IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 5763

**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 SYDNEY DALE STANFIELD

without holding an inquest pursuant to section 52(3A) of the *Coroners Act 2008* (Vic):

find that the identity of the deceased was SYDNEY DALE STANFIELD

born 22 December 1961

and the death occurred on 3 October 2017

at Wantirna Health Palliative Care Unit 251 Mountain Highway, Wantirna, Victoria 3152

**from:**

1 (a) ASPIRATION PNEUMONIA

(b) SEVERE ACQUIRED BRAIN INJURY

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

1. Sydney 'Dale' Stanfield was 55 years of age at the time of his death. He resided at 45 Lemon Grove, Nunawading, in a Disability Accommodation Service (**DAS**) group home funded by the Department of Health and Human Services (**DHHS**).

2. As a result of a severe Acquired Brain Injury (**ABI**) during childhood, Mr Stansfield suffered many conditions including an intellectual disability, quadriplegia, and low kidney function. He was treated with numerous medications in relation to these conditions. At the time of his death, Mr Stanfield's sister Carole Coghlan was his medical guardian and was in charge of his financial affairs. She was actively involved in all aspects of her brother's life, including healthcare and medical treatment.

3. On 3 October 2017, Mr Stanfield died in the Wantirna Palliative Care Unit (**PCU**) subsequent to a long decline in his health. Wantirna Health medical professionals determined that Mr Stanfield had died from aspiration pneumonia.

## CORONIAL JURISDICTION

4. Mr Stanfield's death is reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) (**'the Act'**) because he was a person placed in care at the time of his death. Section 3 of the Act states that a person placed in care includes a person who is under the control, care or custody of DHHS. However, Mr Stanfield's in care status was not reported to the Court by DHHS, the DAS group home's staff, or the Wantirna PCU.

5. Mr Stanfield's death was reported to the Court by the Registrar of Births Death and Marriages (**BDM**) upon production of his Death Certificate. Mr Stanfield's death certificate was signed by Dr Alannah Kavanagh of Wantirna Health. His cause of death was listed as aspiration pneumonia which arose as a consequence of a severe ABI.

6. Upon receipt of the Death Certificate, I determined that Mr Stanfield's death was reportable pursuant to section 4 of the Act;[1] his death appeared to be related to the ABI he suffered as a result of an injury.

7. A Death Certificate does not include details of a person's residential status. Consequently, Mr Stanfield's death was not considered in light of his being in care and the Coronial Investigation was finalised by way of a Form 38 *Finding into a Death without Circumstances* on 7 December 2017. This document specified that Mr Stanfield was not, before his death, a person placed in custody or care. The document stated that there was no public interest to be served in making Findings regarding the circumstances of his death.

[1] *Coroners Act 2008* (Vic) ss 4(10) and 4(2)(a).

8. Upon receiving the Finding, Mrs Coghlan contacted the Court to advise that Mr Stanfield was, in fact, in care prior to his death. Consequently, a Court Registrar contacted DHHS for further information on 20 December 2017.

9. On 27 December 2017, a Senior Program Officer at DHHS, Lillian Kearney, confirmed Mr Stanfield's in care status. A Form 44 *Determination Following Application to Set Aside Finding* was created to reopen the investigation into Mr Stanfield's death as I found that their were new facts and circumstances sufficient to reopen the matter. Pursuant to the Act, a Coroner must make written Findings in respect of the death of an individual who resided in care.[2]

10. Section 52(3A) of the Act provides, *inter alia*, that a Coroner is not required to hold an Inquest into the death of a person who was in custody or care immediately before their death, if the Coroner considers that their death was due to natural causes. Mr Stanfield's death falls under the auspices of this section of the Coronial legislation and, consequently, I have determined that it was appropriate to finalise my Investigation by way of a Form 38 *Finding into a Death with Circumstances.* Such a Finding must be published, pursuant to section 73(1B) of the Act.

## INVESTIGATIONS

*Police investigation*

11. Leading Senior Constable (**LSC**) Darren Cathie was the nominated Coroner's investigator.[3] In light of Mr Stanfield's in care status, I directed LSC Cathie to conduct an investigation of the circumstances surrounding Mr Stanfield's death, including preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Operations Manager at DHHS Todd Keating, General Practitioner (**GP**) Dr Kolin Lu and Palliative Care Physician Dr David Kenner of Box Hill Hospital and Wantirna Health.

