IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 004931

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Paul Lawrie
Deceased:	Lorraine Earl
Date of birth:	18 October 1947
Date of death:	11 September 2019
Cause of death:	1(a) Complications of cerebral palsy
Place of death:	Eastern Health, Wantirna Hospital, 251 Mountain Highway, Wantirna, Victoria, 3152
Keywords:	Death in care; natural causes

INTRODUCTION

1. On 11 September 2019, Lorraine Earl was 71 years old when she died at Wantirna Hospital (**Wantirna**). At the time of her death, Ms Earl lived at Unit 12, 33 Cain Avenue, Northcote, a group home administered by Home@Scope.[1]

2. Ms Earl's medical history included a range of health conditions including arthritis, constipation, hay fever, groin rashes, gastric reflux, pressure sores, Vitamin D deficiency and a consistent wheeze. She also suffered from dysphagia (difficulty swallowing), recurrent urinary tract infections, and hyperkalaemia (elevated blood potassium), which required her to have a low potassium diet.

3. Ms Earl had, since birth, a significant intellectual disability and cerebral palsy. She had spastic quadriplegia and contractures of her left knee with poor peripheral circulation. Ms Earl used a wheelchair for mobility and required hoists to access her bed. She needed a high level of support with eating, toileting, and other personal care activities.

4. From infancy, Ms Earl lived at Kew Residential Services before eventually moving to a group home in Northcote operated by the then Department of Health and Human Services (**DHHS**).[2] Management of the group home transferred to Home@Scope on 21 July 2019, who provided care to Ms Earl for nearly two months prior to her death.

5. Staff assisted Ms Earl to participate in activities such as gardening, music, massage therapy, and social outings. She also attended a day service at Able Australia five days per week.

6. Ms Earl was unable to communicate verbally but used eye contact, facial expressions, vocalisations, and body language to do so. She was able to respond to her name and had a personal communication dictionary that informed staff about her communication style and personal needs.

7. Ms Earl's sister, Denise Brazier, and cousins maintained contact with her, initially at Kew Cottages and then at her group home. Ms Brazier was Ms Earl's medical treatment decision maker.

[1] Home@Scope is a subsidiary of Scope and provides supported independent living and short-term accommodation and assistance services previously provided by the Department of Health and Human Services.
[2] Now known as the Department of Families, Fairness and Housing.

THE CORONIAL INVESTIGATION

8. Ms Earl's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. The death of a person in care requires a mandatory report to the Coroner even if the death appears to have been from natural causes.

9. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

10. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

11. Following Ms Earl's death, the office of the Disability Services Commissioner (**DSC**) conducted an investigation pursuant to section 128I of the *Disability Act 2006* (Vic) into the services provided to Ms Earl by Home@Scope during her lifetime. A copy of this report was provided to the Court on 25 March 2020.

12. This finding draws on the totality of the coronial investigation into the death of Lorraine Earl including information contained in the DSC report. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

[3] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.

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

Circumstances in which the death occurred

13. On 13 August 2019, Ms Earl experienced an episode of vomiting. The following day, Ms Earl experienced vomiting, coughing, diarrhoea, and a congested chest. She refused food and fluid and cried constantly. Ms Earl was transported to Box Hill Hospital (**BHH**) by ambulance where she was given analgesics and assessed for the cause of vomiting and bowel concerns. These investigations later revealed an impacted bowel. She was discharged on 18 August 2019 and returned home.

14. On 21 August 2019, group home staff observed that Ms Earl was suffering from a loss of appetite and took her to a general practitioner where she was diagnosed with oral thrush and prescribed medication.

15. On 22 August 2019, Ms Earl again experienced vomiting, with loose bowel movements and was unable to eat or drink. She was unable to take her medication and was readmitted to BHH.

16. Ms Earl was assessed by a speech pathologist and deemed unsafe for any oral intake due to her severe oropharyngeal dysphagia, which worsened whilst at BHH. Following a multi-treatment team review which determined that she was unable to receive food orally or via a nasogastric or PEG route,[4] Ms Earl was placed on an end-of-life pathway and commenced on risk feeding.

