IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 2418

FINDING INTO DEATH WITH INQUEST

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

Findings of:	**CORONER MICHELLE HODGSON**
Deceased:	MARCO ANGELO VIRGONA
Delivered on:	16 SEPTEMBER 2019
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	13 AUGUST 2019
Counsel assisting the Coroner:	Senior Constable Jeffrey Dart, Victoria Police
Representation:	Ms Robyn Kaye for Ambulance Victoria Mr Robert Harper for Yooralla

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HER HONOUR:

BACKGROUND

1 Marco Virgona was 45 years of age when he passed away as a result of **1(a) Aspiration Pneumonia** and **(2) Acquired Brain Injury** as a contributing factor.

2 Mr Virgona had been a long-term resident of Yooralla having sustained an acquired brain injury as a result of a motor vehicle accident when he was 8 years of age.

3 In addition to an acquired brain injury, he had a medical history of epilepsy, deep vein thrombosis and pulmonary embolism. His medications included anticonvulsants and warfarin.

4 On the day of his death, an emergency ambulance was called to attend to him at his residence.

5 The paramedics who attended that morning assessed Mr Virgona and were of the view that Mr Virgona had gastroenteritis and advised staff to keep his fluids up and to call Ambulance Victoria if there were any further concerns.

6 Mr Virgona became more unwell that afternoon, when he developed respiratory distress and noisy breathing. Ambulance Victoria was called again and Mr Virgona was transported to Frankston Hospital by ambulance.

7 At the time of transfer, it was clear that he was very unwell with a diagnosis of aspiration pneumonia that was confirmed on x-ray.

8 In the Emergency Department, Mr Virgona continued to deteriorate and medical staff decided that he required intubation and respiratory support. In the process of intubation, Mr Virgona suffered a cardiac arrest.

9 Mr Virgona did not respond to resuscitation measures and passed away at 7.13 pm that evening.

10 Mr Virgona was a much-loved member of his family and community. He is remembered as someone who loved "his life, his music, his coffee and a good joke most of all."

THE PURPOSE OF A CORONIAL INVESTIGATION

11 Mr Virgona's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as his death occurred in Victoria, and was unexpected.[1]

12 The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The purpose of a coronial investigation is to independently 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.

13 It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

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

15 For coronial purposes, the circumstances in which death occurred refers to the context or background and circumstances surrounding the death. Rather than being a consideration of all circumstances which may 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.

16 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.

17 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

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[1] *Coroners Act 2008* (Vic) s4.
[2] *Coroners Act 2008* (Vic) s89(4).
[3] *Keown v Khan* (1999) 1 VR 69.

(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.

18 These powers are the vehicles by which the prevention role may be advanced.

19 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*.[4] 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.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

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

20 On 26 May 2017, Mr Virgona was visually identified by his sister, Terzita Virgona.

21 Mr Virgona's identity is not in dispute and therefore requires no further investigation.

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

22 On 29 May 2019, Dr Yeliena Baber, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine **(VIFM)** conducted an autopsy of Mr Virgona's body. Dr Baber provided a written report, dated 22 June 2017, which concluded that a reasonable cause of death was 1(a) ASPIRATION PNEUMONIA and (2) ACQUIRED BRAIN INJURY as a contributing factor.

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

FAMILY CONCERNS

23 In a series of communications to the Court, Mr Virgona's family, through their representatives, namely his mother Mrs Concetta Virgona and sister Ms Terzita Virgona, have raised a number of questions relating to the circumstances of Mr Virgona's death.

Why was Mr Virgona's face red after death?

24 On 6 February 2019, a meeting was held between VIFM staff and Mrs Concetta and Ms Terzita Virgona. VIFM staff explained that despite the belief that Mr Virgona's discolouration was a consequence of internal bleeding, this is not so, and discolouration was within the normal range decompositional changes that occur post mortem.

