IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 3947

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Jennifer Anne Jones
Date of birth:	9 November 1957
Date of death:	21 July 2020
Cause of death:	1(a) Sepsis secondary to lower respiratory tract infection
Place of death:	University Hospital Geelong, 272 Ryrie Street, Geelong, Victoria
Keywords:	In care, disability, sepsis

INTRODUCTION

1. On 21 July 2020, Jennifer Anne Jones was 62 years old when she died at University Hospital Geelong. At the time, Ms Jones lived at Colac in a supported disability care facility.

2. Ms Jones had a complex medical history which included Down's Syndrome, mental sub-normality, strabismus (right) convergent, bilateral hearing loss, depression, hypothyroidism, epilepsy, dysphagia, incontinence, hepatitis A, haemorrhoids and an informal diagnosis of Alzheimer's disease and early onset dementia. She could not communicate verbally and instead did so through vocalisations, actions, gestures, facial expressions, and eye contact.

3. Ms Jones' medication regime at the time of her passing included Eleupohrat ointment (betamethasone), Epilim syrup (sodium valproate), levothyroxine sodium, melatonin, mirtazapine, Movicol, Ostelin Vitamin D3, Rectogesic ointment, Sudocrem and Tinaderm powder spray.

4. Due to Ms Jones' dysphagia, she required supervision while eating and drinking and required a diet of minced and blended meals and thickened fluids. She used a walking frame and wheelchair for mobility and required assistance in all aspects of her personal care.

5. Ms Jones was placed into care when she was six days old and remained in care until the time of her death. She resided at 20 William Street, Colac, from 2011 with four other residents. The home was formerly operated by the (then) Department of Health and Human Services (**DHHS**) and transferred to Home@Scope on 13 October 2019. Ms Jones was also the recipient of funding and support from the National Disability Insurance Scheme.

THE CORONIAL INVESTIGATION

6. Ms Jones' death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Generally, reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.[1]

7. While Ms Jones' death was reported to the Coroner, I note with concern that, as funding for disability services has shifted from the Department of Families, Fairness and Housing

[1] See the definition of "reportable death" in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of "person placed in custody or care" in section 3 of the Act.

(**DFFH**) to the National Disability Insurance Scheme (**NDIS**), the definition of a person placed in custody or care in section 3(1) of the Act to include 'a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health' no longer adequately captures the group of vulnerable people in receipt of disability services that the legislature had intended. Where the deaths of those people are from natural causes and not otherwise reportable, then, though this cohort is as vulnerable as ever, their deaths and the circumstances in which they died – including the quality of their care – would not be subjected to coronial scrutiny.

8. 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.

9. 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.

10. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Jones' death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into Ms Jones' death, including evidence contained in the coronial brief. 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.[2]

[2] 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

Identity of the deceased

12. On 29 July 2020, Jennifer Anne Jones, born 9 November 1957, was visually identified by her disability care worker, Leonie Anderson, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

14. Forensic Pathologist, Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 24 July 2020 and provided a written report of his findings dated 31 July 2020.

15. The post-mortem examination revealed bilateral lung changes, probable infection, a small liver cyst, cerebral atrophy, but no intracranial haemorrhage or skull fracture. There was no other skeletal trauma identified.

16. Routine toxicological analysis of post-mortem samples detected morphine and its metabolite codeine[3], clonazepam and its metabolite 7-aminoclonazepam[4], midazolam[5], mirtazapine[6], haloperidol[7] and levetiracetam[8], but no alcohol or other commonly encountered drugs or poisons.

17. Dr Bouwer provided an opinion that the medical cause of death was from natural causes, namely *"1(a) Sepsis secondary to lower respiratory tract infection"*.

18. I accept Dr Bouwer's opinion.

Circumstances in which the death occurred

19. The Victorian Civil and Administrative Tribunal (**VCAT**) appointed the Office of the Public Advocate (**OPA**) as Ms Jones' guardian on 5 August 2015 until the time of her death under

[3] Morphine is a narcotic analgesic used for the treatment of moderate to severe pain. Morphine is the primary constituent of crude opium and metabolite of codeine, ethylmorphine, heroin, and pholcodine.
[4] Clonazepam is a nitrobenzodiazepine indicated for the treatment of seizures. Clonazepam may not be detected post-mortem due to bacterial conversion of the parent nitrobenzodiazepine to its 70-amino metabolite.
[5] Midazolam is an imidazobenzodiazepine derivative used as a preoperative medication, antiepileptic, sedative-hypnotic, and anaesthetic induction agent.
[6] Mirtazapine is indicated for the treatment of depression.
[7] Haloperidol is a butyrophenone derivative used therapeutically as an anti-psychotic agent.
[8] Levetiracetam is an antiepileptic used for the control of partial onset seizures.

successive guardianship orders. The only period during that time that Ms Jones was not subject to a guardianship order was from 31 March 2019 to 30 April 2020. Mariella Camilleri of the OPA was Ms Jones' allocated guardian during each guardianship order. The VCAT order from 19 September 2018 to 31 March 2019 was a self-executing order and expired on 31 March 2019. When Ms Jones' health declined in early 2020, a fresh application for guardianship was made to VCAT, which was granted on 30 April 2020.

