IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 007425

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Heather Maree Smith
Date of birth:	9 January 1958
Date of death:	28 December 2022
Cause of death:	1(a) Complications of hospital acquired pneumonia and COVID 19 infection
Place of death:	St Vincent's Public Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065
Keywords:	In care, COVID-19, natural causes, hospital acquired pneumonia

INTRODUCTION

1. On 28 December 2022, Heather Maree Smith was 64 years old when she passed away at St Vincent's Hospital, Melbourne (**SVHM**). At the time of her death, Ms Smith lived in specialist disability accommodation (**SDA**) run by Scope in Kew, Victoria.

2. Ms Smith's medical history included osteoporosis, osteoarthritis, visual impairment, asthma, cerebral palsy, dysphagia, epilepsy, hiatus hernia, gastric reflux, and oedema. She had limited verbal communication skills, although she was able to convey to her carers when she was happy, unhappy, in pain or upset. She could not independently stand due to her quadriplegia and required two carers to assist with all transfers and some personal care tasks.

THE CORONIAL INVESTIGATION

3. Ms Smith's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act).[1] The sole reason for the report was that Ms Smith was a "*person placed in custody or care*" pursuant to the definition in section 4 of the Act, as he was a "*prescribed person or a person belonging to a prescribed class of person*" due to her status as an "*SDA resident residing in an SDA enrolled dwelling*".[2]

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The 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.

5. 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.

6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Smith's death. The Coroner's Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

---

[1] Section 4(1), (2)(c) of the Act.

[2] Pursuant to Reg 7(1)(d) of the *Coroners Regulations 2019*, a "*prescribed person or a prescribed class of person*" includes a person in Victoria who is an "*SDA resident residing in an SDA enrolled dwelling*", as defined in Reg 5. I have received information that Ms Smith resided at an address where the residents meet these criteria.

7. This finding draws on the totality of the coronial investigation into the death of Heather Maree Smith 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.[3]

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

Circumstances in which the death occurred

8. On 6 December 2022, Ms Smith was reviewed by her general practitioner (**GP**) Dr Hiran Edirisinghe, who noted cellulitis on her left leg, below the knee. Dr Edirisinghe prescribed antibiotics and advised staff to send her to hospital for intravenous antibiotics if she became febrile.

9. On 7 December 2022, staff at Ms Smith's SDA observed she had a mild temperature of 38.5℃, so they called for an ambulance to attend. Ms Smith was conveyed by ambulance to SVHM for assessment and treatment.

10. At SVHM, Ms Smith was diagnosed with left leg cellulitis and a fracture in her left knee, although it was unclear when the fracture occurred. Her admission was challenging, as she was non-compliant with some of her treatment such as blood tests and thickened fluids. She was discharged home with antibiotics.

11. On 11 December 2022, a nurse from SVHM's Hospital in the Home (**HITH**) program was attempting to insert a canula when she observed Ms Smith was experiencing laboured breathing. Ms Smith was conveyed to hospital by ambulance and was admitted to SVHM.

12. At SVHM, Ms Smith was noted to have COVID-19, high oxygen requirements and high inflammatory markers. Clinicians suspected she also had superimposed bacterial pneumonia. Her electrolytes were also abnormal, including hypernatremia and hypokalaemia. She received intravenous fluids, electrolytes, remdesivir and antibiotics, however there was difficulty gaining compliance with these treatments. She was discharged home on 16 December 2022.

[3] 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. On 18 December 2022, Ms Smith experienced another episode of laboured breathing, lethargy, and had a temperature of 38°C. Staff called Ms Smith's GP, who requested they call an ambulance for her, and she was conveyed by ambulance to SVHM.

14. Upon arrival at the SVHM Emergency Department (**ED**), Ms Smith was noted to be drowsy, febrile, and hypoxic. She was managed for a post-COVID bacterial pneumonia, complicated by delirium and recurrent electrolyte derangement. She received high-flow nasal prong oxygen, intravenous antibiotics and intravenous fluids and electrolytes.

15. Ms Smith was again non-compliant with many aspects of her treatment and refused to consume thickened fluids. SVHM staff consulted with Ms Smith's brother and medical decision treatment maker, and they jointly decided to discharge Ms Smith home, in the hope that she might be more likely to eat and drink in a familiar environment. Ms Smith was discharged home on 23 December 2022 with antibiotics and medication to treat her low potassium and low phosphorus levels. According to her carers, Ms Smith "*appeared very happy*" to be home and had no difficulty consuming thickened fluids.

16. Over 24 and 25 December 2022, Ms Smith was observed to have an increased work of beathing and was less responsive than usual. On 25 December 2022, she was observed to have difficulty breathing and was unresponsive to staff prompts. She was conveyed by ambulance to SVHM for further testing.

17. Upon arrival at SVHM, Ms Smith was observed to have reduced consciousness, was non-responsive and hypoxic. She had mild tachypnoea, diffuse crepitations in her lungs and her electrolyte levels were deranged. Clinicians diagnosed her with aspiration/nosocomial pneumonia, complicated by delirium, and Ms Smith was commenced on low-flow oxygen, intravenous fluids, antibiotics and electrolyte replacement. Ms Smith continued to experience reduced consciousness during her admission and refused food and fluids.

18. On the morning of 28 December 2022, staff found Ms Smith in her bed unresponsive. As she was recorded as not suitable for resuscitation or intubation, no medical intervention was provided, and she was declared deceased.

Identity of the deceased

19. On 28 December 2022, Heather Maree Smith, born 9 January 1958, was visually identified by her carer, Courtney Skelly.

20. I am satisfied that the identification is correct. Identity is not in dispute and requires no further investigation.

Medical cause of death

21. Forensic Pathologist Dr Victoria Francis, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 30 December 2022 and provided a written report of her findings dated 6 January 2023.

22. The post-mortem examination revealed findings in keeping with the reported circumstances.

23. Examination of the post-mortem CT scan showed severe longstanding cerebral atrophy with peripheral oedema, muscle wasting, bilateral pleural effusions with increased lung markings and marked thoracic skeletal abnormalities with kyphosis and lordosis.

24. Toxicological analysis of post-mortem samples was not indicated and was therefore not performed.

25. Dr Francis provided an opinion that the medical cause of death was "*1(a) Complications of hospital acquired pneumonia and COVID 19 infection"* and that the death was due to natural causes.

26. I accept Dr Francis' opinion.[4]

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Heather Maree Smith, born 9 January 1958;

    b) the death occurred on 28 December 2022 at St Vincent's Public Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065, from complications of hospital acquired pneumonia and COVID 19 infection; and

    c) the death occurred in the circumstances described above.

I convey my condolences to Ms Smith's family for their loss.

[4] Pursuant to s 52(3A) of the Act, a coroner is not required to hold an inquest where the deceased was, immediately before death, a person placed in custody or care, if the coroner considers that the death was due to natural causes.

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:

Andrew Smith, Senior Next of Kin

St Vincent's Hospital Melbourne

First Constable Alex Kimberley, Victoria Police, Coroner's Investigator

Signature:

Coroner Catherine Fitzgerald

Date : 12 August 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.