25 Ms and Mrs Virgona gave an account at this meeting that they were told by coronial staff that the cause of death was obviously internal bleeding. I have been unable to find any record of this conversation in the contact log with VIFM staff and can only assume that some miscommunication occurred. There is very clear medical evidence that Mr Virgona did not suffer from internal bleeding prior to his death from aspiration pneumonia.

26 Given the family concerns and the content of the E-medical Deposition Form, when Dr Baber conducted the autopsy, one of the matters she gave particular care to was whether there was any evidence of internal bleeding that may have contributed to Mr Virgona's death.

27 She concluded:

> *At autopsy, there was no evidence of "coffee ground" material i.e. altered blood in the stomach. The gastric mucosa was free of gastritis and ulceration. The material vomited reflected the dark colouration of the stomach contents (mushrooms, etc). <u>The remainder of the gastrointestinal tract showed no evidence of acute or remote haemorrhage.</u>*

28 The E-Medical Deposition Form from Frankston Hospital denotes that at the time of admission at 4.14 pm, the admission diagnosis was haematemesis.[5]

29 Mr Virgona was then independently examined at the hospital:

> *Subsequent examination of Mr Virgona at Frankston Hospital showed bilateral aspiration pneumonia. Mr Virgona was subsequently resuscitated with intravenous fluid, intravenous antibiotics and high flow oxygen to optimise his condition.*
>
> *Consultations were made with Intensive Care, Gastroenterology and General Surgery.*

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[4] (1938) 60 CLR 336.

[5] Haematemesis is simply defined as 'vomiting blood'. It is caused by bleeding from part of the upper portion of the gastrointestinal tract. It has a wide range of possible causes, depending on the site of blood loss and the tissue that is actively bleeding.

At 1834 hours, following review and attempt of resuscitation without improvement of his respiratory and haemodynamic status, a decision was made for Mr Virgona to be intubated. Mr Virgona underwent Rapid sequence Induction with ketamine, Suxamethonium with Metraminol for inotropic support.

At 1837 hours, Mr Virgona was intubated.

At 1838 hours had a VF arrest and advanced life support (ALS) was commenced. At this time the endotracheal tube (ETT) had brown fluid coming out of it. The ETT was removed and Mr Virgona was ventilated with an oropharyngeal airway and bag, mask ventilation on suspicion of oesophageal intubation. A repeat endotracheal intubation was undertaken at 1847 hours.

Despite multiple cycles of ALS with 1mg boluses of adrenaline, resuscitation efforts were unsuccessful and his resuscitation was ceased at 1913 hours on 23 May 2017.

30 Therefore, it is incorrect to assert that Mr Virgona was treated as though he had internal bleeding. Rather, Mr Virgona was treated symptomatically as detailed in the medical records and statement of Dr Shyaman Menon.

What caused the vomiting?

31 It is very difficult to ascertain the cause of Mr Virgona's vomiting.

32 In the absence of evidence of gastrointestinal bleeding or structured bowel obstruction, it is most likely that Mr Virgona was suffering from gastroenteritis, usually a short-term illness triggered by infection in, and inflammation of the digestive system.

33 The causes of gastroenteritis are many and varied and can include viruses, bacteria, bacterial toxins, parasites, particular chemicals and some drugs.

Why wasn't Marco taken to hospital by paramedics in the morning of 23 May 2019?

34 In light of Mr Virgona's death in the afternoon of 23 May 2017, the family's representatives questioned why Ambulance Victoria paramedics decided not to transport Mr Virgona to hospital on the morning of his death and ask whether Mr Virgona's death was preventable in the circumstances.

35 Upon review of the Coronial Brief, there were inconsistencies in the accounts provided by Ms Kim Franzi and Ms Leanne Woodman, carers at Yooralla that morning and the attending paramedics, Ms Chloe Cupit and Ms Zoe Welsh.

What were the observations of Paramedics Welsh and Cupit?