17. Group home staff became concerned about the decision to treat Ms Earl under palliative care as they believed that this was based on inconsistent advice about her dysphagia management. The group home staff sought from the Office of the Public Advocate and Ms Earl's medical team to clarify the decision-making framework around palliative care.

18. In early September 2019, a case conference was held to discuss Ms Earl's ongoing treatment and care pathways at BHH. This conference included hospital medical staff, Ms Brazier, and a representative from the group home.

[4] Percutaneous Endoscopic Gastrostomy. This is a procedure by which a flexible feeding tube is placed through the abdominal wall into the stomach to allow for the mouth and oesophagus to be bypassed.

19. The rationale for the decision to cease providing Ms Earl with food orally was explained to the group home managers. They were understanding of the decision and expressed a desire to support Ms Earl at home. They recognised, however, that they were 'unable to handle administration of opiates and benzodiazepine medications that may make her end of life more comfortable'.

20. On 4 September 2019, Ms Earl was transferred to palliative care at Wantirna where she had 'negligible oral intake' and 'increased fatigue'. She continued to lose weight, and eventually passed away on 11 September 2019.

Identity of the deceased

21. On 6 September 2019, Lorraine Earl, born 18 October 1947, was visually identified by her carer, Silvana Walters.

22. Identity is not in dispute and requires no further investigation.

Medical cause of death

23. Dr Melanie Archer, Forensic Pathologist, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 12 September 2019 and provided a written report of her findings dated 4 October 2019.

24. A post-mortem computed tomography (**CT**) scan examination revealed patchy opacities in the right lung middle lobe with emphysematous change, liver steatosis, and a distended gallbladder.

25. Toxicological analysis was not performed as there was no indicated need to do so.

26. Dr Archer provided an opinion that the medical cause of death was '1 (a) complications of cerebral palsy'.

27. I accept Dr Archer's opinion.

DISABILITY SERVICES COMMISSIONER INVESTIGATION

28. The report provided by the DSC identified the following issues relating to the provision of disability services by Home@Scope to Ms Earl. A copy of the draft DSC report was provided to Home@Scope on 14 February 2020 who accepted the findings.

Management of Ms Earl's hyperkalaemia

29. The DSC investigation determined that Ms Earl's Specific Health Management Plan (**SHMP**) correctly identified her diagnosis of hyperkalaemia, however her support and health plans did not consistently reflect this, nor did they reflect her requirement for a low potassium diet. Group home staff did not receive consistent information regarding her dietary requirements, and records provided by Home@Scope indicated that Ms Earl was intermittently given foods high in potassium throughout 2019.

30. Hyperkalaemia management strategies and recommended foods should have been noted in relevant support documentation, including the mealtime profile, so as to ensure Ms Earl was provided with a low potassium diet. This was particularly important given her history of severe dysphagia, refusal to eat, weight loss, and deteriorating health.

31. Maintaining consistency of information regarding Ms Earl's hyperkalaemia and management strategies would have ensured that group home staff were clearly informed about her mealtime support needs and prevented any potential confusion.

Record keeping

32. Accurate record keeping is important for ensuring clients receive adequate responses to their health and welfare needs. In Home@Scope's own review, it was noted that the records were generally of a good standard with sufficient information and clear instructions, however there were times when the progress notes were very brief.

33. It was further identified that Ms Earl's Communication Diary was not up to date, with the last review of it having taken place in March 2017 despite her ongoing communication needs. In addition, Ms Earl's weight record was only updated monthly despite her frequently fluctuating weight.

34. Ms Earl's food intake charts recorded the foods consumed daily but did not consistently record the quantity of food eaten. Food intake charts were also not updated during Ms Earl's time at the day service.

35. Improved record keeping in relation to Ms Earl's food intake charts would have enabled group home staff to identify and respond to any changes, including her constipation, refusal to eat and weight loss.

Monitoring fluid intake

36. Ms Earl's medical conditions, including dysphagia, hyperkalaemia, constipation, and loose bowel motions, along with her previous experiences of urinary tract infections, meant that inadequate fluid intake could have had a significant impact on her health. It therefore required close monitoring.

