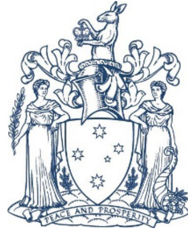


IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 005588

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Damien Mark Stone
Date of birth:	22 April 1969
Date of death:	28 September 2022
Cause of death:	1a: Aspiration pneumonia in the setting of down syndrome and pelvic fractures
Place of death:	University Hospital Geelong, Bellerine Street, Geelong, Victoria, 3220

INTRODUCTION

1. On 28 September 2022, Damien Mark Stone was 53 years old when he died at University Hospital Geelong. At the time of his death, Damien lived in Specialist Disability Accommodation (**SDA**) in Grovedale.

2. Damien was adopted at the age of 11 by Kevin and Margot. He had one younger sister, Bridgitte.

3. Damien lived at home until the age of 18 when he moved into the SDA, where he established a great relationship with the care staff. He was employed at the local recycling plant in his younger years.

4. Damien lived with Down Syndrome and was diagnosed with early onset Alzheimer's disease in 2018. He was largely non-verbal, required increasing assistance with mobility and had begun to show aggressive, violent and disruptive behaviours which presented a challenge for his carers.

THE CORONIAL INVESTIGATION

5. Damien'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. In addition, I have determined to consider Damien's death to be an 'in care' death for the purposes of my investigation.

6. Since 2019, funding for disability services in Victoria has shifted from the Department of Families, Fairness and Housing to the National Disability Insurance Scheme. This shift meant that the definition of *person placed in custody or care* in section 3(1) of the *Coroners Act 2008* 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' was no longer sufficient to capture the group of vulnerable people in receipt of disability services that the legislature had intended.

7. The Coroners Regulations 2019 were amended on 11 October 2022 to create a new category of person considered to be 'in care' under Regulation 7 of the Coroners Regulations 2019, being a 'person in Victoria who is an SDA resident residing in an SDA enrolled dwelling'. The amendments also introduce an associated reporting obligation under Regulation 8 for a person who: (ii) is funded to provide an SDA resident with daily independent living support;

and (ii) has reasonable grounds to believe that the resident's death has not been reported to a coroner or the Institute.

8. While Damien was not formally ‘in care’ at the time of their death on 28 September 2022, he was an SDA resident in an SDA-enrolled dwelling at the time of his death. If reported today, his death would be considered to be an ‘in care’ death that requires additional steps be taken in the coronial process. It is of significance that the Coroners Regulations have now been updated to capture the passings of potentially vulnerable persons such as Damien, with these enhanced investigative processes, to ensure that any issues associated with their care are appropriately and independently canvassed by the Coroner.

9. Although I have considered Damien to be ‘in care’ for the purposes of my coronial investigation and given the aforementioned gap in the legislation at the time of his death, I deemed it not necessary to hold an Inquest into his death as I do not consider that the calling of individual witnesses would further my investigation. If Damien’s death had occurred today, an Inquest would be mandated under section 52(2)(b) of the Act.

10. 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.

11. 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.

12. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Damien’s death. The Coronial 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.

13. This finding draws on the totality of the coronial investigation into the death of Damien Mark Stone 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.[1]

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

Circumstances in which the death occurred

14. On 6 September 2022, Damien was seen by his general practitioner Dr Dominic Harris after falling out of bed and reportedly hitting his head.

15. By 12 September 2022, Damien had become noticeably more unsteady on his feet and his behaviour had deteriorated. Dr Harris ordered a brain scan.

16. On 15 September 2022, Damien was reviewed by Dr Harris in the presence of his father, Kevin. The scan revealed possible hydrocephalus and Damien was referred to a neurosurgeon. Dr Harris noted *"assuming this is irreversible, needs constant 1 on 1 care and supervision in day time 7am to 9pm, still has quality of life eg going to pub for lunch, KFC, sense of family and belonging, sleeps well at night"*[2]. Dr Harris wrote to the NDIS requesting Damien be supported to stay in his home but with a significantly increased level of care.

