IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006580

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Angela Bella Kettyle
Date of birth:	14 May 1969
Date of death:	8 November 2022
Cause of death:	1(a) ASPIRATION PNEUMONIA COMPLICATING LARGE BOWEL OBSTRUCTION DUE TO FAECAL IMPACTION
Place of death:	The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004
Keywords:	Specialist Disability Accommodation, in care, natural causes, aspiration pneumonia

INTRODUCTION

1. On 8 November 2022, Angela Bella Kettyle[1] was 53 years old when she died at the Alfred Hospital.

2. At the time of her death, Angela was a National Disability Insurance Scheme (**NDIS**) participant. She received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling provided by Scope Australia (**Scope**), located in Malvern East.

Background

3. In 2010, at 41 years of age, Angela experienced a stroke. Angela spent the ensuing years in various hospitals and inpatient facilities receiving rehabilitation therapy. She used a wheelchair for the remainder of her life.

4. In 2013, Angela began residing at the Scope facility in Malvern East and had regular visits from her brother, Samual Kettyle (**Samual**). According to Samual, *'during her time at Scope her weight fluctuated, and her eating habits were poor'*, though eating was reportedly a source of great pleasure for her.

5. Angela was settled and well-cared for at Scope; according to Samual, '*she loved living at the facility, and got on with all the staff and other residents really well*'. 'Call on Clare' nursing services were organised to attend the facility twice-daily to administer her insulin and take care of her nursing needs.

Medical History

6. Angela had multiple medical diagnoses including Type II diabetes mellitus, asthma, constipation, depression, hypertension, hepatitis Type C, cirrhosis and aspiration pneumonia.

7. In the year preceding her death, Samual recalls that Angela's health rapidly deteriorated. He recalls that *'she was in constant pain'* and that she '*was in and out of the Alfred Hospital …the main reasons she would need to go into hospital was due to liver and kidneys shutting down, constipation, difficulty eating, aspiration, lower back pain and swollen throat amongst other things'.* These observations were echoed by Scope staff, who noted Angela to become *'extremely weak and delirious to the point where she didn't recognise familiar staff members'.*

[1] Referred to throughout my Finding as 'Angela' unless more formality is needed.

8. Around September or October 2022, Angela made an advanced care directive and *'decided that she did not want [a feeding tube] as eating was one her few joys left in life. She was finding [hospital] admissions scary and painful. She wanted to avoid [the Intensive Care Unit] and spend as little time in hospital as possible. She also wanted to be free from pain'.*

THE CORONIAL INVESTIGATION

9. Angela'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, Angela resided in a specialist disability accommodation (**SDA**) enrolled dwelling and was considered to have been 'in care' under the Act. The death of a person in care or custody is a mandatory report to the coroner, even if the death appears to have been due to natural causes.

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

11. 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.

12. 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.

13. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Angela'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.

14. Then-Deputy State Coroner Jacqui Hawkins initially held carriage of the investigation into Angela's death, until it came under my purview for the purposes of finalising the investigation and making findings.

15. This finding draws on the totality of the coronial investigation into the death of Angela Bella Kettyle 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

16. On 3 November 2022, Angela was admitted to the Alfred Hospital. She presented with a distended abdomen, and when listening to the lungs, clinicians heard *'coarse crackles bilaterally'*.

17. Due to her distended abdomen and constipation, Angela was transferred to the gastroenterology unit. On assessment, Angela had a fluctuating Glasgow Coma Scale score and only provided one-word responses.[3] When listening to her chest, there were *'coarse crackles'* upon inhalation.

18. On 4 November 2022, a computed tomography (**CT**) scan depicted a mechanical large bowel obstruction with recto-sigmoid faecal impaction.

19. On 5 November 2022, Angela developed tachycardia and tachypnoea with increasing drowsiness. Medical practitioners considered this was likely secondary to aspiration pneumonia.

20. Angela's condition continued to deteriorate, and in line with her care plans and advanced care directive, she was transitioned to an end-of-life pathway. On 8 November 2022, at approximately 3:10am, medical practitioners administered morphine to keep Angela comfortable. Approximately 15 minutes after receiving the morphine, Angela experienced a brief seizure, followed by respiratory arrest. She was declared deceased at 3:35pm.

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[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.

[3] The Glasgow Coma Scale (**GCS**) is a numerical score which reflect a patient's level of consciousness in response to targeted stimuli.

IDENTITY OF THE DECEASED

21. On 18 November 2022, Angela Bella Kettyle, born 14 May 1969, was visually identified by her brother, Samual Kettyle, who completed a Statement of Identification to this effect.

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

MEDICAL CAUSE OF DEATH

23. Forensic Pathologist Dr Gregory Young (**Young**) from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 21 November 2022 and provided a written report of his findings dated 24 November 2022.

24. The post-mortem examination did not reveal any evidence of unexpected injury or wounds. A post-mortem computed tomography (**CT**) scan did not show any residual bowel obstruction. The lungs showed increased infective markings.

25. Dr Young stated that aspiration pneumonia is an infection of the lungs that occurs after an individual inhales foreign material, such as food or vomitus. In this case, the aspiration was caused by a large bowel obstruction due to constipation.

26. Dr Young provided an opinion that the medical cause of death was 1 (a) *aspiration pneumonia complicating large bowel obstruction due to faecal impaction*. Dr Young further stated that the death was due to natural causes.

27. I accept Dr Young's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Angela Bella Kettyle, born 14 May 1969;

    b) the death occurred on 8 November 2022 at The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, 3004, from *aspiration pneumonia complicating large bowel obstruction due to faecal impaction*; and

    c) the death occurred in the circumstances described above.

29. Having considered all of the circumstances, I find that Angela Bella Kettyle died due to natural causes. I note that she had an extensive medical history including an acute worsening of her symptoms in the lead-up to her passing.

30. I find that the medical treatment provided by practitioners of Alfred Hospital was appropriate and the decision to transition Angela Bella Kettyle to palliative care was in keeping with her wishes for a comfortable and dignified passing. In addition, the long-term care provided by Angela Bella Kettyle's GP was comprehensive, thoughtful and patient-oriented, considering her wishes and needs in the context of rapidly declining health.

31. The factual matrix of Angela Bella Kettyle'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. Based on the evidence before me, the care provided to her by Scope Australia was appropriate, respectful and comprehensive, and included, in the last nine months of her life, care team meetings between Scope staff, her GP and her NDIS support coordinator in order to promote coordination of her care.

I convey my sincere condolences to Angela's family for their loss, as well as to all who cared for and loved her.

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:

Mr Jake Hill, Senior Next of Kin

Samual Kettyle

Alfred Health

Scope Australia

Dr Fiona Waters, GP

Senior Constable Kieran Stephens, Coroner's Investigator

Signature:

Coroner Ingrid Giles

Date: 13 November 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.