20. Ms Jones was admitted to Colac Hospital from 3 to 4 March 2020 following a seizure. She was readmitted to Colac Hospital from 6 to 20 March 2020 because her blood pressure, heartbeat and respiration were low. During this second admission, she was transferred to University Hospital Geelong for three days for scans and further testing.

21. According to Ms Camilleri, during Ms Jones' admission to University Hospital Geelong in March 2020, she was being treated palliatively. Ms Camilleri stated that Ms Jones had been unresponsive, and she believed the hospital did not appear to know what was causing Ms Jones' ill-health despite multiple investigations. Barwon Health progress notes dated 9 March 2020 stated the following plan:

    (a) "*Comfort care GOM"*

    (b) *Not for further Ix (interventions) or Mx (management)*

    (c) *Contact Colac tomorrow re: t/f (transfer)"*

22. Discharge notes from Barwon Health on 12 March 2020 stated, "*decline of unknown cause"* and "*Given perceived low quality of life and medical futility for comfort care only."* On 13 May 2020, Ms Camilleri spoke with Ms Jones' general practitioner, Dr Mohammad Gadi who explained that the previous six months of increased seizure activity led him to suspect Ms Jones had a brain tumour. Ms Jones was admitted to Geelong Hospital where she had a brain scan, and no lesions or tumours were identified. Dr Gadi also noted that Ms Jones did not have any acute conditions to be managed, rather that her overall dementia presentation was increasing, and her body was showing signs of age. Similarly, she was eating and drinking less, and her blood pressure was low which could lead to increased falls.

23. Ms Jones' deterioration continued from March 2020. She experienced increased seizure activity for which her epilepsy medication was adjusted accordingly. During this time, her mobility decreased, she would sleep more during the day, was consuming less food and drink,

and was noted to be listless. She no longer participated in many of the activities that she had previously enjoyed. In June 2020, her condition appeared to stabilise.

24. On 8 July 2020, Ms Jones became unwell with a cough, and her general practitioner was consulted. A COVID-19 test, blood tests and a chest x-ray were all ordered. She was diagnosed with a respiratory tract infection and prescribed antibiotics.

25. At about 6.00am on 19 July 2020, Ms Jones was found asleep on the floor, with her head on the mattress next to her bed. Her carers noted that she was not distressed but that she felt cold to touch. She was given a warm shower and offered breakfast. She refused food but accepted juice and her medication.

26. Ms Jones' temperature was recorded as 34.6 degrees and she was noted to be pale, lethargic, and remained cool to touch. Her carers contacted Nurse on Call, who recommended an ambulance be called. The ambulance arrived at 11.45am and conveyed her to the University Hospital Geelong.

27. Upon admission, Ms Jones was assessed as bradycardic, hypothermic, and having a decreased conscious state. She was considered to be suffering from cold sepsis in the setting of a lower respiratory tract infection. No acute injuries that could have been sustained from a fall were identified.

28. Hospital staff spoke with the OPA, and a decision was made to cease active treatment. Ms Jones was treated palliatively thereafter and kept comfortable until she passed away on 21 July 2020.

REVIEW BY THE DISABILITY SERVICES COMMISSIONER

29. On 31 July 2020, the Disability Services Commissioner (**DSC**) commenced an investigation under section 128I of the *Disability Act 2006* into the disability services provided by Home@Scope to Ms Jones.

30. The DSC finalised their investigations and made no adverse findings. In a letter dated 26 November 2021, the DSC advised the Coroners Court that Home@Scope conducted their own review into the disability services provided to Ms Jones at the time of his passing. Home@Scope did not identify any issues relating to the services provided to Ms Jones.

FINDINGS AND CONCLUSION

31. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was Jennifer Anne Jones, born 9 November 1957;

    (b) the death occurred on 21 July 2020 at University Hospital Geelong, 272 Ryrie Street, Geelong, Victoria;

    (c) the cause of Ms Jones' death was sepsis secondary to lower respiratory tract infection; and

    (d) the death occurred in the circumstances described above.

32. I am satisfied that her death was due to natural causes and that there was no want of clinical management and care on the part of those caring for Ms Jones that caused or contributed to her death.

I convey my sincere condolences to Ms Jones' 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 website in accordance with the rules.

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

Jillian Jones, senior next of kin
Barwon Health
Office of the Public Advocate
First Constable Sebastian Piccoli, Victoria Police, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date : 15 September 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.