12. In the course of the investigation, LSC Cathie learned that Mr Stanfield's ABI was sustained at a very early age. Mr Stanfield had lived in the family home for the majority

[2] *Coroners Act 2008* (Vic) s 67(2)(b)(i).

[3] 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 receives directions from a Coroner and carries out the role subject to those directions.

of his life before moving into the group home on 7 May 2008. Mr Keating stated that Mr Stanfield could communicate verbally but required a very high level of physical support, including the use of an electric wheelchair operated by DHHS staff. Mr Stanfield needed a Percutaneous Endoscopic Gastrostomy (**PEG**) tube[4] for nutrition as he was unable to consume a full range of nutrients orally.

13. Mr Keating stated that Mr Stanfield had initially participated five days per week in a day program operated by Scope Victoria. However, during the final two years of his life, his health and stamina had deteriorated and he was no longer able to participate. Mr Stanfield was able to enjoy low impact activities at the group home where he could rest when necessary. Mr Keating commented that Mr Stanfield was well-liked and respected for his calm and friendly demeanour; he always enquired after staff and how they were doing.

14. Mr Keating said that Mr Stanfield's medical needs were managed by General Practitioners at the Whitehorse Medical Centre in Mitcham and the Royal District Nursing Service (**RDNS**).

15. Between 12 February 2016 and 23 March 2017, Dr David Carne was Mr Stanfield's regular GP, a role that was acquired by Dr Lu upon Dr Carne's retirement. Prior to this period, Dr Lu stated that Mr Stanfield's general healthcare had been managed through North Mitcham Clinic. Dr Lu stated that Mr Stanfield was a complex patient whose medical history included: Type 2 Diabetes Mellitus since 2005, Recurrent Aspiration Pneumonia since 2007, Chronic Renal Failure since 2012, Chronic Hyponatremia[5] since 2016, Steroid Responsive Hypercalcaemia[6] since 2016 and constipation since 2016. He was also treated for electrolyte imbalance and Lower Respiratory Tract Infections.

16. Dr Lu stated that Mr Stanfield's Type 2 Diabetes Mellitus, Chronic Hyponatremia and Hypocalcaemia were frequently reviewed by the Box Hill Endocrinology Unit. When these conditions stabilised, he had regular blood tests for monitoring.

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[4] A PEG Tube is inserted into a person's stomach through their abdominal wall.

[5] Hyponatremia is a condition whereby the sodium in the blood is diluted due to water retention, symptoms may include nausea, headache and confusion or fatigue.

[6] Hypercalcaemia is a condition whereby calcium content in the blood is increased due to overactive parathyroid glands or cancer, symptoms may include increased urination, stomach pain, nausea, confusion or fatigue.

17. On 23 March 2017, Mr Stanfield's first consultation with Dr Lu resulted in his being referred to Box Hill Hospital immediately for urgent assessment and management of Hyponatremia, Hypercalcaemia, Renal Failure and Leukocytosis.

18. On 24 June 2017, Dr Lu received urgent results from Dorevitch Pathology who had identified that Mr Stanfield had sufficiently low sodium levels (119 mEq/L)[7] to warrant transfer to the Emergency Department of Box Hill Hospital. Dr Lu made the arrangements immediately.

19. On 26 July 2017, Dr Lu reviewed Mr Stanfield in person for a second and final consultation. At that time, Mr Stanfield had been treated by another doctor for a Lower Respiratory Tract Infection which he had throughout the previous week. He was prescribed Amoxicillin in combination with Metronidazole. Dr Lu also prescribed Augmentin Duo Syrup to take twice per day with meals for a week. He scheduled a further review if Mr Stanfield's condition did not improve.

20. On 16 August 2017, Dr Lu reviewed Mr Stanfield's electrolytes and found that his sodium levels were low (124 mEq/L) again. However, on this occasion, Dr Lu discussed his patient's condition with Mrs Coghlan and the hospital, and a mutual decision was made not to admit him. The determination was based on the fact that Mr Stanfield's electrolytes were higher than before, he appeared otherwise well and he would likely be more comfortable in his home environment.

21. On 29 August 2017, Mr Stanfield's condition deteriorated. He was admitted to Box Hill Hospital for assessment and probable end of life care in the setting of: acute on chronic renal failure, primary hyperparathyroidism, Type 2 Diabetes Mellitus, aspiration pneumonia and hyponatraemia on the background of a severe ABI. He was initially managed with intravenous N-saline, ceftriaxone[8] and insulin.