17. On 18 September 2022, Damien's carers called an ambulance because he had not been his usual self and had not gotten out of bed for a few days. Kevin observed him screaming when transferred to the stretcher, but it was unclear if this was due to pain or not wanting to cooperate. Paramedics noted no observable distress during the transfer to hospital.

18. Damien was taken to the University Hospital Geelong (**UHG**) Emergency Department and admitted on 19 September 2022 with a three-week history of acute on chronic functional decline, chest congestion and possible hydrocephalus. An abdominal x-ray was undertaken to assess for constipation. Medical staff commenced Damien on antibiotics and referrals were made to allied health professionals to address his functional decline.

19. On 20 September 2022, Damien appeared to be guarding his abdomen which Kevin believed was due to him experiencing abdominal pain. A medical officer ordered oxycodone[3] 5mg which was administered at 6:15am, though there is no record of its effectiveness. Although

---

[1] 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.

[2] The Highton Clinic medical record p. 27.

[3] Oxycodone is a Schedule 8 analgesic indicated for the treatment of moderate-to-severe acute or chronic pain.

there was reference to Damien being distressed during a wash that day, the physiotherapist who saw him made no reference to distress or agitation, though noted he was reluctant to move.

20. On 21 September 2022, Damien had a neurological consultation which recommended against surgical treatment of his suspected hydrocephalus. A brain scan was performed on 22 September 2022, the results of which suggested it was unlikely he had hydrocephalus.

21. On the morning of 24 September 2024, Damien appeared to be in pain and was given paracetamol to good effect. That night, Damien became very unsettled, yelling and hitting out when a health care worker changed his incontinence pad.[4]

22. At around 2am on 26 September 2022, Damien had a witnessed seizure lasting approximately 40 seconds. A MET call[5] was made although the seizure self-resolved. Damien was reviewed by a medical officer at 4:30am and did not appear to be in discomfort. The plan was made to consult with the neurology team regarding the possible cause and treatment of the seizure.

23. On the morning of 26 September 2022, Damien was noted to be more unsettled than usual. He was given oxycodone 2.5mg at 10:05am but neither the location of the pain nor efficacy of the analgesia were documented.

24. Later that day, Damien complained of pain in his left leg and was given oxycodone 2.5mg with small effect at 3:30pm and 7:40pm. Nursing staff requested a medical review but where informed that it may not be possible that night.[6] Damien was reportedly groaning in pain when touched and was unable to move his left leg.

25. At 5:20am on 27 September 2022, Damien was seen by a medical officer to address his slow urine output.

26. Damien was unsettled while being washed in bed with carer assistance. He was still finding it difficult to move his left leg and was in pain when touched. A speech pathologist conducting a swallowing trial later that morning made no notes of him being distressed or agitated.

---

[4] Information obtained as part of BH Clinical Incident Review. Coronial Brief, p. 21.

[5] The Medical Emergency Team call is a hospital-based emergency medical call system, designed for a nurse (or other staff member) to alert and call other staff for help. A major trigger for calling at MET is when a patient's vital signs have fallen outside set criteria.

[6] Barwon Health medical record p. 233.

27. At 1:30pm, Damien was reviewed by a medical officer who noted that he was experiencing left hip pain, and his leg was externally rotated and unstable. An x-ray was taken which showed a pelvic fracture. He was administered oxycodone 5mg at 6:30pm, and Targin[7] 5/2.5mg and oxazepam[8] 7.5pm at 8pm.

28. At 8:15pm, Damien was given oral lorazepam[9] 2mg and subcutaneous morphine[10] 2.5mg to facilitate a hip CT scan, which confirmed a complex pelvic fracture. At 11:30pm he was noted to be resting comfortably.

29. At 1:30am on 28 September 2022, a MET call was made as Damien was difficult to rouse and his oxygen saturation levels had dropped. His deterioration was thought to be due to him being *"relatively opiate naïve"*.[11] He was administered naloxone[12] with good effect and commenced for treatment on sepsis in case that was the cause of his deterioration.

30. At 2:55am a further MET call was made. Damien again responded well to naloxone and was transferred to the high dependency unit for naloxone infusion and airway monitoring.

