IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2020 5929**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	**PHILLIP BYRNE, CORONER**
Deceased:	**ELLA FELICITY HITCHEN**
Date of birth:	**7 AUGUST 1988**
Date of death:	**29 OCTOBER 2021**
Cause of death:	**I(a) ASPIRATION PNEUMONIA** **1(b) SEVERE CEREBRAL PALSY**
Place of death:	**ST VINCENT'S HOSPITAL** **41 VICTORIA PARADE** **FITZROY VIC 3065**

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Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

I, PHILLIP BYRNE, Coroner having investigated the death of ELLA FELICTIY HITCHEN without holding an inquest:
find that the identity of the deceased was ELLA FELICITY HITCHEN
born on 7 August 1988
and the death occurred on 29 October 2021
at St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria 3065

from:

I (a) ASPIRATION PNEUMONIA

1(b) SEVERE CEREBRAL PALSY

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

BACKGROUND

1. Ms Ella Felicity Hitchen 32 years of age was in care at the time of her death. She had very significant disabilities including cerebral palsy, quadraplegia, an intellectual disability, and vision impairment. She also had epilepsy resulting in seizures. Ms Hitchen's parents Mr Keith and Mrs Karen Hitchen were formally responsible for decisions on their daughter's treatment. Due to her dysphagia and the risk of aspiration, in 2011 Ms Hitchen had a percutaneous endoscopic gastrostomy (PEG) tube inserted. Not surprisingly in light of her significant health issues Ms Hitchen had in place detailed specific Health Management Plans. In this finding I propose to focus upon issues proximate to Ms Hitchens death.

2. In November 2019 Ms Hitchen had a month- long admission to St Vincent's Hospital due to aspiration pneumonia. Following discussion with Ms Hitchen's parents, her GP, staff from the group home and the treating team at St Vincent's plans were put in place to provide a

suctioning machine and train staff as to its use to hopefully reduce the prospect of further aspiration pneumonia episodes.

BROAD CIRCUMSTANCES SURROUNDING DEATH

3. On 18 October 2020 having experienced shortness of breath Ms Hitchen was admitted to the short stay unit at St Vincent's Hospital. She was medically assessed and later in the day discharged back to Glasgow Group Home in Reservoir where she resided with an antibiotic prescription.

4. On 27 October 2020 in spite of antibiotic therapy Ms Hitchen was re admitted to St Vincent's due to a gradual deterioration. In consultation with Ms Hitchin's parents and senior clinicians with the treating team a decision was made not to escalate treatment but provide antibiotics and fluids. Ms Hitchin's condition continued to deteriorate and in further consultation with a senior clinician and Ms Hitchen's parents she was palliated, kept comfortable and passed away peacefully early on 29 October 2020.

REPORT TO THE CORONER

5. Ms Hitchen's death was reported to the coroner. Having considered the circumstances and having conferred with a senior forensic pathologist and noting Mr and Mrs Hitchen preferred that an autopsy not be performed, I directed an external only post-mortem examination. The directed post-mortem examination was undertaken at the Victorian Institute of Forensic Medicine (VIFM) by forensic pathologist Dr Paul Bedford who, in a subsequent report advised Ms Hitchen's death was due to

I(a) I (a) ASPIRATION PNEUMONIA

1(b) SEVERE CEREBRAL PALSY

Dr Bedford further advised Ms Hitchen's death was due natural causes.

FURTHER INVESTIGATION

6. In December 2020 I was advised the Disability Services Commission (DSC) proposed to commence an investigation under the Disability Act 2006 into the services provided to Ms Hitchen. In February 2021 DSC advised their investigation was complete and that they made no adverse findings into the services provided to Ms Hitchen by Aruma. However, the DSC suggested Aruma review some of their service provisions. Following a review Aruma have satisfied DSC that suggested improvements have been made to several service provisions, DSC and have decided no further action is required.

7. While DSC undertook their investigation, following my normal practice, I left my investigations in abeyance. I have now revisited my file. Section 7 of the Coroners Act 2008 provides that to expedite investigations into death coroners should endeavour to avoid unnecessary duplication of investigations. It should be understood that the scope of the investigations undertaken by DSC is very often far broader than a coronial investigation, in that I am only entitled to investigate issues that could reasonably be seen as causal or contributing factors in the death under investigation; whereas DSC consider the adequacy of service provision generally.

8. Of necessity my focus has been on the care provided to Ms Hitchen at the group home, the medical management of Mr Hitchen during admissions to St Vincent's Hospital when she has experienced episodes of aspiration pneumonia in the period proximate to death - October 2020-November 2020.

9. It is clear that Mr and Mrs Hitchen, over an extended period, have provided unwavering love and support to their daughter. Regrettably the restrictions imposed by the Covid 19 pandemic curtailed many of the activities that Ms Hitchen so enjoyed; it has been a cruel time for many.

10. I note that in first family contact with Coronial Admissions and Enquiries Mr and Mrs Hitchen advised that they held no concerns regarding the care/treatment of Ms Hitchen.

CONCLUSION

11. I conclude the care/treatment /management of Ms Hitchen by all those involved, from parents, through to staff at the group home and the clinicians at St Vincent's Hospital has been reasonable and appropriate in difficult times.

FINDING

12. I formally find Ella Felicity Hitchen died at St Vincent's Hospital Melbourne on 29 October 2020 due to

I (a) ASPIRATION PNEUMONIA

1(b) SEVERE CEREBRAL PALSY

COMMMENT

13. Being in care at the time of her death this finding is required to be placed on the court website even though her death was due to natural causes.

DISTRIBUTION OF FINDING

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

    Senior Next of Kin; and

    Coroner's Investigator, Victoria Police.

Signature:

PHILLIP BYRNE
CORONER
Date: 11.5.21