IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 004245

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Sarah Gebert, Coroner
Deceased:	Yvonne Dekkers
Date of birth:	11 June 1967
Date of death:	6 August 2020
Cause of death:	1(a) Natural causes unascertained
Place of death:	Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria

INTRODUCTION

1. On 6 August 2020, Yvonne Dekkers was 53 years old when she died in hospital following a deterioration in her health.

2. At the time of her death, Yvonne lived in a group home in Glenroy.

3. Yvonne was a Department of Families, Fairness and Housing (**DFFH**) (formerly Department of Health and Human Services (**DHHS**)) client until her residence at 3 Prospect Street, Glenroy transferred to Home@Scope on 23 June 2019.

THE CORONIAL INVESTIGATION

4. Yvonne'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. However, if a person satisfies the definition of a person placed in care immediately before the death, the death is reportable even if it appears to have been from natural causes.[1]

5. While Yvonne's death was reported to the Coroner, I note that as funding for disability services shifted from the 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 captured the group of vulnerable people in receipt of disability services as envisaged by the legislation when it was passed. This meant that where the deaths of those people were from natural causes and not otherwise reportable their deaths and the circumstances in which they died – including the quality of their care – were not be subjected to coronial scrutiny despite this cohort being as vulnerable as ever.

6. More recently, on 11 October 2022, this lacuna in the legislation was rectified when amendments to the Coroners Regulations 2019 came into effect. Sub-regulation 7(1)(d) provides that a 'person placed in custody or care' now includes *"a person in Victoria who is an SDA resident residing in an SDA enrolled dwelling."*[2] [3] Yvonne would now likely meet

[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(1) of the Act.
[2] 'SDA resident' has the same meaning as in the *Residential Tenancies Act 1997* (Vic) and captures a person who is an SDA recipient (that is, an NDIS participant who is funded to reside in an SDA enrolled dwelling).
[3] 'SDA enrolled dwelling' also has the same meaning as in the *Residential Tenancies Act 1997* and is defined as a: *"long-term accommodation for one or more SDA resident and enrolled as an SDA dwelling under the National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016 of the Commonwealth as in force from time to time or under other rules made under the National Disability Insurance Scheme Act 2013 of the Commonwealth."*

the new definition of person placed in custody or care. For this reason, I intend to treat her death as one occurring in care, and I will publish this finding in accordance with the rules.

7. 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.

8. 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.

9. Victoria Police assigned Sergeant Hayley Neville to be the Coroner's Investigator for the investigation of Yvonne'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.

10. This finding draws on the totality of the coronial investigation into Yvonne's 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.[4]

Background

11. Yvonne was born with Down syndrome (trisomy 21) and became a ward of the state in about 1968. For the first part of her life Yvonne was a resident at Janefield Training Centre (**the centre**), which was a state government run institution for children with intellectual disabilities.

12. In 1993, the centre was decommissioned, and Yvonne moved to a group home located at 3 Prospect Street, Glenroy, where she lived with five other residents. Yvonne remained a resident at this group home until her death.

[4] 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.

13. While she was still active, Yvonne engaged in activities through a Recreation Access Program run by Moreland City Council and programs run by Sussex Street Neighbourhood House. Yvonne enjoyed dancing, loud music, dolls, blocks, balloons, teddy bears, drives in the bus, cake, getting dressed up, and watching movies.

14. Yvonne's medical history included intellectual disability, cataracts, cellulitis, congenital heart disease, congestive cardiac failure, hypertension, faecal and urinary incontinence, hypothyroidism, Vitamin D deficiency and severe dysphagia. Her health remained relatively stable for a number of years.

15. In 2010, Yvonne had all of her teeth removed as a result of a congenital heart defect. She also had surgery for cataracts the following year. In 2016, Yvonne was diagnosed with dementia following a decline in her cognitive state.