31. Damien's condition continued to deteriorate and following discussion with his family, he was transitioned to comfort care. He died at 11:56am.

Identity of the deceased

32. On 28 September 2022, Damien Mark Stone, born 22 April 1969, was visually identified by his father, Kevin Stone, who completed a Statement of Identification.

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

Medical cause of death

34. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Damien Stone on 29 September

---

[7] Oxycodone (opioid analgesic) and naloxone (opioid antagonist) combination, for the treatment of moderate to severe pain.

[8] Oxazepam is a medium acting benzodiazepine. It is indicated in the treatment of anxiety, panic disorder, sleep disorders, seizures acute behavioural disturbance and acute alcohol, barbiturate or benzodiazepine withdrawal.

[9] Lorazepam is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety or anxiety associated with depressive symptoms and alcohol withdrawal.

[10] An analgesic medication of the opioid class used to treat moderate to severe pain. When used for chest pain, it can reduce the heart muscle's oxygen requirements.

[11] Barwon Health medical record p. 310.

[12] Naloxone is a drug used to counter the effects of opiate overdose, as it is an opioid antagonist. It has a short half-life of approximately one hour.

2022. Dr Archer considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, E-Medical Deposition Form from University Hospital Geelong and the VIFM contact log and provided a written report of her findings dated 6 March 2023.

35. Examination of the postmortem CT scan showed a comminuted fracture through the left ilium and acetabulum with partial subluxation of the femoral head. There was also a large associated left psoas haematoma. The ventricles of the brain were dilated, and the brain itself was atrophic. There were multifocal lung opacities with the appearance of aspiration pneumonia.

36. The external examination showed an externally rotated and slightly shortened left leg with a 5cm scabbed and healing injury on the anterior tibia.

37. Forensic Radiologist Dr Chris O'Donnell reviewed Damien's admission ante-mortem abdominal x-ray and confirmed that the pelvic fracture was not present and was therefore sustained during the hospital admission.

38. The issue of Damien's bone health was discussed with Dr O'Donnell to determine if the deceased may have been more prone to sustaining a fracture with a lower energy mechanism. There was no evidence on the post mortem CT scan of overt osteoporosis or bone fragility. Damien's medical record shows that his bone density in the lumbar spine and proximal femur had markedly improved between 2019 and his most recent bone densitometry scan on 24 March 2022.

39. The manner in which the fracture was sustained could not be elucidated, however the severity and nature of the fracture was not typical for a normal routine handling of a bed bound person. Dr O'Donnell considered that the pattern of the fracture was most often seen with axial loading, that is when force is delivered from below, such as a fall onto a dropped knee or foot. The fracture was also not typical for having been sustained by a seizure, owing to its severity. Dr Archer considered that an undescribed handling incident or fall may have been a possibility.

40. Dr Archer examined the medical records for a haemoglobin drop, as bleeding would be expected from a large fracture and a large haematoma was noted around the pelvis on the post mortem CT scan. Damien's haemoglobin was at the upper end of normal (170 g/L) at 11:10am on 26 September 2022, and dropped to the lower end of normal (137 g/L) by 6:50pm the next day. Dr Archer was unable to ascribe the significance of this in terms of fracture timing.

41. Dr Archer provided an opinion that the medical cause of death was 1(a) ASPIRATION PNEUMONIA IN THE SETTING OF DOWN SYNDROME AND PELVIC FRACTURES.

FAMILY CONCERNS

42. Damien's father Kevin submitted concerns to the Court relating to the origin of Damien's pelvic fracture, the appropriateness of administering opioid analgesia, whether Damien had sepsis that may have contributed to his death, and the appropriateness of Damien's care generally at UHG, particularly with respect to his disability.

