IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2015 2093

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 MARIA ELIZABETH VALLER

without holding an inquest pursuant to section 52(3A) of the *Coroners Act 2008*:
find that the identity of the deceased was MARIA ELIZABETH VALLER
born 13 November 1958
and the death occurred on 29 April 2015
In a residential care mini-bus, outside 1493 Mount Dandenong Tourist Road, Olinda Victoria 3788
from:

1 (a) ASTHMA

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

1. Maria Elizabeth Valler[1] was 56 years of age at the time of her death. Maria had lived for three years in Department of Health and Human Services (DHHS) shared support accommodation in Manchester Road, Mooroolbark; she had previously resided at the Austin Hospital's secure

[1] At the Mention Hearing on 11 October 2016, Maria Elizabeth Valler was referred to as 'Maria'. For consistency, I have used the name Maria throughout this Finding.

psychiatric unit. Maria's medical history included autism, an intellectual disability, morbid obesity and asthma. She was taking a number of prescription medications, including quetiapine, escitalopram and lamotrigine.

2. At around 4.00pm on 29 April 2015, Maria was taken to 'Bulldog Track' in Olinda, to participate in a regular walking excursion with four other residential housemates and three disability support workers, Justin Philpott, Kwasi Owusu-Agyenan and Peter Lewis. The group commenced their walk at around 4.26pm. After reaching a specific rock, the people at the front of the group started to turn back, but Maria insisted on also walking to the rock with Mr Lewis. As she approached the rock, Maria showed some signs of fatigue.

3. At about 5.12pm, after reaching the rock and starting to return to the mini-bus, Maria became short of breath and was struggling to walk. Mr Lewis tried to contact Mr Philpott, but there was no phone reception. Maria became blue in the lips and her legs were unable to support her bodyweight. One of the carers moved the mini-bus approximately 100 metres closer to Maria. She struggled to get into the mini-bus and required the assistance of her carers. Mr Lewis joined Maria at the back of the mini-bus, to monitor her on the trip back to the residential unit. The mini-bus commenced the journey home, but Maria collapsed at about 6.00pm, slumping in her seat. The mini-bus was pulled over to the side of Mount Dandenong Tourist Road, emergency services were called and carers commenced cardiopulmonary resuscitation (CPR) pursuant to the call-taker's instructions. Ambulance paramedics arrived at 6.09pm but were unable to render assistance to Maria and she was declared deceased at 6.20pm. Police were also in attendance.

4. Maria's death was reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) ('the Act') because immediately before her death she was a person placed in care, as defined by section 3 of the Act.

INVESTIGATIONS

Forensic pathology investigation

5. Dr Paul Bedford, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed a full post mortem examination on the body of Maria and referred to the Victoria Police Report of Death, Form 83. At autopsy, Dr Bedford found evidence of underlying asthma, but no evidence of a pulmonary embolus nor significant heart disease. Dr Bedford ascribed Maria's death to natural causes, being asthma.

Police investigation

6. Leading Senior Constable Melinda Bailey-Taylor, the nominated coroner's investigator,[2] conducted an investigation of the circumstances surrounding Maria's death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Acting Area Manager at Department of Human Services[3] Sharen Calheiros, Disability Services Carers Justin Philpott, Kwasi Owusu-Agyenan and Peter Lewis, General Practitioner Dr Li Ping Zou, and Acting Disability Accommodations Services Manager Marita Carew.

7. In the course of the investigation, police learned that Maria's health was overall considered to be quite good. She had a comprehensive health assessment program, which can only be done once every 365 days. The primary focus for carers was her history of violent behaviour, including property destruction and staff assaults. The three disability support workers, Mr Philpott, Mr Owusu-Agyenan and Mr Lewis, and Sharen Calheiros, the DHHS Acting (area) Operations Manager at the time, had different levels of awareness that Maria suffered from asthma, and none of them knew of any asthma plan.

8. The evidence indicated that the Bulldog Track is an isolated track, away from the public, and was chosen because of the residents' needs and behaviours. Maria's behaviour was not considered particularly unusual when she was returning to the mini-bus; she was known to huff and puff with physical activity.

9. A treatment sheet faxed by Ms Calheiros to Leading Senior Constable Bailey-Taylor listed Seretide 250/25mcg[4] dose two puffs twice per day (dated February 2015), and Ventolin 100mcg dose as required (dated March 2015). Ms Calheiros was only aware of the Seretide, and believed it was for a 2014 bout of bronchitis. Ms Calheiros stated that given the listing of Ventolin, Maria should have had her puffer in her bag on 29 April 2015.

