's quality of life, or decrease her high risk of

aspiration. On 25 February 2016, a discussion was held between clinicians and the Office of the Public Advocate, and there was a consensus that the goals of care were changed to comfort and palliative care.

3. On 26 February 2016, Ms Smith was transferred to the palliative care unit at Wantirna Health, for symptom control and end of life care. Her symptoms included distress and agitation, and an inability to clear secretions. Ms Smith's condition deteriorated; on 1 March 2016, she experienced an episode of faecal vomiting. At 6.37am on 2 March 2016, Ms Smith was declared deceased.

4. Ms Smith's death was considered reportable pursuant to section 4 of the Coroners Act 2008 (Vic) ('the Act') because at the time of her death, it was unclear if she was, immediately before her death, considered to have been a person placed in care. Pursuant to section 3 of the Act, a person placed in care includes a person who is under the control, care or custody of the Department of Health and Human Services.

INVESTIGATIONS

Forensic pathology investigation

5. Dr Jacqueline Lee, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed a full post mortem examination upon the body of Ms Smith, reviewed a post mortem computed tomography (CT) scan and e-Medical Deposition Form from Eastern Health – Wantirna Health, and referred to the Victoria Police Report of Death, Form 83. At autopsy, Dr Lee observed *inter alia* evidence of cerebral palsy, cachexia, potential functional obstruction of the duodenum and aspiration pneumonia. Ms Smith was assessed to have a body mass index (BMI) of 16.6.[1] Primarily midzonal hepatocellular necrosis was identified; the cause for the pattern of necrosis in this case was not ascertained, but Dr Lee reported that causes can include toxins, medications and shock. There was no evidence of any injuries which may have caused or contributed to Ms Smith's death.

6. Dr Lee observed that Ms Smith had lost weight as a consequence of progressive developmental deficits associated with her cerebral palsy. It was considered likely that the marked weight loss caused her to develop a functional obstruction of the duodenum, due to compression of the

[1] Body Mass Index (BMI) uses weight and height to determine if an adult is within the healthy weight range, underweight, overweight or obese. It provides an estimate of total body fat and a person's risk of developing weight-related diseases. A BMI between 18.5 and 24.9 is considered a healthy weight range. A BMI below 18.5 is considered underweight.

bowel between the artery that passes over the duodenum and the spine. Dr Lee reported that this obstruction causes abdominal pain and vomiting, and is worsened by factors including immobilisation in a supine position and weight loss.

7. Dr Lee opined that Ms Smith's death was due to a combination of functional obstruction of the small bowel and aspiration pneumonia, which occurred on a background of functional impairment due to cerebral palsy. Ms Smith's death was ascribed to natural causes, being complications of cachexia and aspiration pneumonia, on a background of cerebral palsy.

Police investigation

8. First Constable Gyannath Seegolam, the nominated coroner's investigator,[2] conducted an investigation of the circumstances surrounding Ms Smith's death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Ms Smith's sister-in-law Irene Carman, General Practitioner at Blackburn South Medical Centre Dr Shirley Tang, Registrar at Box Hill Hospital Dr Ahmad Zargari and Clinical Director of Palliative Care at Eastern Health Dr Margaret Bird.

9. Irene Carman stated that Ms Smith was her husband's step sister. Mrs Carman reported that she had known Ms Smith since she was eight; she had always needed somebody to care for her, and assistance to move her wheelchair. She stated that Ms Smith was placed in the care of Scope in approximately 1990, when her mother became too elderly to care for her full time.

Further investigation

10. Following the receipt of the coronial brief, I directed that further information be sought from Scope in relation to Ms Smith's care. By way of statement dated 9 February 2017, Charlotte Stockwell, General Manager East Division of Scope Victoria, provided further information to the Court. Ms Stockwell confirmed that Ms Smith had no family members active in her life. Ms Smith was hospitalised several times with aspiration pneumonia in the period preceding her death. Ms Stockwell stated that she was often ill and underweight to an extent that a PEG procedure could not be safely undertaken without risk to her life.

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[2] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death:

1. Section 52 of the Act mandates the holding of an Inquest if the deceased was, immediately before death, a person placed in care, save for circumstances where the person is deemed to have died from natural causes, pursuant to section 52(3A). By way of email dated 23 December 2016, Shane Beaumont, Manager of Complex Support and Systemic Improvement at DHHS, advised that as Ms Smith was a resident of Scope, the Department did not consider she was in the 'care, control or custody' of the Secretary immediately prior to her death.

2. I view the distinction made by the DHHS between clients of residential services operated by funded disability service providers, and clients residing in properties operated by the Disability Accommodation Services branch of the Residential Client Services division of the DHHS, to be arbitrary at best. As Ms Smith had no next of kin, had been in residential care since 1990, suffered from cerebral palsy, was non-verbal and resided with Scope, I have determined that her circumstances were sufficiently analogous so as to be considered as if she was 'in care' immediately prior to her death. In the circumstances, as Dr Lee has ascribed Ms Smith's death to natural causes, being complications of cachexia and aspiration pneumonia on a background of cerebral palsy, I have determined it is appropriate to conclude this investigation by way of an in-chambers Finding.

FINDINGS

Ms Smith had a significant number of medical co-morbidities. On the evidence available to me, I find that the provision of care to Ms Smith appears to have been reasonable and appropriate.

I accept and adopt the medical cause of death as ascribed by Dr Jacqueline Lee, and find that Lynette Dawn Smith died from natural causes, being complications of cachexia and aspiration pneumonia on a background of cerebral palsy.

Pursuant to section 73(1B) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

Dr Yvette Kozielski, Eastern Health
Mr Shane Beaumont, Department of Health and Human Services
First Constable Gyannath Seegolam

Signature:

AUDREY JAMIESON
CORONER

Date: **27 June 2017**