IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 004176

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Diane Maree Pearse
Date of birth:	24 January 1969
Date of death:	3 August 2020
Cause of death:	1(a) Status epilepticus on a background of Lennox Gastaut syndrome and cerebral palsy
Place of death:	Wantirna Health, 251 Mountain Highway, Wantirna, Victoria, 3152

INTRODUCTION

1. On 3 August 2020, Diane Maree Pearse was 51 years old when she died at Wantirna Health in Wantirna. Until 1975, Ms Pearse lived with her family.

2. In 1975, Ms Pearse moved into State care, initially residing in a Melba Support Services facility in Mt Evelyn (then called Rosine Nursing Home). Ms Pearse continued to live in the care of the State thereafter. At the time of her death, Ms Pearse had been residing at 2 Reilly Court, Croydon South, an NDIS disability facility managed by Melba Support Services. Her family remained in regular contact with her and supported her throughout her life.

3. Ms Pearse's medical history included Lennox Gastaut Syndrome, cerebral palsy, paroxysmal hypothermia, an intellectual disability, aspiration pneumonia, recurrent urinary tract (**UTI**) and chest infections, renal calculi with hydronephrosis, optic atrophy, menorrhagia, sleep apnoea, and severe scoliosis. Her seizures developed soon after birth and persisted throughout her life despite high doses of multiple medications.

THE CORONIAL INVESTIGATION

4. Ms Pearse'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, as well as the death of any person placed in custody or care,[1] irrespective of the cause of death.

5. 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.

6. 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.

[1] See the definition of "person placed in custody or care" in section 3 of the Act which includes 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".

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Pearse's 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.

8. This finding draws on the totality of the coronial investigation into the death of Diane Maree Pearse 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]

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

Identity of the deceased

9. On 3 August 2020, Diane Maree Pearse, born 24 January 1969, was identified her mother, Carloyn Pearse, who signed a formal Statement of Identification to this effect before a member of clinical staff at Wantirna Health.

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

Medical cause of death

11. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 4 August 2020 and provided a written report of her findings dated 6 August 2020.

12. The post-mortem computed tomography (**CT**) scan displayed severe scoliosis, an intrauterine contraceptive device, right lower lobe pneumonia, and loss of grey-white differentiation of the brain with distorted brain anatomy.

13. Dr Baber advised that it would be reasonable to attribute Ms Pearse's death to natural causes, namely *1(a) status epilepticus on a background of Lennox Gastaut syndrome and cerebral palsy.*

[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.

14. I accept Dr Baber's opinion.

Circumstances in which the death occurred

15. At the time of her final hospital admission, Ms Pearse was prescribed anti-seizure medications clonazepam, valproate, lacosamide and levetiracetam; coloxyl for constipation; the anticoagulant enoxaparin; supplements cholecalciferol and magnesium aspirate; methenamine for recurrent UTIs; metoclopramide for vomiting and nausea; and the anti-fungal medication nystatin.

16. Towards the end of 2019, Ms Pearse's health deteriorated due to hypothermic episodes leading to significant drowsiness and dysphagia. This resulted in episodes of aspiration pneumonia and poor tolerance of her regular anti-epileptic medications. No obvious cause for these episodes was identified during Ms Pearse frequent hospital admissions. Ms Pearse was also admitted several times to Maroondah Hospital and Box Hill Hospital during 2020 for severe seizure activity despite the addition of new epilepsy medications.

17. On 9 July 2020, due to her increasing difficulty swallowing her oral medications, Ms Pearse was referred to the Hospital Admission Risk Program (**HARP**) for care coordination. The HARP review found that Ms Pearse's food and fluid needs were not able to be met safely via oral intake due to worsening dysphagia and a risk of aspiration triggering further infections and seizures.

18. Ms Pearse was referred to gastroenterology for consideration of the insertion of a percutaneous endoscopic gastrostomy (**PEG**) tube to secure her oral intake. However, on review, it was identified that such a procedure would be high-risk for complications due to Ms Pearse's severe scoliosis and the distortion of her anatomy.