10. General Practitioner Dr Li Ping Zou indicated that Maria was diagnosed with asthma in August 2012; in October 2012 she was prescribed Seretide – one puff twice per day as a preventer. Her last flare up had been in January 2014, and was treated with regular Seretide and then Ventolin

---

[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.

[3] I note that the Department of Human Services is now known as the Department of Health and Human Services.

[4] Seretide 250/25 connotes 250 mcg fluticasone propionate and 25 mcg salmeterol.

as required. Dr Zou indicated that an asthma management plan and action plan was provided to - and discussed with - Maria's carer; including the timing and frequency of the preventer; when Maria was to be reviewed if she did not respond to treatment; and when to call for an ambulance.

11. Marita Carew, Acting Disability Accommodations Services Manager attached a number of documents to her statement dated 3 March 2016, including a copy of Maria's 'Specific health management plan for Asthma'.

Coroners Prevention Unit review

12. I requested that the Coroners Prevention Unit (CPU)[5] review the circumstances surrounding Maria's death. The review noted that a 2013 case study found between 2005 and 2009, 283 people in Australia, aged under 70 years of age died from asthma. There were preventable or modifiable factors identified in 70% of these deaths.

13. It was identified that the Seretide and Ventolin medication listed in Maria's treatment sheet indicated she was prescribed maximal doses of preventer and reliever medication. The treatment was scheduled for a review in May 2015.

14. The documentation provided by Ms Carew indicated Maria had an asthma management plan dated 14 October 2014. The plan was detailed in a 2009 DHHS generic template, and 14 October 2014 was also listed as the next review date. In the box asking 'is specific training required for this management plan' the answer 'no' was inserted. The review noted that this DHHS template differs from the standard asthma management plan templates available on the National Asthma Council of Australia website. This DHHS template does not specify the frequency and dosage of reliever and preventer medication iu the setting of changing severity of symptoms.

15. The review noted several issues with Maria's 2014 asthma management plan. In particular, the instructions for recognising and managing an exacerbation of asthma symptoms were unclear and incomplete. For example, there were no specific details on how to identify worsening asthma symptoms or how to manage an acute exacerbation of asthma. There was no indication of the level of education and level of understanding of Maria's asthma by the disability support

[5] 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, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

workers. Maria did not have her Ventolin with her on 29 April 2015, nor was there an indication that disability support staff identified the basic first aid steps for an acute asthma attack, or the need to administer Ventolin.

16. It was identified that asthma education includes educating the person experiencing asthma symptoms, and their parents and carers, about developing a written asthma action plan, recognising and managing an exacerbation of asthma, and implementing an emergency plan. As Maria's disabilities negatively impacted upon her health literacy; her reliance on disability support workers with likely limited health training, meant she and the workers required individualised asthma education.

Mention Hearing on 11 October 2016

17. A Mention Hearing was held on 11 October 2016, in order to progress my investigation, inform the DHHS that I was intending to make adverse comment in relation to Maria's care, and enable parties to raise any further matters that might warrant the holding of an Inquest, or alternatively completing my investigation by way of an in-chambers Finding.

18. In advance of this Hearing, the Court asked the DHHS to provide information in order to clarify the way it manages clients such as Maria, who suffer from asthma. By way of email dated 4 October 2016, Ms Catrina Boemo, Senior Solicitor at DHHS provided a statement made by Acting (area) Manager of Residential Client Services Rebecca Fitzsimons, together with 11 annexures. In particular, I note that Ms Fitzsimons stated:

    - An external consultant engaged by the DHHS to conduct a review following Maria's death, identified a number of practice issues, including:
        i. the quality of health documentation, treatment sheets and medical notes at the facility;
        ii. lack of communication and training to staff regarding Maria's medical conditions and the Specific Health Management Plan for asthma;
        iii. there was also a lack of asthma specific training, which is required by the DHHS' Residential Services Practice Manual.
        iv. It was also noted that staff did not appreciate the seriousness of Maria's asthma and were not aware of their responsibilities to ensure Ventolin as required was available to be administered. The Manual requires staff to ensure that there is sufficient medication for the entire period of any temporary absence, which did not occur on this occasion.