37. Despite this, Home@Scope's own review noted that there was 'no evidence of staff obtaining' information regarding Ms Earl's fluid intake during her time at her day service, meaning it was not possible for staff to identify whether she had drunk the requisite six to eight glasses of fluid per day across the days when she was at her day service. Despite Ms Earl's DHHS records containing specific instructions that she should consume six to eight 250ml cups of clear fluids per day, her Home@Scope records did not include this information. Home@Scope acknowledged that 'fluid charts do not state daily target for fluid intake or what actions to take if [there is] insufficient fluid intake.'

Home@Scope review

38. On 13 September 2019, at the request of the DSC, Home@Scope conducted their own review of the disability services provided to Ms Earl at the time of her death. This report was provided to the DSC on 23 October 2019.

39. Home@Scope identified that daily documentation, including Ms Earl's progress notes, bowel, food, and fluid charts were not completed consistently. Consequently, Home@Scope stated that it would amend its practices to ensure that daily entries are recorded as required and that the House Supervisor would discuss the issue and monitor staff in performance of their duties.

40. In addition to Home@Scope's review, the DSC identified two findings:

    i. Group home staff did not follow directions that Ms Earl should be provided low potassium food to manage her hyperkalaemia; and

    ii. Group home staff did not obtain or accurately record information about Ms Earl's health and support needs, in particular her fluid intake requirements, to ensure that she was adequately supported.

FINDINGS AND CONCLUSION

41. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the caution required by *Briginshaw*.[5] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

42. I find that, for the most part, the services provided by Home@Scope to Ms Earl were appropriate and provided in a manner that promoted her rights, dignity, wellbeing, and safety. Whilst none of the issues of concern identified during the DSC investigation related to the circumstances of Ms Earl's death, they were noted to impact the quality of services provided to her.

43. I note that, as a result of their investigation, the DSC issued a Notice to Take Action to Home@Scope, requiring that Home@Scope:

    a) Share the findings and subsequent recommendations for service improvement detailed in the DSC investigation with staff at 8 Botanic Drive, Kew.

    b) Ensure that information and instructions contained within mealtime profiles at 8 Botanic Drive, Kew is confirmed with health professionals and is consistent with residents' medical conditions, SHMP and associated mealtime needs.

    c) Ensure that at 8 Botanic Drive, Kew client support documentation, including residents' mealtime profiles and food and fluid charts, are clearly recorded, can be understood by staff and are implemented consistently.

    d) Ensure that processes are in place at 8 Botanic Drive, Kew to exchange and record information related to mealtime support strategies and practices between the group home staff and day program staff.

[5] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

44. In response, Home@Scope developed an action plan to address the Notice to Take Action, which detailed actions that had been undertaken, and were being undertaken, by their service to address the identified issues.

45. I am satisfied that the DSC Notice to Take Action adequately addresses the identified deficiencies in the care provided to Ms Earl and will hopefully ensure an improvement in Home@Scope's practices.

46. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Lorraine Earl, born 18 October 1947;

    b) the death occurred on 11 September 2019 at Eastern Health, Wantirna Hospital, 251 Mountain Highway, Wantirna, Victoria, 3152, from complications of cerebral palsy; and

    c) the death occurred in the circumstances described above.

47. I note the compassion displayed by group staff following Ms Earl's admission to hospital and that Home@Scope altered its staffing arrangements to enable staff to visit her regularly. Group home staff also provided advice to nursing staff at the hospital when Ms Earl was admitted and modelled practical techniques for how to provide care and support her. I note also that group home staff advocated strongly for Ms Earl when they felt medical staff did not fully understand her care needs.

I convey my sincere condolences to Ms Earl's family for their loss.

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

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

Denise Brazier, Senior Next of Kin

Dr Yvette Kozielski, Eastern Health

Arthur Rogers, Disability Services Commissioner

Mary Simpson, Scope (Aust) Ltd

Senior Constable Shannon Foden, Victoria Police, Reporting Member

Signature:

Coroner Paul Lawrie

Date: 12 December 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.