43. In his statement forming part of the coronial brief, Kevin said *"During Damien's time in the hospital, I don't feel that he was treated or cared for appropriately. I feel that he was treated unfairly, due to his disability. There was no Disability Liaison Officer available and given Damien's difficulties in communicating, I feel we really needed one. There didn't seem to be any plan in place, it was a very chaotic, almost manic atmosphere."*

REVIEW OF CARE

44. I requested that the Coroners Prevention Unit (**CPU**)[13] conduct a review of the care provided to Damien, including his recent care in Specialist Disability Accommodation, the timeliness of his transfer to hospital, and UHG's consideration of Damien's disabilities.

45. The Court was unable to obtain records from Damien's SDA. Encompass Community Services Inc, the operator of the Damien's SDA, went into voluntary administration in February 2023, and the appointed administrators informed the Court they were not provided with Damien's records. Consequently, the CPU's review was restricted to his admission to UHG in September 2022.

Barwon Health Clinical Incident Review

46. Barwon Health conducted a Clinical Incident Review (**CIR**) into Damien's death and concluded that the pelvic fracture was likely due to the seizure on 26 September 2022. The CIR further concluded:

[13] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

Several factors affected the delay in escalation of care that subsequently led to the diagnosis of the hip fracture. These factors included:

- *The absence of an obviously traumatic event*
- *The patient's limited ability to communicate*
- *The absence of the use of an appropriate pain assessment tool*

It was noted that the patient's pain was not adequately assessed or documented on the observation and response chart. When the patient was noted to be in pain, which was not relieved by prescribed analgesia, escalation of care was not followed.

The cause of the patient's deterioration is unclear. Whilst naloxone appears to have provided initial effect the patient continued to deteriorate, and additional naloxone did not produce any effect indicating narcosis was unlikely.[14]

47. The CIR panel made the following recommendations to address the failure to escalate care:

- *Review MET call procedure to ensure criteria descriptors for worried and controlled pain are well articulated as reasons for MET calls*

- *Undertake a series of forums for all clinical staff to increase the understanding of rapid response systems aimed to improve the culture of calling METs. The forum should include the importance of escalating to a MET call if staff are worried or uncontrolled pain exists*

- *Review of Escalation to Consultant procedure to include an escalation pathway for nursing staff to be empowered when patient care issues have not been able to be resolved.*[15]

48. The CIR also identified learnings related to other care delivery problems or identified opportunities for improvement that did not contribute to the outcome.

- *The family reported that the community carer provider felt they were required to provide a significant amount of daily care to this patient which they felt was a nursing duty.*

[14] Clinical Incident Review, Coronial Brief, p.35.
[15] Ibid, p. 36.

- *A Disability Liaison Officer (DLO) wasn't engaged during this admission. Engagement may have facilitated an earlier discharge or stronger engagement with clinical resources but it is unlikely to have changed this outcome.*

- *The assessment and recognition of this ongoing pain and its management may have [been] influenced by this patient being differently able.*

- *There is no evidence of the Abbey pain scale being used to formally assess this patient's pain. Since this incident there have [sic] been significant work undertaken on the assessment and management of patients with a cognitive impairment.*

- *Barwon Health did not have a procedure for assessing pain in different abled patients in the acute setting.*[16]

Consideration of Damien's disabilities by University Hospital Geelong

Assessment and management of pain

49. Damien was thought to be experiencing abdominal pain not long after admission, requiring narcotic analgesia. However, his pain appeared to escalate following a seizure on 26 September 2022. While it remains unclear exactly when Damien sustained the pelvic fracture, a fracture of that type undoubtedly would have resulted in pain.

50. Damien was unable to verbalise that he was in pain but according to Kevin, he had always been able to demonstrate that he was in pain. The CIR panel viewed Damien's communication difficulties as a factor in identifying and escalating his pain. Communication issues and cognitive impairment can interfere with a patient's ability to verbalise pain but, the CPU advised me that it could be reasonably expected that health professionals would be well informed about observing behaviour as an external indicator of pain.

51. Pain behaviours can be highly individual and the CPU noted that good practice would have been to obtain this information from Damien's family and carers. The Department of Health recommends use of self-report to obtain information on pain, cross validated with an observational pain assessment and, where appropriate, discussions with the patient's family or carer.[17]

---

[16] Ibid, p. 35-36.
[17] Department of Health, Identifying Pain (2024). https://www.health.vic.gov.au/patient-care/identifying-pain#comprehensive-pain-assessment.

