IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006316

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

(Amended pursuant to section 76A of the Coroners Act 2008)[1]

Findings of:	Coroner David Ryan
Deceased:	Jennifer Rowallan Turnbull
Date of birth:	28 November 1942
Date of death:	2 November 2022
Cause of death:	1(a) Aspiration pneumonia in a woman with covid-19 and multiple medical co-morbidities
Place of death:	Cabrini Hospital, 181-183 Wattletree Road, Malvern, Victoria
Keywords:	In care; disability services; natural causes

[1] This document is an amended version of the Finding into the death of Jennifer Turnbull dated 29 March 2023. The Finding has been amended pursuant to section 76A of the *Coroners Act 2008* to insert paragraphs 1 to 47 to include circumstances of Ms Turnbull's death.

INTRODUCTION

1. On 28 November 1942, Jennifer Rowallan Turnbull was 79 years old when she passed away at Cabrini Hospital Malvern. At the time of her death, Ms Turnbull resided in a residential care facility at 14B Byron Street, Clayton South, managed by Scope Australia. Ms Turnbull had a medical history of cerebral palsy.

THE CORONIAL INVESTIGATION

2. Ms Turnbull'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.

3. On 29 March 2023, having commenced an investigation into Ms Turnbull's death, I determined to discontinue my investigation under section 17 of the Act.

4. Since concluding the investigation, it has come to my attention that Ms Turnbull's death satisfied the definition of a reportable death in section 4(2)(c) of the Act as Ms Turnbull was, immediately before her death, a person placed in care or custody by virtue of her status as a Specialist Disability Accommodation (**SDA**) resident residing within an SDA enrolled dwelling. In those circumstances, I am required by the Act to make findings with respect to the circumstances of Ms Turnbull's death and have done so accordingly within this amended finding.

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.

7. This finding draws on the totality of the coronial investigation into Ms Turnball's death. While 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

Circumstances in which the death occurred

8. On 6 October 2022, Ms Turnbull was admitted to Epworth Freemasons Hospital for treatment of pneumonia and aspiration. Before her admission, Ms Turnbull had already received two courses of oral antibiotics. Despite this treatment, she experienced an ongoing cough. Ms Turnbull's treating general practitioner prescribed another course of oral antibiotics before she required admission to Epworth.

9. Upon assessment by a speech therapist, it was determined that Ms Turnbull's oral intake would be unsafe due to her increased risk of aspiration. A computed tomography (**CT**) brain scan performed on admission did not identify any acute changes. Ms Turnbull was commenced on intravenous antibiotics and oral fluconazole for the treatment of aspiration pneumonia.

10. On 9 October 2022, Ms Turnbull was discharged home.

11. On 13 October 2022, Ms Turnbull presented to the emergency department of Cabrini Hospital Malvern with shortness of breath, low grade fever, and increased confusion. A chest X-ray conducted on admission revealed an acute pulmonary infection. Ms Turnbull's oxygen saturations were reduced at 91%, but subsequently improved following oxygen delivery via nasal prongs.

12. On 14 October 2022, Ms Turnbull underwent a nasogastric tube (**NGT**) insertion for feeding.

13. On 17 October 2022, Ms Turnbull's condition was observed to be improving and her NGT feeds continued. That same day, a meeting was held with Ms Turnbull and her sister, Margaret Chapman. The discussion focused on balancing the risks and possible benefits of

[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.

percutaneous endoscopic gastrostomy (**PEG**) tube insertion for feeding, in light of Ms Turnbull's recurrent aspirations and unsafe oral intake.

14. On 18 October 2022, following a further discussion and review by gastroenterologist Dr Leon Fisher, both Ms Turnbull and her sister agreed to proceed with PEG tube insertion,

15. On 19 October 2022, Ms Turnbull's condition continued to improve and her oral antibiotics continued.

16. Ms Turnbull was observed to tolerate ongoing NGT feeds on 21 October 2022, though her blood pressure was noted as high and her Irbesartan dosage was increased as a result.

