IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 001581

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Dianne Elizabeth Harper
Date of birth:	15 February 1958
Date of death:	23 March 2022
Cause of death:	1(a) Aspiration pneumonia in a woman with multiple comorbidities
Place of death:	The Mornington Centre, Peninsula Health, 24 Separation Street, Mornington, Victoria, 3931
Keywords:	In care, disability, Specialist Disability Accommodation, natural causes, aspiration pneumonia

INTRODUCTION

1. Dianne Elizabeth Harper[1] was 64 years old when she passed away on 23 March 2022.

2. At the time of her death, Dianne was a National Disability Insurance Scheme (**NDIS**) participant. She received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling at The Mornington Centre of Peninsula Health.

Background

3. Since her childhood, Dianne had had a severe intellectual disability. In 1995, her parents were no longer able to provide her with adequate care and Dianne went into state care. She had one older sister, from whom she was estranged and who now resides in the United Kingdom.

4. Her medical history included hypertension, hypothyroidism, bipolar affective disorder, renal impairment, hypercholesterolaemia, recurrent urinary tract infections, and osteoarthritis.

5. In 2021, Dianne experienced a cognitive decline and was admitted to Frankston Hospital. She was eventually transferred to The Mornington Centre where she remained until her death. She received a high level of care for a wide range of daily activities, as well as allied health support through physiotherapists and occupational therapists.

6. On 12 January 2022, Dianne contracted COVID-19 and was admitted to Frankston Hospital. On 19 January 2022, once cleared of the virus, she returned to The Mornington Centre.

THE CORONIAL INVESTIGATION

7. Dianne'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. At the time of her death, Dianne resided in a specialist disability accommodation (**SDA**) enrolled dwelling and as such is considered to have been 'in care' under the Act. The death of a person in care or custody must be reported to the Coroner, even if the death appears to have been from natural causes.

8. Section 52(2)(b) of the Act provides that it is mandatory for a coroner to hold an Inquest into a death if the deceased was, immediately before death, a person placed in custody or care, unless the death is due to natural causes. Given the evidence that Dianne's death was due to

[1] Referred to throughout the Finding as 'Dianne', unless more formality is required.

natural causes, pursuant to section 52(3A) of the Act, I determined not to hold an Inquest into her death.

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

12. Coroner Sarah Gebert initially held carriage of the investigation, until it came under my purview in July 2023 for the purposes of obtaining further information, finalising the investigation and handing down Findings.

13. This finding draws on the totality of the coronial investigation into the death of Dianne Elizabeth Harper 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]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

14. On 21 January 2022, a physiotherapist observed that Dianne was coughing while sipping water. She was subsequently assessed by a medical team who concluded she was stable.

[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.

15. On 27 January 2022, Dianne's cough developed. Her oxygenation was stable on room air.

16. On 1 February 2022, a speech pathologist determined Dianne had mild dysphagia, laryngeal penetration and aspiration with thin fluid with straw use. A repeat review conducted nine days later, by a second speech pathologist, demonstrated Dianne's swallowing had deteriorated and she had moderate oropharyngeal dysphagia.

17. Clinicians were unable to locate and contact a member of Dianne's family for the purposes of discussing her medical treatment. The treating team also attempted to contact a substitute medical decision maker and the Office of the Public Advocate. The team implemented risk feeding protocols and continued her on fluids.

18. On 11 March 2022, Dianne received a third COVID-19 vaccination. The following day she was hypothermic, with a temperature of 35.3°C. By 14 March 2022, her temperature was 33°C, though her other vitals were normal. A thermal blanket was applied.

19. On 15 March 2022, the medical team assessed Dianne to have a cough though a *'chest examination was clear'.* Clinicians determined Dianne had *'micro aspiration pneumonia'*. Her condition declined over the following days, and she became *'very lethargic and unable to mobilise'.*

20. Dianne had continued consults with multiple speech pathologists, and she continued to risk feed. Clinicians did not observe any choking episodes.

21. On 22 March 2022, clinicians noticed that Dianne's oral intake had declined, and she was commenced on subcutaneous fluids.

22. The following day, on 23 March 2022, Dianne entered a reduced conscious state, and a decision was made to transition her to comfort care. At approximately 6:50pm, Dianne passed away.

IDENTITY OF THE DECEASED

23. On 23 March 2022, Dianne Elizabeth Harper, born 15 February 1958, was visually identified by clinician, Susan Sinclair, who signed a Statement of Identification.

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

MEDICAL CAUSE OF DEATH

25. On 24 March 2022, Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination. Dr Zhou reviewed the Victoria Police Report of Death for the Coroner (**Form 83**), e-Medical Deposition form, medical records from Carrum Downs Medical Centre and Peninsula Health, the VIFM contact log, and post-mortem computed tomography (**CT**) scan and provided a written report of her findings.

26. The external examination was consistent with the reported circumstances and did not show any evidence of injuries of a type likely to have caused or contributed to death.

27. The post-mortem CT scan showed bilateral small pleural effusions and patchy bilateral increased lung markings including within the bilateral lower lobes.

28. Dr Zhou provided an opinion that the medical cause of death was 1 (a) *aspiration pneumonia in a woman with multiple comorbidities*. On the basis of the information available, Dr Zhou was of the opinion the death was due to natural causes.

29. I accept Dr Zhou's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Dianne Elizabeth Harper, born 15 February 1958;

    b) the death occurred on 23 March 2022 at The Mornington Centre Peninsula Health 24 Separation Street, Mornington, Victoria, 3931, from *aspiration pneumonia in a woman with multiple comorbidities*; and

    c) the death occurred in the circumstances described above.

31. Having considered all of the circumstances, including the post-mortem examination report of Dr Chong Zhou, I find that Dianne Elizabeth Harper died due to natural causes.

32. I have noted the medical treatment provided to Dianne Elizabeth Harper and find that practitioners of Peninsula Health acted reasonably in managing her multiple comorbidities and made appropriate and continued efforts to locate a next of kin and alternative medical treatment decision maker. I consider that Dianne Elizabeth Harper's medical practitioners adopted a reasonable course of action in the lead-up to her death.

33. The factual matrix of Dianne Elizabeth Harper's death does not support a conclusion that her being 'in care' at the time of her death – according to the Act – had a causal relationship with her death.

I convey my sincere condolences to Dianne's family, and those who cared for her, for their loss.

ORDERS AND DIRECTIONS

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:

Julie Robinson, Senior Next of Kin

Peninsula Health

National Disability Insurance Agency

Office of the Public Advocate

Senior Constable David Cousins, Coroner's Investigator

Signature:

Coroner Ingrid Giles

Date: 11 March 2025

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.