19. Dr Paul Urquhart, Director of Endoscopy at Eastern Health, opined that Ms Pearse's aspiration risk would continue even once a PEG tube was placed due to continuing saliva secretions. A decision was made not to insert the PEG tube, which was consistent with Ms Pearse's Advanced Care Directive[3] (**ACD**). Following this decision, a referral was made to the Eastern Palliative Care service for symptom management. Any further crises would be approached as end-of-life care.

[3] Signed by Ms Pearse's mother, Carolyn Pearse (Ms Pearse's authorised Medical Treatment Decision Maker), on 11 March 2020.

20. On 29 July 2020, Ms Pearse began experiencing multiple episodes of generalised seizures. She was transported by ambulance to the Peter James Centre (part of the Wantirna Palliative Care Unit) in accordance with her ACD. Initially, she was managed with a subcutaneous infusion of clonazepam as her regular epilepsy medication was unable to be administered orally due to ongoing seizure activity and dysphagia.

21. On 30 July 2020, Ms Pearse was assessed by a speech pathologist who noted worsening chronic severe oropharyngeal dysphagia resulting in a chronic aspiration risk. Ms Pearse was able to tolerate liquid and crushed forms of her anti-epileptic medications with some modified textured food and fluids.

22. On 31 July 2020, Ms Pearse presented as alert and was tolerating some oral intake. Dr Grace Walpole, Palliative Medicine Specialist, met with Ms Pearse and her carer, and discussed the goal of administering oral medication to allow Ms Pearse to stay at home for as long as possible. Her subcutaneous clonazepam was ceased and changed to sublingual drops.

23. However, at about 3.30pm, Ms Pearse developed status epilepticus despite the use of breakthrough subcutaneous clonazepam and midazolam. Dr Walpole discussed the situation with Ms Pearse's neurologist, Dr Paul Mullen, who noted Ms Pearse's severe dysphagia and increasing seizure activity.

24. Ms Pearse was changed to a syringe driver of phenobarbital and clonazepam; it was felt that short term measures, such as an intravenous drip or nasal feeding tube, would be unhelpful and ultimately inconsistent with her ACD. Given her advanced stage of Lennox Gastaut Syndrome, a decision was made to focus on symptom management and comfort measures.

25. On 2 August 2020, Ms Pearse was visited by her mother, her sister and her brother, as well as by staff from Reilly Court who came to say their goodbyes. Later in the evening, staff called Ms Pearse's mother to advise that she should come in straight away as her daughter was deteriorating quickly. Carolyn Pearse stayed with her daughter who was kept comfortable until she passed away at 3.10am on 3 August 2020.

26. In a statement provided by Mrs Pearse directly to the Court, she was complimentary about the care that her daughter had received throughout her life saying that "Had it not been for the love and care that Diane received from the staff at Rosine Nursing Home and Melba Support Services she would not have lived for as long as she did."

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Diane Maree Pearse, born 24 January 1969;

    b) the death occurred on 3 August 2020 at Wantirna Health, 251 Mountain Highway, Wantirna, Victoria, 3152;

    c) the cause of Ms Pearse's death was from *status epilepticus on a background of Lennox Gastaut Syndrome and cerebral palsy*; and

    d) the death occurred in the circumstances described above.

28. As noted above, the deaths of people who are in care when they die are required to be reported to the Coroner, irrespective of the cause of death. The policy underlying this aspect of the legislation recognises the vulnerability of people who are in the care of the State by requiring an independent coronial appraisal of the circumstances in which they died, including the quality of personal care and medical management provided to them during life.

29. Such deaths are subject to a mandatory inquest, another measure of protection for the vulnerable, except that a Coroner is not required to hold an inquest if they consider the death was due to natural causes.[4] In this case, I am so satisfied, and as there is nothing in the available evidence to suggest Ms Pearse was not provided with appropriate clinical management and care and appropriate personal care during her life, I have exercised my discretion to finalise the coronial investigation of her death without inquest.

30. I wish to extend my condolences to Ms Pearse's family and to the carers from Melba Support Services who cared for her, particularly in the latter stages of her life.

31. 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.

[4] See sections 52(2)(b) and 52(3A)

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

Carol Pearse, Senior Next of Kin

Yvette Kozielski, Eastern Health

Melba Support Services

First Constable Stephen Vella, Victoria Police, Coroner's Investigator

Signature:

Paresa Antoniadis Spanos

Coroner

Date: 12 January 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.