- A number of actions have been taken by the DHHS following Maria's death, including a reflective practice session with staff on 1 May 2015; the recruitment of a full time, permanent House Supervisor at the Manchester Road residence; an audit of Specific Health Management Plans for all clients in the area in August 2016; and training regarding these plans to all House Supervisors in the area in April 2016. In January 2016, the DHHS entered a state-wide contract with Premium Health, so as to provide training to staff regarding specific health conditions including asthma.
- Staff at the Manchester Road facility had not been provided with training specific to Maria's asthma diagnosis, because her condition was not recognised as being as serious as it should have been. Only two staff members at the facility had completed asthma training; one of these had completed it ten years previously and had difficulty recalling the specific training.
- The incorrect template (from 2009, rather than 2012) was used for Maria's Specific Health Management Plan dated 14 October 2014. This document contained minimal information and was not signed by Maria's General Practitioner.

19. At the Mention Hearing I indicated to Ms Boemo that I was of the view that problems that had arisen in relation to Maria's death were systemic, and related to deficiencies in training, rather than to individual action or inaction. I also noted that I was unclear as to why the DHHS does not use the Asthma Action Plan template that is used by the National Asthma Council.

20. In addition, I noted that although disability support workers are trained in CPR and first aid by Life Saving Victoria, the response at the time of Maria's collapse did not appear to be appropriate. In particular, I noted that Maria seemed to have already been compromised medically when she was put in the bus with the intention of driving back to the facility.

21. I asked the DHHS to provide a further statement, to address why the National Asthma Council template for Asthma Action Plans is not used by the DHHS; what first aid training is provided to staff; and what requirements exist for disability support workers to keep training up to date and undertaken periodically. In addition, I asked for information pertaining to the specific Manchester Road facility, its staff, and their level of training.

22. At the Mention Hearing, Maria's legal guardian Chrissy Perrott provided some further information. In particular, Ms Perrott noted that when Maria transitioned to the care of the DHHS in Mooroolbark, her life blossomed and she started to come into herself; *'she was in a really good place'*. Ms Perrot added that the staff at the Manchester Road facility were very

good to her, and emphasised that Maria loved the three staff members that were with her on 29 April 2015.

Further statement by Rebecca Fitzsimons

23. By way of email dated 28 October 2016, Ms Boemo, provided a further statement made by Ms Fitzsimons, together with three annexures. In particular, I note that Ms Fitzsimons stated that the standard asthma action plan template developed by the National Asthma Council focuses on the individual self-managing their asthma. However, it does not contain information about the role of carers or staff in managing the person's asthma or approval by a treating medical or health professional, which is required by the DHHS' Specific Health Management Plan (SHMP) template.

24. Ms Fitzsimons noted that the 'Asthma care plan for education and care services' developed by Asthma Australia is also available on the National Asthma Council's website. The DHHS considered this template more suitable for use in residential services, because it contains information for staff about managing an asthma attack, daily asthma management, known triggers for the person's asthma and a medication plan; includes Asthma First Aid information which staff are expected to be trained in; and has been designed to be completed by the person's treating doctor.

25. Ms Fitzsimons stated that this asthma care plan is currently used in services that support children. However, in response to Maria's death, the DHHS contacted Asthma Australia and the National Asthma Council to seek their involvement in reviewing the SHMP template for people with a disability, who have been diagnosed with asthma and live in residential services managed by the department. Asthma Australia has agreed to work with the DHHS to develop a specific template for adults that reflects contemporary practice for supporting people with asthma. A meeting between DHHS and the Victorian office of Asthma Australia was scheduled for 22 November 2016, to discuss ways of adapting the asthma care plan for use with adults in disability residential services. The National Asthma Council also supports the DHHS' intention to engage with Asthma Australia and have agreed to review the template that is developed.

26. Ms Fitzsimons reported that when finalised, the new template will be introduced into the Residential Services Practice Manual and used in asthma management training delivered to departmental residential services staff by Premium Health. As part of the training, staff will learn how to correctly complete the template. The Victorian office of Asthma Australia has also

informed the DHHS that once the new template has been finalised, it will be made available on their website as a resource for all disability service providers.

27. In relation to first aid training for disability support workers, Ms Fitzsimons stated these staff must hold current certificates in first aid and CPR. Life Saving Victoria is the registered, authorised training provider. The DHHS requires that staff have a current 'Apply First Aid' certification that is renewed every three years, and a current 'Perform CPR' certification that is renewed every 12 months.

28. In December 2015, a new system was introduced that enables staff to keep track of the currency of their certification and training. Details regarding a staff member's current certifications and their expiry is recorded on their fortnightly payslip. Staff are responsible for monitoring the expiry dates of their certification and enrolling in the appropriate training prior to the expiry date. Managers are required to ensure that staff whose certifications are not current are not rostered for shifts until they have undergone the required first aid or CPR training and their certificate is renewed.

