IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 4360

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of:	RAE LYNN LUKIES
Delivered On:	20 May 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Date:	20 May 2014
Findings of:	CAITLIN C ENGLISH, CORONER
Police Coronial Support Unit	Leading Senior Constable Kelly Ramsey 33004

I, CAITLIN CREED ENGLISH, Coroner having investigated the death of RAE LUKIES

AND having held an inquest in relation to this death on 20 May 2014
at MELBOURNE
find that the identity of the deceased was RAE LYNN LUKIES
born on 14 June 1955
and the death occurred on 14 October 2012
at St Vincent's Hospital, 41 Victoria Parade, Fitzroy 3065
from:

1 (a) ASPIRATION PNEUMONIA IN A WOMAN WITH CEREBRAL PALSY

in the following circumstances:

1. Ms Lukies was a 57-year-old female who resided in high level care at 9 Stainers Street, Kew. Ms Lukies had severe intellectual and physical disabilities and she required assistance for all daily activities.

2. The group home, managed by the Department of Human Services (DHS) accommodates 5 adults with a range of high support needs. Ms Lukies previously resided at Kew Residential Services (formally known as Kew Cottages) for most of her life, having moved there when she was aged 5. She lived there until it closed in 2008. Fe Abbot cared for Ms Lukies for 12 years prior to her death as an employee of DHS.

3. Due to Ms Lukies' '*in care*' status, her death is a reportable death to the coroner (s 11 *Coroners Act* 2008). Further, her 'in care' status mandates a coroner to hold an inquest into her death (s 52(2)(b)).

4. Ms Lukies had a complicated medical history including; severe cerebral palsy, epilepsy, osteoarthritis. She was non-verbal, non ambulant and blind. Ms Lukies' general practitioner Dr Hiran Edirisinghe treated Ms Lukies from 3 December 2009 until her death. Dr Edirisnghe stated that Ms Lukies "had poor bulbar function which predisposed [her] to aspiration" and that "[i]n the past she had multiple episodes of aspiration pneumonia".[1]

Police Investigation

5. A police investigation was conducted into the circumstances surrounding Ms Lukies' death.

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[1] Statement of Dr Hiran Edirisinghe, 3/4/2013

6. On 8 October 2012, Ms Lukies was seen Dr Crawford following a slight temperature and a cold. She was prescribed antibiotics.

7. On 10 October 2012, Ms Lukies was experiencing breathing problems and a high temperature. Ms Lukies was seen by Dr Crawford in the morning. Her condition worsened in the afternoon. Emergency services were contacted at 5.26pm who arrived at 5.36pm and took Ms Lukies to St Vincent's Hospital.

8. Ms Abbott noted that Ms Lukies *"wasn't able to breathe properly and her temperature was very high, and she wasn't able to cough anything out."*[2] Ms Abbott stated that *"[d]uring the 12 years that I have known her, she was quite stable in her health but did begin to deteriorate in the last 6 months prior to her death. She had a condition, aspiration pneumonia which causes high temperatures, and she was prone to this since she was young."*[3]

9. Ambulance Paramedic Alice McCann who transported Ms Lukies to hospital described Ms Lukies recent history as follows:

> *"...the patient developed a cough and a wheeze 3 days ago, doctor diagnosed a chest infection, prescribed oral antibiotics (Keflex), and Ventolin for her wheeze. Carer thought initially improved yesterday but this morning though patient was getting worse, doctor assessed and advised carer that the patient should stay home and wait to see if patient improved with another 24 hours. By the afternoon the carer thought the patient had deteriorated and called AV at 17:26."*[4]

10. Admitting Consultant Physician at St Vincents Hospital, Dr Petrova Lee summarised Ms Lukies admission as follows:

> *"Ms Lukies arrived at St Vincent's Emergency Department via ambulance with shortness of breath and difficulty breathing on the 10/10/12 following several days of symptoms of an upper respiratory tract infection that did not respond to antibiotics. Her carer called an ambulance when they noted she was cyanosed.*
>
> *She was diagnosed with aspiration pneumonia and given her background of cerebral palsy, epilepsy and previous aspiration pneumonia, was admitted to 8 West under*

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[2] Statement of Fe Abbott, Department of Human Services Carer, 19/3/13.

[3] Ibid.

[4] Statement of Ambulance Paramedic Alice McCann, 17/4/13.

General Medical B for treatment with IV antibiotics. Her CXR was consistent with a pneumonia.

