IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 5321

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**CORONER DARREN J BRACKEN**
Deceased:	**Kathleen Mary Thomas**
Date of birth:	30 January 1937
Date of death:	23 October 2018
Cause of death:	Aspiration Pneumonia
Place of death:	Wangaratta Hospital, 35-47 Green Street, Wangaratta, Victoria

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HIS HONOUR:

BACKGROUND

1. On 23 October 2018, Kathleen Mary Thomas was 81 years old when she died in hospital from natural causes. Ms Thomas came under the care of the Department of Health and Human Services (**DHHS**) at an early age.[1] Immediately prior to her death, Ms Thomas resided at a group home at 7-11 Larkins Street, Wangaratta, operated under the auspices of DHHS (**the DHHS Residence**).[2] Ms Thomas was totally dependent on care for all activities of daily living; she was wheelchair bound and unable to communicate, feed, dress or care for herself.[3]

2. At the time of her death Ms Thomas' was single and did not have any children. She had a brother, Lewis, in Victoria and a sister, Eileen, in New South Wales.[4]

3. Ms Thomas' medical history included intellectual disability, behavioural difficulties, gastro-oesophageal reflux disease and recurrent dermatitis of the face.[5] Ms Thomas had cerebral palsy and difficulty swallowing, with a history of chest infections and aspiration.[6] On the recommendation of a speech pathologist, staff at her DHHS Residence implemented a softened diet and thickened fluids for Ms Thomas.[7] Ms Thomas' regular medications included, amongst others, Nexium for reflux, risperidone for agitation, laxative medication and pain relief medication.[8]

4. Ms Thomas last saw her general practitioner, Dr Shuaib Syed, on 19 October 2018 for a review of her Nexium medication.[9] She also had longstanding oedema of her limbs due to poor mobility and was referred to a physiotherapist.

5. In the months prior to her death Ms Thomas' health declined and she was commenced on Ordine, an opioid analgesic.[10]

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[1] Statement of Adele Chung, Coronial Brief, p.13.
[2] Statement of Adele Chung, Coronial Brief, p.13; Statement of Shuaib Syed, Coronial Brief, p.16.
[3] Statement of Shuaib Syed, Coronial Brief, p.17.
[4] DHHS File note, Coronial Brief, p.74.
[5] Statement of Shuaib Syed, Coronial Brief, p.16.
[6] Statement of Adele Chung, Coronial Brief, p.14.
[7] Statement of Adele Chung, Coronial Brief, p.13.
[8] Statement of Anne Goodley, Coronial Brief, p.5. Statement of Shuaib Syed, Coronial Brief, p.17.
[9] Statement of Shuaib Syed, Coronial Brief, p.17.
[10] Statement of Anne Goodley, Coronial Brief, p.6; Statement of Shuaib Syed, Coronial Brief, p.17.

THE CORONIAL INVESTIGATION

Coroners Act 2008

6. Ms Thomas' death was a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**) as her death occurred in Victoria, and, immediately before her death, Ms Thomas was a person placed in custody or care.[11] A coroner must hold an inquest if such a person was, immediately before death a person placed in custody or care[12] unless the coroner considers that the death was due to natural causes[13].

7. The Act requires a coroner to investigate reportable deaths such as Ms Thomas' and, if possible, to find:

   (a) The identity of the deceased;

   (b) The cause of death; and

   (c) The circumstances in which death occurred.[14]

8. For coronial purposes, "*circumstances in which death occurred*",[15] refers to the context and background to the death including the surrounding circumstances. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death relevant circumstances are limited to those which are sufficiently proximate to be considered relevant to the death.

9. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[16] It is not the Coroner's role to determine criminal or civil liability,[17] nor to determine disciplinary matters.

10. One of the broader purposes of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through comments made in findings and by making recommendations.

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[11] Section 4 *Coroners Act 2008*.
[12] *Coroners Act 2008 (Vic) s 52(2)(b)*.
[13] *Coroners Act 2008 (Vic) s 52(3A)*.
[14] *Coroners Act 2008* (Vic) preamble and s 67.
[15] *Coroners Act 2008* (Vic) s 67(1)(c).
[16] *Keown v Khan* [1999] 1 VR 69.
[17] *Coroners Act 2008* (Vic) s 69 (1).