22. On 22 September 2017, Mr Stanfield was discharged to Wantirna PCU following a meeting with Box Hill Hospital medical professionals, palliative care support staff, and Mrs Coghlan. The goals of his care were agreed to be end-of-life management.

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[7] Sodium levels in the blood are measured by "milliequivalents" per litre and a person is considered to have Hyponatremia where their sodium levels are below 135 mEq/L.

[8] A drug which may treat a number of different bacterial infections.

23. On 23 September 2017, Dr Kenner reviewed Mr Stanfield and determined that it was highly likely he would die from recurrent aspiration pneumonia. Mr Stanfield received modified PEG tube feeding; he was reviewed by a dietitian and provided with a reduced volume diet, gastro-kinetic agents[9] and insulin.

24. Dr Kenner stated that Mr Stanfield's condition deteriorated and he remained a high risk for further episodes of aspiration pneumonia. After discussion between Mrs Coghlan and health professionals, a decision was made to discontinue antibiotic administration. Mr Stanfield had intermittent fevers which were managed with pain relief. His condition worsened and he became febrile on 2 October 2017.

25. On 3 October 2017 at 5.05am, Mr Stanfield was declared deceased.

## COMMENTS

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

1. There is no evidence to suggest that there is any public interest in taking this matter to a Hearing by way of an Inquest. Mr Stanfield's medical care and treatment appears reasonable; there have been no issues identified in relation to his medical care and treatment. There are no family concerns in relation to the same.

2. My Investigation has corroborated the information provided to me in the Death Certificate, that is, Mr Stanfield's death arose from natural causes. As such, section 52(3A) of the Act provides that it is not mandatory to hold an Inquest into this matter. However, his death has been investigated pursuant to the mandate to investigate and produce written findings in relation to all deaths which occur "in care". Additionally, the Finding must be published, pursuant to section 73(1B) of the Act.

3. I acknowledge that it may be difficult for Mr Stanfield's loved ones, and especially his sister, to understand why an Investigation must be conducted in these circumstances. Coronial Investigations into "in care" or "in custody" deaths operate to identify any issues which arise when an individual is in the care of the State of Victoria. In that regard a

[9] This medication increases the body's ability to process food by promoting the ability of the gastro-intestinal tract to propel and move food.

Coroner's Investigation operates as an important, albeit final, safeguard in relation to the protection of such persons' rights and interests.

4. I am deeply concerned that neither DHHS, the DAS Group Home staff nor Wantirna Health staff recognised their duty to report Mr Stanfield's death to the Coroners Court, pursuant to their general and specific legislative obligations to report the death.[10] There is no way of knowing whether this kind of failure to report occurs regularly. I am reliant upon those responsible to report a death that occurs in care so that I may properly dispense my duty under the Act.

**FINDINGS**

The investigation has identified that Sydney 'Dale' Stanfield suffered a number of health conditions and that his condition deteriorated significantly in the final months of his life, resulting in hospitalisation.

I accept and adopt the medical cause of death indicated by Dr Alannah Kavanagh of Wantirna Health pursuant to the Death Certificate, and I find that Sydney Dale Stanfield died from aspiration pneumonia which arose as a consequence of a severe Acquired Brain Injury.

I find that there is no causal connection between the cause of Sydney Dale Stanfield's death and the care provided to him by the Department of Health and Human Services by way of the Lemon Grove Disability Access Service Group Home.

I further find that there is no causal connection between Sydney Dale Stanfield's death and the medical care and treatment provided to him by Wantirna Health.

[10] *Coroners Act 2008* (Vic) ss 10, 11, and 12.

**RECOMMENDATIONS**

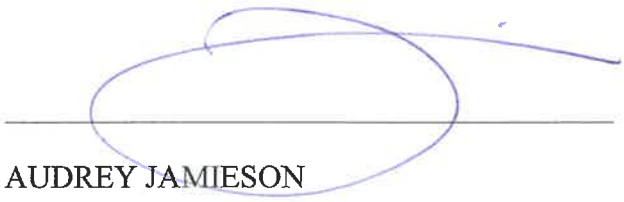
Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations:

1. With the aim of promoting public health and safety, **I recommend** that the Department of Health and Human Services implement training to educate the staff of their residential units on their specific and general obligation to report "in care" deaths to the Coroners Court of Victoria.

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:
Mrs Carole Coghlan
Wantirna Health
The Disability Services Commissioner
Dr Kolin Lu of Whitehorse Medical Centre
The Department of Health and Human Services

Signature:




AUDREY JAMIESON
CORONER
Date: **24 October 2018**