17. On 25 October 2022, Ms Turnbull's PEG tube was inserted by Dr Fisher.

18. On 26 October 2022, a MET (Medical Emergency Team) call was made due to Ms Turnbull suffering reduced oxygen levels and increased respiratory rate. Clinicians observed fluid and feed at her mouth and she required six litres of oxygen via face mask. Staff noted that Ms Turnbull received a large bolus of fluid via the PEG tube earlier that morning (400mL, then possibly 200 mL).

19. On 27 October 2022, Ms Turnbull tested positive for Covid-19. She was reviewed by a respiratory physician and received antiviral treatment.

20. On 28 October 2022, Ms Turnbull's feeds were restarted via PEG tube at a rate she had last tolerated.

21. At approximately 3.00am on 29 October 2022, Ms Turnbull rolled out of bed but did not suffer any injuries. Staff recorded that her PEG tube had been pulled out as a result of the roll out. Due to the Covid-19 outbreak on the ward, a medical review was not conducted.

22. On 29 October 2022, Ms Turnbull underwent an NGT insertion but it became blocked.

23. On 30 October 2022, the NGT was replaced, however Ms Turnbull pulled it out later that same day.

24. On 31 October 2022, Ms Turnbull expressed a wish to treating clinicians not to undergo any further invasive medical interventions.

25. At approximately 9.00am on 31 October 2022, a further MET call was made due to Ms Turnbull's increased respiratory rate and bilateral expiratory wheeze. She was commenced on IV antibiotics and salbutamol.

26. On 1 November 2022, discussions took place between Ms Chapman and consultant physician Dr Jonathan Snider regarding Ms Turnbull's prognosis. Dr Snider advised that continued NGT or PEG feeds were not recommended due to her aspiration risks. As a result of these discussions, a decision was made to transition Ms Turnbull to palliative care and implement measures for her comfort. Ms Turnbull was reviewed by the palliative care team later that day.

27. Ms Turnbull subsequently passed away on 2 November 2022 at 7.55pm.

Identity of the deceased

28. On 2 November 2022, Jennifer Rowallan Turnbull, born 28 November 1942, was visually identified by her sister, Margaret Chapman.

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

Medical cause of death

30. Forensic Pathologist Dr Janet Fronczek from the Victorian Institute of Forensic Medicine conducted an examination on 7 November 2022 and provided a written report of her findings dated 23 November 2022.

31. Dr Fronczek reviewed a post-mortem CT scan, which revealed bilateral pleural effusions, consolidation in the left and right lung lower lobe, focal coronary artery calcifications, and fatty liver. Dr Fronczek did not observe any evidence of intracranial haemorrhage, fractures, or any other traumatic injuries. A nasopharyngeal swab was positive for Covid-19.

32. Dr Fronczek provided an opinion that the medical cause of death was 1(a) Aspiration pneumonia in a woman with Covid-19 and multiple medical co-morbidities. Dr Fronczek considered that Ms Turnbull's death was due to natural causes.

33. I accept Dr Fronczek's opinion.

FAMILY CONCERNS

34. In her submission to the Court dated 11 November 2022, Ms Chapman expressed concerns regarding the care her sister received at Cabrini Hospital Malvern. In particular, Ms Chapman raised concerns that no additional precautions were taken to secure the NGT from becoming dislodged, and that her feeding became critical due to the removal of NGT and PEG tube and her Covid-19 infection.

35. Ms Chapman also expressed concerns regarding the ability of hospital staff to communicate with her sister, resulting in a misunderstanding and disregard of Ms Turnbull's wishes.

FURTHER INVESTIGATION

36. In order to better understand the circumstances leading up to Ms Turnbull's death, in the context of Ms Chapman's concerns, further information was sought from Cabrini Hospital Malvern.

37. A statement was subsequently provided by Dr David Rankin, the Director Clinical Governance & Informatics at Cabrini Hospital. Dr Rankin detailed the discussions regarding ongoing PEG feeding at the family meeting held on 17 October 2022 with Ms Turnbull and her sister. He drew particular attention to a signed consent for the procedure and a referral made to the gastroenterologist to conduct the PEG insertion, whom Ms Chapman subsequently contacted to confirm the planned procedure.