36 An inquest of was held on 13 August 2019, to clarify the circumstances of the Ambulance paramedics' attendance and to determine whether they were aware of the information that Mr Virgona's vomit was black in colour.

37 The concern regarding black vomit or diarrhoea relates to the possibility of internal bowel bleeding. When blood from the upper gastrointestinal tract is digested in the gut, it becomes black, which is known as melena. Vomiting black vomit is very unusual and implies the vomiting of digested blood.

38 Ms Leanne Woodman and Ms Kim Franzi, experienced Disability Support Workers who cared for Mr Virgona and Paramedics Cupit and Welsh gave evidence at the inquest.

39 Ms Franzi attended to Mr Virgona upon his waking that morning. She described his vomit as "dark in colour and that there were chunks of undigested food matter in it, and it was still quite wet in some areas."

40 Ms Woodman arrived at the residence at around 9.50am, having been advised by Ms Franzi that Mr Virgona had been vomiting and had diarrhoea.

41 Yooralla staff members made attempts that morning to have a GP or locum attend to Mr Virgona, however had been unsuccessful.

42 At around 10.20am Ms Woodman rang Ambulance Victoria.

43 An entry in Ambulance Victoria records at 10.20am on the morning of 23 May 2017 displays the words "Problem Black V & D". This indicates that Ms Woodman advised Ambulance Victoria that Mr Virgona had expelled black vomiting and diarrhoea.

44 A Chronology Report – Event ID 86268163[6] displays what would have come up on a screen in the ambulance to alert Paramedics Cupit and Welsh as to the nature of the job that they were about to attend.

[6] Page 90, Coronial Brief

45 In evidence, Paramedic Welsh stated that she would have seen that entry.[7] In relation to how the paramedics would have regarded that entry Paramedic Welsh stated:

> *"Generally, we would take them with a grain of salt because that problem is recorded as what the call taker – whoever is calling the ambulance, that's literally what they're saying to the dispatcher. And so that's the dispatcher's job to write it down. We generally take it with a grain of salt and start assessment fresh when we get to a job because a lot of the time it's completely off base from what's actually going on."*

46 Paramedic Welsh says however, that she could not from memory recall reading "Black V & D".

47 Paramedic Cupit also could not recall whether she was aware of the entry when she attended at the residence, and stated:

> *"We still-like, go in and still do our same observations and treatment regardless of what comes up because it's not always exactly correct so you kind of go in there with an open mind and, yeah, do all the vital signs and what-not and make your own judgment of what's actually going on"*

48 Ms Woodman states that she spoke to Paramedic Welsh upon her arrival at Yooralla.

49 Paramedic Welsh agreed that it was possible that she was advised by Ms Franzi and Ms Woodman that Mr Virgona had vomited black material and that he was on warfarin, although she had no independent recollection of being told this.

50 There remains a conflict in the evidence as to whether Paramedic Welsh was present when Mr Virgona vomited or saw Mr Virgona shortly after he vomited.

51 In her statement dated 22 September 2017, Paramedic Welsh noted that Mr Virgona had three episodes of vomiting that morning, and stated:

> *"The care worker led us into the house to one of the bedrooms, where I saw a male person in bed. He was conscious and breathing. I also noticed what appeared to be vomit down the front of his shirt, which was being cleaned up by two female care workers."*

[7] Ms Welsh is a paramedic who has formal qualifications with a Bachelor Degree and two years post graduate training as a paramedic as well as 10 years' experience at the time of these events. Ms Cupit was in her second or third month as a paramedic graduate trainee.

52 Ms Woodman stated that as she entered the room with Paramedic Welsh, Mr Virgona began to vomit at which point she grabbed a towel and held it around Mr Virgona's head as he vomited into the towel.

53 Ms Franzi took over talking to the paramedics whilst Ms Woodman attended to Mr Virgona at this stage. This is consistent with her evidence that she did not observe the vomit that would have been observed by Paramedic Welsh or Paramedic Cupit, though she concedes that what they observed may well have been light in colour given the contents of Mr Virgona's breakfast (banana and oats).

