IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2016 5430**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**SHIRLEY GOODALL**
Date of birth:	**27 DECEMBER 1949**
Date of death:	**16 NOVEMBER 2016**
Cause of death:	**PNEUMONIA IN A WOMAN WITH MULTIPLE MEDICAL COMORBIDITIES**
Place of death:	**SUNSHINE HOSPITAL** **176 FURLONG ROAD** **ST ALBANS VICTORIA 3021**

HIS HONOUR:

BACKGROUND

1. Shirley Goodall was born on 27 December 1949. She was 66 years old at the time of her death. Shirley lived at the Disability Group Home at 41 Black Forest Road Werribee.

2. Shirley had an intellectual disability and was diagnosed with bipolar disorder. She suffered from aortic valve regurgitation which causes drop attacks. Shirley had limited expressive and receptive communication skills and required full support with most areas of her life. Shirley had two sisters, both of whom are deceased. Later in life Shirley had reconnected with her cousins who provided bed side support when she was in palliative care.

3. Shirley's general health was monitored by her General Practitioner, Dr Angelo La Spina, of the Werribee Medical Centre. Her mental health was monitored by Dr Tom Wisinger and Shirley's aortic valve regurgitation was monitored by her cardiologist, Dr Louise Creati.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Shirley's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as immediately before death she was a person placed under the care of the secretary to the Department of Health and Human Services ('DHHS').[1] Ordinarily, a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and the deceased person was immediately before death a person placed in custody or care.[2] However, a coroner is not required to hold an inquest if they consider that the death was due to natural causes.[3]

5. The jurisdiction of the Coroners Court of Victoria is inquisitorial[4]. The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

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[1] Section 4, definition of 'Reportable death', *Coroners Act 2008;* Section 4, definition of 'Person placed in custody or care', *Coroners Act 2008.*
[2] Section 52(2)(b) *Coroners Act 2008.*
[3] Section 52(3A), *Coroners Act 2008.*
[4] Section 89(4) *Coroners Act 2008.*

6. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

7. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

8. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

9. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

10. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

11. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[6] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

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[5] *Keown v Khan* (1999) 1 VR 69.
[6] (1938) 60 CLR 336.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

12. Shirley Goodall was visually identified by her cousin, John Sebire, on 28 November 2016. Identity is not disputed and requires no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

13. On 18 November 2016, Dr Victoria Francis, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an inspection on Shirley's body and provided a written report dated 25 November 2016, concluding a reasonable cause of death to be "I(a) Pneumonia in a woman with multiple medical comorbidities". I accept her opinion in relation to the cause of death.

14. Dr Francis noted that on the basis of the information available to her, Shirley's death was due to natural causes.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

15. On 24 September 2016 Shirley was admitted to hospital with upper respiratory tract infections. She remained in hospital until 27 September 2016. On 28 September 2016 Shirley had a follow up appointment with Dr La Spina, who prescribed antibiotics and a chest x-ray in 4 weeks' time. On 30 September 2016 Shirley saw a locum doctor because she was struggling to eat and drink. No treatment was prescribed. Shirley saw Dr Spina on 3 October 2016 and found Shirley to be anaemic. Dr Spina ordered a blood test and arranged for Shirley to be seen by her Occupational Therapist in relation to Shirley's unsteadiness since her hospitalisation. She was seen by an Occupational Therapist on 12 October 2016.

16. From 13 October 2016 to 31 October 2016 Shirley saw Dr La Spina and a locum doctor a number of times, but her health was not improving. On 31 October 2016 Shirley was transported by Ambulance Paramedics to Sunshine Hospital with aspiration pneumonia. Shirley did not respond to treatment, and on 7 November 2016 family and the group home were notified that Shirley was palliated. At 8.00pm on 16 November 2016 Shirley passed away.

FINDINGS

17. Having investigated Shirley Goodall's death and having considered all of the available evidence, I am satisfied that no further investigation is required.

18. I find that the care provided to Shirley by the Department of Health and Human Services and Sunshine Hospital was reasonable and appropriate in the circumstances.

19. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Shirley Goodall, born 27 December 1949;

    (b) that Shirley Goodall died on 16 November 2016, at Sunshine Hospital, 176 Furlong Road, St Albans, Victoria from pneumonia in a woman with multiple medical comorbidities; and

    (c) that the death occurred in the circumstances described in the paragraphs above.

20. I convey my sincerest sympathy to Shirley's family and friends.

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

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

    (a) Shirley's family, senior next of kin;

    (b) Investigating Member, Victoria Police; and

    (c) Interested Parties.

Signature:

MR JOHN OLLE
CORONER

Date: 30 May 2017