11. Coroners are also empowered to:

(a) Report to the Attorney-General on a death;[18]

(b) Comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[19] and

(c) 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.[20]

Standard of Proof

12. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities, giving effect to the principles explained by the Chief Justice in *Briginshaw* v *Briginshaw*.[21] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[22] The principles enunciated by the Chief Justice in *Briginshaw* do not create a new standard of proof; there is no such thing as a "*Briginshaw Standard*" or "*Briginshaw Test*" and use of such terms may mislead.[23]

13. Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[24] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[25] Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved and the content of the finding based on those facts.[26]

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[18] *Coroners Act 2008* (Vic) s 72(1).
[19] *Coroners Act 2008* (Vic) s 67(3).
[20] *Coroners Act 2008* (Vic) s 72(2).
[21] (1938) 60 CLR 336, 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 89, 95.
[22] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[23] *Qantas Airways Ltd v Gama* (2008) 167 FCR 537, [123]-[132].
[24] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[25] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[26] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers' Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.

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

Identity of the Deceased - Section 67(1)(a) of the Act

14. On 23 October 2018, Anne Goodley identified the deceased as Kathleen Thomas, born 30 January 1937, whom she knew as a resident.

15. Ms Thomas' identity is not in dispute and requires no further investigation.

Cause of death - Section 67(1)(b) of the Act

16. On 25 October 2018, Dr Michael Burke, a Senior Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination upon Ms Thomas' body. Dr Burke provided a written report, dated 7 November 2018, in which he opined that the cause of Ms Thomas' death was '*aspiration pneumonia*'. I accept Dr Burke's opinion.

17. Dr Burke advised that a post-mortem computed topography scan showed pleural effusions, increased lung markings and that an external examination did not identify any evidence to suggest the death was due to anything other than natural causes.

18. Toxicological analysis of ante mortem samples detected the presence of acetone at 150 mg/L. Acetone is an endogenous compound. Concentrations are markedly elevated during fasting and may range from 100-700 mg/L. The drug 9-hydroxyrisperidone, a metabolite of risperidone, was detected at a therapeutic level.

Circumstances in which the death occurred - Section 67(1)(c) of the Act

19. On 20 October 2018, Ms Thomas returned to the DHHS Residence by taxi from an outing for morning tea. Her carer observed that Ms Thomas did not look well and accompanied her to Wangaratta Hospital, North East Health (**the Hospital**) that day.[27]

20. On arrival at the Hospital, Ms Thomas presented with a one-week history of worsening lethargy and lack of appetite. She had a chronic cough but no apparent change recently and no coryzal symptoms.[28] Ms Thomas had no apparent chest pain, nausea, vomiting, skin lesions, rashes or recent medication changes. There was no evidence of recent contact with other persons in ill-health. She was investigated for infective and inflammatory processes and a chest X-ray was suggestive of aspiration pneumonia in the left lung. The diagnosis was supported by Ms

[27] Statement of Anne Goodley, Coronial Brief, p.6.
[28] Irritation and swelling of the mucous membrane in the nose.

Thomas' history of chronic aspiration and she was treated with intravenous antibiotics and oxygen supplementation for a period of 48 hours.[29]

21. Ms Thomas' condition did not improve and on 22 October 2018, the decision was made in conjunction with the Office of the Public Advocate to treat Ms Thomas palliatively.[30] Ms Thomas was kept comfortable until she passed away on 23 October 2018.[31]

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

22. At the time of her death, Ms Thomas was a '*person placed in custody or care*' as defined in section 3 of the *Coroners Act 2008* (**the Act**) because she was in the care of the DHHS immediately prior to her death.[32]

23. Ms Thomas' designation as a '*person placed in custody or care*' is significant. This is because the Act recognises that people in the control, care or custody of the State are vulnerable and therefore, irrespective of the nature of the death, requires it to be reported to the Coroner and so subject to the independent scrutiny and accountability of a coronial investigation.