54 Paramedic Cupit also has no recollection of Mr Virgona actually vomiting in her presence. She stated that the vomit she observed on Mr Virgona's shirt front was light coloured and appeared to be food matter.

55 Paramedic Cupit states she was there for part of the conversation with Yooralla staff, but was attending to other tasks and did not hear the entirety of the conversation between Yooralla staff members and Paramedic Welsh.

56 Paramedic Welsh stated that her own observations of the vomit allayed her concerns that there was blood in the vomit. She stated that if she had not had the opportunity to observe the vomit herself, she would have been dependant on the assessment or reporting of the staff members, however she was able to exercise her own clinical judgment and was satisfied that the vomit did not contain blood.

> *"If I had not sighted the vomit at all I would absolutely take their word and yes, okay, it's black, because I haven't been able to sight it, you transport him. But because I can see it myself, I can exclude that it's blood."*

57 The decision not to transfer Mr Virgona to hospital was ultimately made by Paramedic Welsh who relied on her observations and clinical assessment of Mr Virgona, having observed the vomit. She received an assurance that it was the same colour as the earlier vomit and the observations that were recorded including normal alertness and a raised temperature.

58 Paramedic Cupit recalls the vomit not being bloody or dark coloured and stated that the same would possibly be life threatening and would require that Marco be taken to hospital.

59 She was adamant that there was no mention of black vomit by Yooralla staff, which is at odds with the other evidence in this matter. It is, however, quite possible that there was simply no mention of black vomit within her earshot.

"I wasn't asked – I wasn't in the history team, so I didn't ask questions. But when I was there when the history team was going on, there was no mention of it...but then I can't...but then I can't remember if Zoe had asked was there black, you know vomit, at all – I can't recall."

60 I accept in most parts the accounts of Paramedics Welsh and Cupit and I also accept the accounts of Ms Franzi and Ms Woodman. The evidence given was not mutually exclusive and any inconsistencies can be accounted for by ordinary confusion in the recollection of events and the passage of time.

61 The essential finding I make is that Paramedic Welsh who, as the most senior assessing Paramedic, made accurate observations that the vomit was mostly made up of food, there did not appear to be any dark material in the vomit and Mr Virgona did not appear to be in any pain.

Was the decision not transport Mr Virgona to hospital in the morning reasonable?

62 I referred this matter to the CPU. The role of the CPU is to assist Coroners investigating deaths, particularly deaths which occurring a healthcare setting. The CPU is staffed by healthcare professionals, including practising physicians and nurses, who are independent of the health professionals and institutions under consideration. The CPU professionals draw on their medical, nursing and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, the autopsy report and any particular concerns which have been raised.

63 In providing their assistance, the CPU considered the statements from the ambulance paramedics and the clinicians who treated Mr Virgona that day and concluded that the diagnosis of Mr Virgona having gastroenteritis was not unreasonable.

64 In relation to the treatment of gastroenteritis, the Ambulance Victoria guidelines provided that:

> *The principal treatment for gastroenteritis is maintaining adequate hydration with water or commercial oral rehydration preparations (such as Gastrolyte or Hydrolyte).*

65 The guidelines state that if the vomiting is severe, then an anti-emetic is indicated, however at the time of the attendance of Paramedics Welsh and Cupit, the volume of vomit was less of a concern to staff than the colour or consistency and that it might indicate internal bleeding.

Mr Virgona's clinical condition did not indicate urgent admission to hospital, and in the circumstances, it was not unreasonable to leave him at his residence as they were satisfied that he would be able to maintain hydration and oral intake.