38. Dr Rankin stated that Cabrini staff contacted Ms Turnbull's facility after Ms Chapman confirmed that the facility's staff could manage PEG feeds and had done so previously. Ms Chapman was later provided with an opportunity to review Dr Rankin's statement and vehemently denied having advised Cabrini staff as such. She asserted that her advice to Cabrini staff was that although broader Scope staff had experience in PEG administration, staff at 14B Byron Street would require training. Consistent with Ms Chapman's recollection, Dr Rankin confirmed that the dietician consulted with Scope staff regarding their ability to manage Ms Turnbull's PEG feeds and offered for staff to attend the hospital for education.

39. Dr Rankin also confirmed that staff employed several strategies to prevent NGT removal, including Ms Turnbull's placement in a high visibility room and the provision of 1:1 care and supervision by a Patient Care Attendant (**PCA**) between 13 and 25 October 2022. The position of the NGT and PEG tube were also monitored and documented daily.

40. Dr Rankin noted Ms Chapman's observations regarding the use of pillows, rather than bed rails, to prevent Ms Turnbull rolling out of bed and dislodging the PEG tube. He advised that pillows were an appropriate substitute for the use of cot sides, as cot sides would have constituted a form of restraint and were inappropriate.

41. Dr Rankin addressed the dislodgement of the PEG tube following Ms Turnbull's unwitnessed roll out of bed on 29 October 2022, noting an internal review of the incident identified that the ward was experiencing staffing resources at the time due to a Covid-19 outbreak. The dislodgement of the PEG tube itself was accidental, as Ms Turnbull had rolled away from the side of the pole which held the pump for feeding administration. Dr Rankin highlighted that the PEG tube had been in position for four days at that point and Ms Turnbull had not attempted to remove it.

42. After Ms Turnbull's PEG tube was dislodged, she was promptly seen by a gastroenterologist, who considered it unsafe to insert a new feeding tube in circumstances where the site had already healed and she had not yet recovered from her Covid-19 infection. In the interim, NGT feeds were recommenced to ensure Ms Turnbull received adequate nutrition and subcutaneous fluids were administered. Dr Rankin explained that the following day, the NGT became blocked and was removed, and nursing staff were unable to replace it despite several attempts. A medical fellow was subsequently successful in inserting a new tube; however, Ms Turnbull removed it hours later. A decision was made to pause further attempts at tube reinsertion until she could be reassessed the following day, and Ms Turnbull continued to receive subcutaneous fluids.

43. Dr Rankin acknowledged Ms Chapman's concerns regarding staff communication with her sister, however he indicated that medical and nursing staff documented several conversations with Ms Turnbull that demonstrated their understanding of her wishes. Dr Rankin further advised that if staff had identified a need for Ms Turnbull to be reviewed by a psychologist or other specialist, they would have made such arrangements.

CONCLUSION

44. Having considered all of the available evidence, I am satisfied that the care Ms Turnbull received at Cabrini Malvern was reasonable and appropriate, and that staff were conscious to balance management of Ms Turnbull's challenging behaviours with maintaining her dignity. Further, I am satisfied that Ms Turnbull and her sister were actively involved in decision-making in relation to her clinical course, and appropriately apprised of the risks and benefits of particular treatment options.

45. The investigation has not identified any opportunities for prevention arising from Ms Turnbull's death, and I therefore consider that no further investigation is required.

FINDINGS

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

    a) the identity of the deceased was Jennifer Rowallan Turnbull, born 28 November 1942;

    b) the death occurred on 2 November 2022 at Cabrini Hospital, 181-183 Wattletree Road, Malvern, Victoria, from aspiration pneumonia in a woman with Covid-19 and multiple medical co-morbidities; and

    c) the death occurred in the circumstances described above.

47. As noted above, Ms Turnbull's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before her death, she was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Ms Turnbull died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an Inquest into her death.

I convey my sincere condolences to Ms Turnbull'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:

Margaret Chapman, Senior Next of Kin

Melanie Gordon, Cabrini Health

Samuel Kelly, National Disability Insurance Agency (NDIA)

Leading Senior Constable John Thompson, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 13 June 2024

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.