16. Concerned that Yvonne may be moved to another residence, staff at the group home applied to the Victorian Civil and Administrative Tribunal (**VCAT**) to have a guardian appointed to make decisions on Yvonne's behalf. Toward the end of 2016, James Huggard from Office of the Public Advocate was appointed as Yvonne's guardian with powers limited to accommodation, healthcare, and access to services. According to Mr Huggard, the most significant factor that determined the need for a guardian was in relation to whether Yvonne should remain at the Glenroy group home or moved to alternative supported accommodation. Mr Huggard's role was to make the decision on behalf of Yvonne as she had been determined to not have decision-making capacity.

17. Over the following months, Mr Huggard met with Yvonne and relevant DHHS staff to determine whether the group home remained appropriate for Yvonne's needs. Mr Huggard recalled that his engagement with Yvonne was difficult due to her being largely non-verbal and having cognitive impairment. However, it was clear that Yvonne had a positive and supportive relationship with the staff around her who were the reference point to establish how she was going. In March 2017, Mr Huggard formalised his decision for Yvonne to remain at the group home in Glenroy and he thereafter continued to assist Yvonne access various services.

18. Over the following years, Yvonne's physical and mental health deteriorated. Her mobility reduced, she was unable to participate in her usual activities, she became less engaged, and her care needs increased.

19. In 2019, Yvonne experienced seizures and aspiration and was admitted to the Royal Melbourne Hospital. Once her condition was stablished and a seizure plan developed, she returned home but her health and swallowing capacity continued to deteriorate.

20. Over the following two years, Yvonne had several hospital admissions due to further seizures, incidents of aspiration and/or chest infections, and deep vein thrombosis. Discussions between Mr Huggard and Yvonne's treating medical clinicians determined that the group home was still appropriate accommodation for Yvonne.

21. On 23 January 2020, Yvonne's general practitioner visited her at the group home. Staff discussed the need for Yvonne to undergo an assessment for aged care and her doctor stated that she would talk with Mr Huggard to initiate 'advance care planning' and 'palliative care'.

22. In June 2020, Mr Huggard had another meeting to determine whether the Glenroy group home remained appropriate for Yvonne's needs. A recent annual medical assessment did not reveal any new medical issues. Staff at the group home were of the view that her services and accommodation were stable and there was no need for further decisions by a guardian at that time. Mr Huggard accordingly applied to revoke the guardianship in July 2020. A hearing at the VCAT was scheduled for 24 August 2020.

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

Circumstances in which the death occurred

23. In mid-July 2020, Yvonne had another short hospital admission for further seizures and aspiration.

24. On 30 July 2020, staff at the group home found Yvonne in a sleepy state and unable to be roused to take fluids or medication. Her oxygen saturation was low, and she had been refusing food and medication for several days. Ambulance Victoria paramedics arrived and found Yvonne to be going in and out of consciousness. She was transported to the Royal Melbourne Hospital for assessment.

25. Yvonne was subsequently assessed in the emergency department and investigations were conducted. A diagnosis of reduced conscious state secondary to advanced Alzheimer's dementia was made. A speech pathologist examined Yvonne and considered that she was at high risk of aspirating if she consumed food and fluid orally. She was subsequently put on an intravenous drip.

26. Following discussions between Mr Huggard, Yvonne's carers at the group home, and her treating clinicians, it was decided that Yvonne would remain in hospital and transition to palliative care. Over following days, Yvonne continued to deteriorate and passed away in hospital at 9.45am on 6 August 2020.

Identity of the deceased

27. On 6 August 2020, Yvonne Dekkers, born 11 June 1967, was visually identified by her support worker, Terri Marriner.

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

Medical cause of death

29. Forensic Pathologist, Dr Brian Beer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 7 August 2020 and provided a written report of his findings dated 3 September 2020.

30. The post-mortem examination was in keep with the clinical history. A post-mortem computed tomography (CT) scan did not reveal any abnormalities.