The attendance of Ambulance Victoria in the afternoon of 23 May 2019

66 Ms Woodman checked on Mr Virgona regularly and appropriately after Paramedics Welsh and Cupit left that morning.

67 He was observed by staff to be singing and saying his name with his headphones on.

68 He slept from around midday until around 1.00pm when he was observed to do a "large black coloured vomit."

69 Ms Woodman observed that Mr Virgona's condition had deteriorated markedly, he very weak, shaking and unable to stand or support himself.

70 She observed that he appeared delirious and rang Ambulance Victoria and conveyed the information that Mr Virgona appeared to be finding it difficult to breathe. She suspected correctly that Mr Virgona may have aspirated some of his vomit.

71 Paramedics Andrew Prosser and Bruno Bageun received a call out to the residence with the dispatch information that the patient had "breathing problems; difficulty speaking between breaths."

72 They arrived within a short period of time (around 3.00pm) and observed significant amounts of vomit that had a "coffee grounds" appearance causing suspicion that he may have had a gastrointestinal bleed and that he appeared very unwell. Paramedic Prosser stated;

> *"He was in an altered conscious state. His breathing sounds resembled "gurgles", which suggested there may have been fluid in his airway. The patient was diaphoretic and appeared hyperventilating. He was febrile and his pulse was rapid."*

73 The immediate treatment involved clearing Mr Virgona's airway of vomit through suction and to provide oxygen therapy, although his was intermittent due to the continuing need to suction further vomit.

74 Oxygen therapy was maintained until his arrival at the Frankston Hospital.

Why did the Ambulance Officers take Mr Virgona to the hospital in the afternoon but not in the morning?

75 There were key differences in the clinical presentation of Mr Virgona in the morning and afternoon that can be summarised as follows:

76 In the morning, Paramedics Welsh and Cupit did not observe back 'coffee grounds' vomit, an altered conscious state or laboured and "gurgling" breathing that indicated aspiration and consequently urgent admission to hospital.

77 He had developed respiratory distress and noisy breathing when Ambulance Victoria was called again and it is clear by this time, he was very unwell with a diagnosis of aspiration pneumonia.

Was the treatment at Frankston Hospital reasonable and appropriate?

78 The Hospital notes disclosed that Mr Virgona experienced a cardiac arrest in the process of endotracheal intubation and that the tube was misplaced in the first instance.

79 The insertion of an endotracheal tube was indicated in these circumstances by Mr Virgona's inability to breathe. Intubation is the process of inserting an endotracheal tube through the mouth and then into the airway to enable a pathway through which Mr Virgona could breathe.

80 Insertion of an endotracheal tube in these circumstances is recognised as a high-risk situation. The misplaced tube was recognised immediately and was replaced. It is not possible to say with certainty if this contributed to the outcome as Mr Virgona was already very ill and had already aspirated prior to arrival in hospital.

FINDINGS AND CONCLUSION

81 Having investigated the death of Mr Marco Virgona and having held an Inquest in relation to his death on 13 August 2019, at Melbourne, I make the following findings and conclusions, pursuant to section 67(1) of the *Coroners Act 2008*:

(a) that the emergency identity of the deceased was Mr Marco Angelo Virgona, born 10 March 1972; and

(b) that Mr Marco Angelo Virgona died on 23 May 2017, at Frankston Hospital, from 1(a) ASPIRATION PNEUMONIA and (2) ACQUIRED BRAIN INJURY, in the circumstances set out above.

(c) That the management of Mr Virgona by Yooralla Staff, Ambulance Victoria and Frankston Hospital was reasonable and appropriate.

82 I convey my sincerest sympathy to Mr Virgona's family and friends. I acknowledge the grief and devastation that you have endured as a result of your loss.

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

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

(a) The family of Mr Virgona;

(b) Coroner's Investigator, Victoria Police;

(c) Ms Amber Salter, Peninsula Health;

(d) Ambulance Victoria;

(e) Ms Kate McCullogh, Yooralla

Signature:

MICHELLE HODGSON
CORONER
Date: 18 SEPTEMBER 2019