52. The latter appeared to take place when Damien experienced abdominal pain, but there was limited documentation of his pain behaviours,[18] and as noted by the CIR panel, there was no use of a tool that could assist staff to record pain/distress behaviours and their frequency and intensity. In the absence of such a tool, it was also difficult for staff to confidently identify the efficacy of the analgesia given to Damien.

53. When nursing staff became aware that Damien was in pain and the prescribed analgesia was not adequate, there were delays in obtaining medical review. On 26 September 2022, Damien was given oxycodone at 10:05am and 3:30pm and at handover to afternoon shift, nursing staff recommended a medical review be requested to address the pain.

54. During the Clinical Incident Review process, the nurse that observed Damien on the 26 September 2022 recollected that he had shown signs of pain on his left side and was reluctant to straighten his leg, and the analgesia had moderate effect.[19] Her recollection was that this was the first time Damien had shown signs of pain.

55. At 7:40pm that evening, Damien was given more oxycodone with escalation eventually made to night medical staff. When they indicated they may not be able to attend that night, due to work overload[20], no further action appeared to be taken.

56. It was unclear why the medical review that did occur at 5:20am made no reference to pain. The medical officer could not recall if nursing staff requested a review of Damien's hip pain but stated his standard practice would be to do so if he was asked.[21]

57. It was not until 1:30pm that the cause of Damien's pain was identified by a medical officer. According to the CIR, nursing staff did not follow the Escalation of Care pathway. The CIR does not provide insight into the factors associated with the delay by nursing staff in requesting a medical review, though it recommended a review of the MET procedure to ensure uncontrolled pain is a reason for a MET call.

Personal care

58. Both Damien's family and SDA carers were concerned about the amount of care the latter needed to provide to him on the ward. During the day, the SDA carers provided Damien with

[18] The only documented pain behaviours where grimacing, groaning and reluctance to move his leg but these were recorded in nursing progress notes with no systematic formal assessment.
[19] Coronial Brief, p. 21.
[20] Clinical Incident Review, Coronial Brief.
[21] Information obtained as part of Barwon Health Clinical Incident Review, Coronial Brief, p. 28.

assistance with meals, bathing, toileting and pressure area care. Kevin noted that at a previous admission in 2020, Damien's carers were invited to stay overnight to help settle him to good effect.

59. The CIR noted that UHG did not identify to what extent Damien's family and carers would be engaged in his care whilst admitted. The CPU concurred with this and added that care planning by UHG was limited, not just in relation to what aspects of care would be met by Damien's carers. There was a brief assessment of Damien's cognitive capacity but no documented assessment of his communication abilities to inform care planning. At various times, Damien was described in the nursing progress notes as non-verbal, able to say a few words, or only able to nod/shake head in response to questions[22]. Thus, there was no guidance for staff on how best to communicate with him.

60. There was no documentation of Damien's hygiene needs, with reference only to it being managed by carers.

61. There was only one entry in a behaviour observation chart[23], despite nursing staff frequently noting he was unsettled and at times yelled and hit out at staff. The CPU considered that when patients display such behaviours of concern, systematically recording such occurrences can be essential to identify triggers and inform effective management strategies.

62. The risk assessment component of Damien's Risk Assessment and Care Plan was not completed on admission, including no documented cognitive risks. There was one entry in the care plan on 19 September 2022 noting Damien was non-verbal and "yells out",[24] but no information was recorded to indicate how staff could best communicate with him. The CPU advised that given Damien's family and carers were easily accessible, it was reasonable to expect nursing staff to have engaged with them to identify risks and how best to meet his needs.

Disability Liaison Officer

63. The CIR identified that the Barwon Health Disability Liaison Officer team was not involved in Damien's care. While the CPU concurred with their observation that their omission was unlikely to have altered the outcome, given the role includes supporting people with disability during their healthcare journey and working with the healthcare team to ensure safer,

[22] Barwon Health medical records, p. 209, 215, 229.
[23] Barwon Health medical records, p. 324.
[24] Ibid p. 253.

accessible and more inclusive care during hospital stays,[25] it would seem that their involvement may have at least improved the capacity of UHG to provide patient-centred care to Damien.