31. Toxicological analysis of post-mortem samples identified the presence of acetone,[5] the metabolite of clonazepam,[6] midazolam,[7] and free morphine.[8]

32. Dr Beer provided an opinion that the medical cause of death was *"1(a) Natural causes unascertained".*

33. I accept Dr Beer's opinion.

FURTHER INVESTIGATION

Disability Services Commissioner

34. On 28 August 2020, the Disability Services Commissioner commenced an investigation pursuant to section 128I of the *Disability Act 2006* into disability services provided by Home@Scope to Yvonne.

[5] Low levels of acetone in the blood (100-300 mg/L) are likely attributable to ketosis secondary to diabetes or a fasted-state.
[6] Clonazepam is indicated for the treatment of seizures.
[7] Midazolam is used as a preoperative medication, antiepileptic, sedative-hypnotic, and anaesthetic induction agent.
[8] Morphine is a narcotic analgesic used for the treatment of moderate to severe pain.

35. Section 7 of the *Coroners Act 2008* requires me to liaise with other investigative authorities, official bodies, or statutory offices to avoid unnecessary duplication of inquiries and investigations. For this reason, the coronial investigation did not review the services provided by Home@Scope to Yvonne. However, for completeness, I have outlined the Disability Services Commissioner's findings.

36. As part of the Commissioner's investigation, Home@Scope conducted a review in the services they provided and identified issues regarding record keeping (recording fluid intake) and a need for an improved response to a client's deteriorating health. As a result, Home@Scope provided education to staff and updated relevant policies and procedures. The Commissioner concluded that these responses were adequate to address the identified issues.

37. The Commissioner also identified a number of additional issues, including end-of-life planning. The Commissioner considered that that end-of-life care plans should be developed for people diagnosed with a life limiting condition:

> *The plan should consider cultural, spiritual and psychosocial needs as well as physical needs. It may include looking at what is working well, maintaining relationships, and making decisions about any lifestyle changes and where the person with a disability would prefer to die. It is a person centred process which focusses on the quality of the last phase of life.*

38. Yvonne had been diagnosed with dementia several years before her death and it was expected that she would eventually deteriorate and likely die from this condition or associated complications. This was recognised by Yvonne's treating clinicians who, at various times, referred to palliative approaches in the event of her deterioration. However, even though Yvonne was diagnosed with two life-limiting conditions, dementia and congestive cardiac failure, there was no end-of-life care plan in place for her.

39. The Commissioner considered that end-of-life care planning should have occurred in 2019, and a plan developed at this time. Had this occurred, a more comprehensive and proactive approach could have been taken to supporting Yvonne in the last phase of her life.

40. The Commissioner therefore made a formal finding that Home@Scope group home staff did not ensure Yvonne had an end-of-life care plan in place. The Commissioner provided an opportunity to Home@Scope to comment on proposed adverse comments/opinions. In response, Home@Scope informed the Commissioner that it accepted all of the findings.

41. The Commissioner subsequently issued a Notice to Take Action regarding the identified issues, including the following:

> *Home@Scope to identify any residents of 3 Prospect Street, Glenroy who may have a life-limiting condition, and ensure they are provided with suitable end-of-life care planning which would include organising for a plan to be prepared by the resident and/or their advocate/guardian/decision maker if they have one, and involving the resident's usual caregivers.*

FINDINGS AND CONCLUSION

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

(a) the identity of the deceased was Yvonne Dekkers, born 11 June 1967;

(b) the death occurred on 6 August 2020 at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria from unascertained natural causes; and

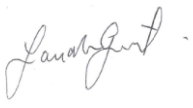
(c) the death occurred in the circumstances described above.

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:

Office of the Public Advocate
Home@Scope
Disability Services Commissioner
Sergeant Hayley Neville, Victoria Police, Coroner's Investigator

Signature:



Coroner Sarah Gebert

Date: 27 April 2023

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.