29. In relation to the Manchester Road facility, Ms Fitzsimons noted that eleven of the twelve staff currently have mandatory first aid certification. One staff member completed a course in May 2016 with an external provider; the first aid component of her training was found to not meet requirements. Ms Fitzsimons said this staff member had been scheduled for 'Apply First Aid' training on 3 November 2016, and was not rostered on to work until after the training was completed.

30. Ms Fitzsimons reported that eleven of the twelve staff have mandatory CPR certification. One staff member's certification had expired on 26 September 2015. An investigation into why the alerts on payslips and in the roster and attendance system failed to activate in this circumstance was currently underway. Ms Fitzsimons stated that this staff member was scheduled for 'Perform CPR' training on 28 October 2016, and was not rostered on to work until after the certification was renewed.

COMMENTS

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

1. It is of considerable concern that the DHHS' care of Maria appears to have focused upon her behavioural issues, rather than providing a holistic approach which adequately encompassed her physical health.

2. Significant systemic issues have been identified in the DHHS' management of Maria's asthma. In particular, I note that staff at the Manchester Road facility had both limited and varied awareness of Maria's asthma, and had no knowledge of any asthma plan. Only two staff members at the facility had completed asthma specific training, which is required by the DHHS' Residential Services Practice Manual. Moreover, Maria's asthma management plan was deficient in a number of ways. It listed the same date for when it commenced as for when it was due for review; it stated that no specific training was required; its instructions for recognising and managing an exacerbation of asthma symptoms were unclear and incomplete; and the incorrect 2009 template, rather than the 2012 version, was used. The fact that Maria did not have her Ventolin inhaler with her at the excursion on 29 April 2015, despite the fact it was listed on her treatment sheet, reflects the lack of communication and training to staff regarding Maria's medical conditions that was found by the DHHS' own external consultant.

3. As I referred to in the Mention Hearing, it is concerning that Maria was placed in the mini-bus to return home, when she was already 'blue in the lips' with her legs unable to support her bodyweight. There is no indication that disability support workers identified the basic first aid steps for an acute asthma attack, or the need to administer Ventolin. The DHHS' new system which enables staff to keep track of the currency of their CPR and first aid certification and training appears to be a welcome addition. I do note, however, that Ms Fitzsimons indicated that a check of whether staff at the Manchester Road facility had up-to-date training in mandatory first aid and CPR, revealed some irregularities. This suggests that vigilance will still be required at residential care facilities to ensure that mandatory training is current.

4. I acknowledge that the DHHS have responded to Maria's death by taking a number of remedial and preventative actions. I commend the DHHS for recruiting a full time, permanent House Supervisor at the Manchester Road facility, conducting training regarding Specific Health Management Plans for all House Supervisors in the area, and entering a state-wide contract with

Premium Health, so as to provide training to staff regarding specific health conditions such as asthma. In particular, I commend the DHHS for engaging Asthma Australia and the National Asthma Council to review the Specific Health Management Plan template to cater for people with a disability who live in DHHS supported accommodation, and suffer from asthma. It is a positive reinforcement of DHHS' remedial and restorative responses that this will be made available for all disability service providers on the Asthma Australia website.

5. 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). In the circumstances, noting Dr Bedford has ascribed Maria's death to natural causes, being asthma; noting the concessions and remedial action taken by the DHHS; and taking into account the compelling comments made by Maria's legal guardian Ms Perrott at the Mention Hearing, I have determined it is appropriate to conclude this investigation by way of an in-chambers Finding.

FINDINGS

The investigation has identified that systemic failings on the part of the Department of Health and Human Services, meant that Maria's asthma was not appropriately managed. I find that a lack of adequate training, regarding asthma and Maria's condition specifically, to the extent that her Ventolin inhaler was not brought on the excursion on 29 April 2015, meant that an opportunity was lost to respond quickly to her symptoms and possibly prevent her death.

I accept and adopt the medical cause of death as ascribed by Dr Paul Bedford, and find that Maria Elizabeth Valler died from natural causes, being asthma.

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:

Ms Jacquelyn Saliba
Ms Catrina Boemo, Department of Health and Human Services
Ms Felicity Munt, Department of Health and Human Services
Ms Kym Peake, Secretary of the Department of Health and Human Services
Leading Senior Constable Melinda Bailey-Taylor

Signature:

AUDREY JAMIESON
CORONER

Date: **17 November 2016**