The patient deteriorated despite treatment, and after consultation with her next of kin, the decision was made to treat Ms Lukies palliatively. She passed away peacefully in the ward on the 14/10/2012."[5]

Health and Medical Investigation

11. The matter was referred to the Coroners Prevention Unit, Health & Medical Investigation Team (HMIT)[6] on 22 January 2014. They concluded that there were no issues with the medical management of Ms Lukies and that she died from a natural death.

The Inspection Report

12. Forensic Pathologist Dr Melissa Baker from Victorian Institute of Forensic Medicine conducted an inspection and examination on Ms Lukies on 16 October 2012. In her report, she made the following comments:

"According to information obtained from the deceased's medical file from St Vincent's Hospital the deceased was a 57 year old woman who was in high level care (Department of Human Services). She had a history of severe cerebral palsy and had been in care since childhood. She was non-verbal, non-ambulant and dependent for all activities of daily living. Her medical history also included blindness, epilepsy, osteoarthritis and aspiration pneumonia. She presented to St Vincent's Hospital on 10th October 2012 with a history of coryzal symptoms for the last four days. The day before she had become more short of breath and was commenced on Cephalexin without improvement. On the day of admission she had deteriorated further with central cyanosis noted by her carer. An ambulance was called and a respiratory rate of 36 was recorded along with oxygen saturations of 69%. She had no fevers or rigors but was diaphoretic. On arrival to hospital she was tachypnoeic (respiratory rate 34) and tachycardiac (heart rate 123). Accessory muscle use was noted. Chest X-ray

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[5] Statement of Dr Petrova Lee, Consultant Physician, St. Vincent's Hospital, Melbourne, 28/2/13.

[6] The role of the Health and Medical Investigation Team (HMIT) is to assist the Coroner's investigation into the nature and extent of deaths which occurred during the provision of healthcare, and identify potential system factors in healthcare related deaths. HMIT personnel comprise of practising Physicians and Clinical Research Nurses who draw on their medical, nursing and research experiences, skills and knowledge to independently evaluate clinical evidence for the investigation of reportable healthcare deaths and to assist in identifying remediable factors that may assist in prevention and risk management in health services settings.

showed apparent opacification of the left lung field. Blood tests revealed a markedly elevated white cell count (34.7 x 10^9/L) and platelet count (966 x 10^9/L) and a C-reactive protein greater than 500 mg/L. She was admitted and treated for severe aspiration pneumonia with intravenous antibiotics and fluid. On 11th October a MET call was made for hypoxia (90% on 15 litres), tachycardia (heart rate 130 to 140) and tachypnoeic (respiratory rate 40). She was on maximal oxygen therapy. Her mother was spoken to and confirmed a poor baseline level of functioning and agreed that intubation and resuscitation attempts would be futile and cruel. She agreed with ward management and comfort measures if the deceased deteriorated. She had a seizure the following day in the setting of withdrawal of anticonvulsant medication secondary to drowsiness. The plan was to continue treatment for three days however following review by the palliative care team intravenous antibiotics and fluids were ceased as it was felt she was in the terminal phases of her illness and was symptomatic with fevers and dyspnoeic. She was commenced on a syringe driver. She remained comfortable and died on 14th October 2012.

According to the deposition from St Vincent's Hospital a possible cause of death was given as 'aspiration pneumonia'. There were not issues to be addressed by the forensic pathologist.

External examination revealed a woman of short stature with muscle wasting and prominent thoracic kyphosis. No significant injuries were identified.

Post mortem CT scan revealed a large left pleural effusion with deviation of the heart to the right, a small right pleural effusion and increased lung markings predominantly involving the right lung."[7]

13. Dr Baker concluded her report with a specific finding of the medical cause of death as aspiration pneumonia in a woman with cerebral palsy. In all the circumstances, I accept that as the cause of Ms Lukis death.

[7] Forensic Pathology Report of Dr Melissa Baker, 29/10/12.

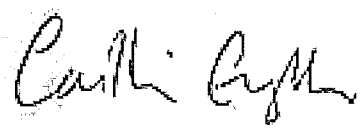
I direct that a copy of this finding be provided to the following:

Mrs Edna Lukies

Constable Peng Gao, Investigating Member, Victoria Police

Melanie Kyezor, Clinical Risk Manager, St Vincent's Health

Signature:



CAITLIN ENGLISH
CORONER
Date: **20 May 2014**