Use of opioid analgesia

64. Kevin reported that in a phone call in the early hours of 28 September 2022, he was told Damien *"had been administered pain relief, resulting in an overdose and leaving Damien in a coma and having what was described as a massive fit"*.

65. A clinician from the Health and Medical Investigations Team within the CPU reviewed Damien's medical record with regard to the administration of opioid analgesia and advised that that opioid dosing was appropriate for a 56kg man who was opioid naïve, with doses of 2.5 – 5mg oxycodone used regularly. They opined that the pain relief given was probably inadequate given the severity of Damien's injury.

Possibility of a fall

66. At the time of his death, the incident that caused Damien's pelvic fracture had not been able to be identified. He had fallen out of bed at his SDA on 6 September 2022 and although his mobility had declined at the SDA, he did not appear to be in pain at the time of his admission to UHG, and the fracture was not present on an abdominal x-ray taken on 19 September 2022.

67. Damien was largely bed-bound during his admission. There were no documented falls during the hospitalisation nor reported incidents during situations such as transfers to radiology, and Damien's carers did not report any incidents.

68. It was first noticed that Damien was experiencing pain in his leg and hip on 26 September 2022 following his seizure, and the CIR concluded that the seizure was the likely cause of the fracture. There were reports of Damien experiencing pain prior to the seizure, but either the source of pain was not identified, or it was noted to be abdominal. Although his pain was never systematically assessed, it did appear to escalate after the seizure and led to nurses requesting a medical review.

69. As discussed under the heading 'Medical cause of death', Dr O'Donnell considered that the pattern of the fracture was most often seen with axial loading, that is when force is delivered

[25] Barwon Health Disability Liaison Office (2024). https://www.barwonhealth.org.au/services-departments/item/disability-liaison-office.

from below, such as a fall onto a dropped knee or foot, and Dr Archer considered that an undescribed handling incident or fall may have been a possibility.

70. In my investigation I have endeavoured to determine the cause of Damien's pelvic fracture. The Court has exhausted avenues of investigation in this regard and I am unable to take the matter further – it is certainly unfortunate, but the cause of the fracture will never be definitively known. However, given the advice of VIFM's forensic pathologist and forensic radiologist, I consider that a fall or manual handling of some type to be a more likely cause than a seizure.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

1. The care provided to Damien, particularly in relation to his disabilities, came into focus during my investigation as a result of the CIR and matters raised by his family.

2. UHG through their own CIR identified that Damien's pain was not adequately assessed or documented and the escalation of care pathway was not followed where his pain was not relieved by prescribed analgaesia. They have responded to these issues by appropriately including the assessment of pain in differently abled persons in their Pain Management policy, and I intend to make a recommendation to support/strengthen the implementation of that policy. UHG have also appropriately reviewed the Escalation to Consultant procedure to include a pathway for nurses to escalate patient issues if not satisfactorily resolved by doctors in training. While the CIR provided no insight into the factors associated with the delay by nursing staff in requesting a medical review, it has recommended a review of the MET procedure to ensure uncontrolled pain is a reason for a MET call, supported by forums for clinical staff to improve their understanding of reasons for a MET call. I consider that these actions should minimise the likelihood of this situation happening again.

3. Damien's personal care while admitted to UHG was predominantly attended to by his own SDA carers. The CIR recommended that the Comprehensive Care Plan be reviewed to ensure it enables the agreed level of management by the patient's family and carers to be recorded. This is commendable step towards improving care planning for patients with a disability.

4. Barwon Health have also developed a *Health Passport*[26] that enables a person with a disability, their family and carers, to document key information about their needs (e.g. how to communicate with them, how to know they are in pain) that accompanies the person to hospital, which could be used to develop a patient-centred comprehensive care plan. I will make a recommendation regarding the use of this document to guide information collection from people with disability, their families, and carers to inform patient-centred care planning.