24. As an additional protection, until the insertion of section 52(3A) into the Act in November 2014, all deaths of people placed in custody or care required a mandatory inquest. Since this amendment became operative a Coroner is no longer required to hold an inquest if satisfied that the death was due to natural causes but must publish Findings made concerning natural causes death of people in custody or care.[33] Of course, the Act preserves a discretionary power to hold an inquest in relation to any death a Coroner is investigating.[34]

25. In his report dated 7 November 2018, Dr Burke opined that the cause of Ms Thomas' death was aspirational pneumonia and that there was no evidence to suggest the death was due to anything other than natural causes. Based on Dr Burke's report and the content of the coronial brief I am satisfied that Ms Thomas's death was due to natural causes and have determined not to hold an inquest.

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[29] Statement of Dr Ian Teh, Coronial Brief, p.21; Statement of Anne Goodley, Coronial Brief, p.6.
[30] Statement of Dr Ian Teh, Coronial Brief, p.22; Statement of Anne Goodley, Coronial Brief, p.6.
[31] Statement of Anne Goodley, Coronial Brief, p.7.
[32] See section 3 for the definition of a "person placed in custody or care" and section 4(2)(c) of the definition of "reportable death".
[33] Section 73(1B).
[34] Section 51(1).

26. The first *Annual review of disability service provision to people who have died 2017-18*[35] presented by the Disability Services Commissioner (**DSC**) in June 2018 highlighted the prominence of respiratory diseases, and particularly aspiration pneumonia, as a cause of death of Victorians with disability.[36]

27. The review noted that aspiration pneumonia is often avoidable with timely medical treatment to reduce the risk of the condition progressing to the stage of infection.[37] It further noted research suggests that people with intellectual disabilities, such as Ms Thomas, experience delays and difficulties in accessing specific and effective interventions for infections and nominates preventative measures such as eating and swallowing assessments and awareness by care staff of client's vulnerability to infections and respiratory conditions.[38]

28. Having reviewed Ms Thomas' medical records and the material provided on the coronial brief, it appears that appropriate measures were in place at the DHHS Residence to reduce Ms Thomas' risk of aspiration pneumonia. She had a specific meal plan in place and her eating practices were appropriately monitored by staff.

29. The available evidence does not support a finding that there was any want of care on the part of DHHS or the staff at the DHHS Residence that caused or contributed to Ms Thomas' death.

30. I am satisfied, having considered all of the available evidence, that no further investigation into Ms Thomas' death is required.

FINDINGS AND CONCLUSION

31. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) The identity of the deceased was Kathleen Mary Thomas, born 30 January 1937;

    (b) Ms Thomas' death occurred;

        i. on 23 October 2018 at Wangaratta Hospital, 35-47 Green Street, Wangaratta, Victoria;

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[35] Disability Services Commissioner, *A review of disability service provision to people who have died 2017 – 18.*
[36] The review found that, of 48 deaths that were both subject to the DSC investigation and within the scope for review by the State Coroner, 16 people died from respiratory diseases – mainly aspiration and pneumonia.
[37] Disability Services Commissioner, *A review of disability service provision to people who have died 2017 – 18*, p.24.
[38] Disability Services Commissioner, *A review of disability service provision to people who have died 2017 – 18*, p.24.

ii. from aspiration pneumonia, and

iii. in the circumstances described in paragraphs 19 - 21 above.

32. Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet in accordance with the rules.

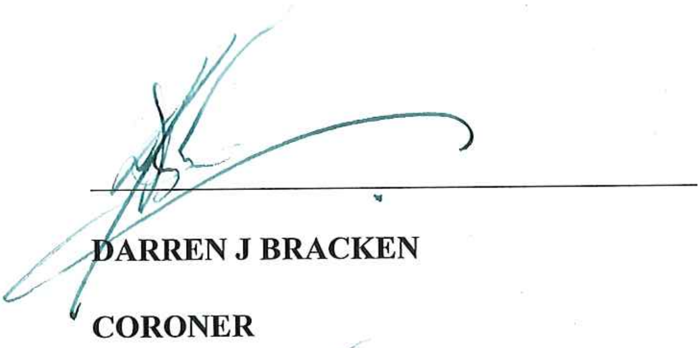
33. I direct that a copy of this finding be provided to the following:

(a) Eileen Hogg, senior next of kin.

(b) Dr Rowena Mann, Northeast Health

(c) Senior Constable Thomas Lonsdale, Coroner's Investigator, Victoria Police.

Signature:



DARREN J BRACKEN

CORONER

Date: 14 January 2020