5. The recent Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission) (2023) identified that people with cognitive disability *"have been and continue to be subject to systematic neglect in the Australian health system"* and that education and training is needed to address this, especially with regard to health professionals communicating with people with cognitive disability and their families.[27] I refer to this to highlight the difficulties experienced in our hospital system by those with disabilities – I certainly do not suggest that Barwon Health subjected Damien to systematic neglect.

6. The Disability Royal Commission directed several recommendations to the Australian Government Department of Health and Aged Care to develop a cognitive disability health capability framework (R6.24 - R6.26) and ensure cognitive disability is sufficiently included in the full spectrum of health professional training (R6.27 - R6.29).[28] I am pleased that this work is progressing at the national level,[29] and will make a recommendation that relevant professional development occurs at a local level also.

7. Whilst not contributory to Damien's outcome, it is a disappointing oversight that the Disability Liaison Officer team were not involved in Damien's care. They perform an extremely valuable role, a view shared by Damien's father Kevin who stated *"I feel we really needed one"*. Though speculative, had a DLO been involved in Damien's care, it is possible that some of the other identified shortcomings identified in the CIR may have been avoided. The CIR panel recommended the DLO team review Damien's case and develop a plan to improve

[26] Barwon Health Health Passport, https://www.barwonhealth.org.au/images/AAA_BH_Health_Passport_Template.pdf
[27] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Final Report -Executive Summary: Our vision for an inclusive Australia and recommendations (September 2023), p.77.
[28] Ibid, p. 227-229.
[29] The Australian Government Department of Health and Aged Care released the Intellectual Disability Health Capability Framework in April 2024.

understanding of their role with clinical directorates. I support this recommendation and presume it will go some way to ensure referrals are enacted where appropriate.

8. Ultimately though, while the CIR did identify some shortcomings in Damien's care, there was no evidence that these concerns contributed to Damien's death.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. In the interests of preventing like-deaths and promoting public health and safety, I recommend that Barwon Health:

    a. Accompany the release of their revised Pain Management Police that includes the assessment of pain in differently abled persons, with training for clinical staff in assessing and managing pain in people with cognitive impairment, especially communication issues.

    b. Consider that nursing staff use the existing Barwon Health *Health Passport* where appropriate and especially when the patient is non-verbal, to guide information collection from people with disability, their families and carers, to inform patient-centred care planning.

    c. Consider implementing professional development for nursing staff on providing patient-centred care to patients with a cognitive disability. The 'disability champion/lead' actioned by the *Inclusive Victoria State Disability Plan 2022-2026* for each health service partnership would be ideally placed to promote appropriate professional development and capacity-building within the service.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Damien Mark Stone, born 22 April 1969;

    b) the death occurred on 28 September 2022 at University Hospital Geelong, Bellerine Street, Geelong, Victoria, 3220;

c) I accept and adopt the medical cause of death ascribed by Dr Melanie Archer and I find that Damien Mark Stone died from aspiration pneumonia in the setting of Down Syndrome and pelvic fractures;

2. The care provided to Damien Stone by Barwon Health with particular regard to consideration of his disabilities was the focus of his family's concerns. Consideration of his disabilities was also raised in Barwon Health's Clinical Incident Review, which suggested that his limited ability to communicate may have contributed to a delay in escalation of care, identified that engagement with a Disability Liaison Officer may have facilitated an earlier discharge or stronger engagement with clinical resources and identified that Barwon Health did not have a procedure for assessing pain in different abled patients in the acute setting. While I accept the family's concerns and the shortcomings identified by the CIR, I find that they were not causal to Damien's death.

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

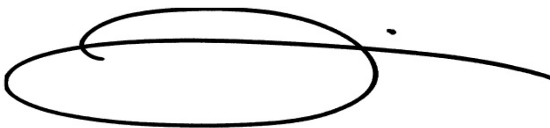
I direct that a copy of this finding be provided to the following:

Kevin and Margot Stone, Senior Next of Kin

Barwon Health

Senior Constable Christopher Donaldson, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 16 April 2026

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.