

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000222

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of: AUDREY JAMIESON, Coroner

Deceased: Rachel Frances Piskun

Date of birth: 9 March 1980

Date of death: 11 January 2023

Cause of death: 1a: Pneumonia
1b: Severe cerebral palsy

Place of death: Sunshine Hospital, Furlong Road, St Albans,
Victoria, 3021

INTRODUCTION

1. On 11 January 2023, Rachel Frances Piskun was 42 years old when she died in hospital. At the time of her death, Rachel lived in Supported Disability Accommodation (SDA) in St Albans operated by Scope Australia Pty Ltd (**Scope**).
2. Rachel had severe cerebral palsy, intellectual disability, visual impairment, epilepsy and was non-verbal. She required 24-hour care and support and conveyed her needs using facial expressions and non-speech sounds. From November 2017, Rachel required PEG-feeding.
3. Rachel loved watching television and movies, listening to audiobooks and relaxing in the sensory room at her home. She was close with her mother, Joan, who saw her often.

Sunshine Hospital/Footscray Hospital admission: September 2021 – November 2021

4. On 16 September 2021, Rachel was taken to the Sunshine Hospital (SH) Emergency Department (ED) with distress, pain and fever, likely due to aspiration pneumonia. She was accompanied by the SDA House Supervisor who provided the ED with Rachel's hospital admission information form, medication record and health support needs summary, but was unable to accompany Rachel to the ward due to restrictions in place due to the COVID pandemic. Rachel wore compression stockings, and the House Supervisor reportedly told nursing staff that these needed to be removed at night.
5. On 17 September 2021 Rachel was admitted to the COVID ward. The nursing admission notes state that Rachel's skin was dry and intact and that she had *'thick bilateral lower leg dressing/?thick tubigrip insitu? Red but blanching skin noted around top of dressings'*.¹ Rachel was transferred to Ward S 3E that afternoon where it was noted she had compression stockings on both feet.²
6. Nursing staff did not document the presence of compression stockings or issues with leg circulation on 18 or 19 September 2021, though it was documented that she received pressure area care and required full nursing care.
7. In the early hours of 20 September 2021, nursing staff on night shift noted *'clear watery leakage seeping through compression bandage at feet'*³ and requested day staff report this to

¹ Western Health EMR, p. 2538.

² Ibid p. 2540.

³ Ibid p. 2548.

the treating team. Documentation of a review by consultant Dr Nicole Lioufas at 8:47am indicated that Rachel's right foot was cyanosed up to her shin and there was a superficial graze on her foot.

8. At 1:28pm, nursing staff documented that Rachel had:

... bilateral leg compression stockings and severe marking on both legs - with necrotic blister on R) heel and multiple skin tears with blisters on R) calf up to the knee-all oozing serous fluid. L) Lower limb has blister on great toe and 2nd toe with ooze. All wounds dressed post wash with mepilex border. Needs to be reviewed. Neurovascular obs - unable to find pulse on R) popliteal and dorsalis pedis as very oedematous and discoloured. L) popliteal-very feeble.⁴

9. At around 3:30pm, Clinical Nurse Consultant (CNC) Fiona Findlay, a wound specialist, documented:

Reading through history this afternoon, leg compressions had been insitu, possibly since admission. No clear documentation that they had been taken down for assessment by medical or nursing staff until this morning. Noted compression wet with serous ooze this morning.⁵

10. A report was made to RiskMan and Rachel was transferred to Ward 2A. Joan was allowed to attend the ward the following day, with visiting permissions to be negotiated on a daily basis.
11. The Scope staff meeting notes for 20 September 2021 indicate that Disability Liaison Officer (DLO) Daniela Neskovski informed them that carers were permitted to visit patients with a disability to provide care and support.⁶
12. Also on 20 September 2021, medical registrar Dr Terance Lee phoned the manager of Rachel's SDA to obtain information on the nursing care regime for her compression garment. He documented that it was supposed to be on for 12 hours during the day and removed at night.⁷ Scope reported a pre-existing treated pressure injury to Rachel's left toe and heel but

⁴ Ibid, p.2549/3562.

⁵ Ibid, p. 2026/3562.

⁶ Scope staff meeting, 20 September 2021.

⁷ This aligns with the *Scope Oedema Management Plan* that stated the 'Easywrap' compression garment was prescribed on 21 June 2021 by GP Dr Peter Nicolaai and Mercy Hospital Lymphoedema Clinic for oedema in Rachel's right foot and leg. The garment was to be worn everyday (but not during bed rest) and removed at night.

no pressure injury to the right foot. Dr Lee informed Joan that the changes to Rachel's right leg were due to the compression garment being left on since admission.

13. On 29 September 2021, debridement of Rachel's leg wounds and skin grafting took place following delays in access to theatre and to procuring an anaesthetist to insert a central line for intravenous antibiotics due to the pandemic conditions.
14. Rachel underwent several more wound debridements under general anaesthetic (**GA**) with Joan and her carers reportedly increasingly concerned about inadequate pain control.
15. On 30 September 2021, Rachel was reviewed by the pain management team who made several amendments to the pain management protocol to ensure adequate pain relief balanced against Rachel's sensitivity to opioids and concerns about over-sedation. Joan and Rachel's carers were urged to educate staff to help them identify cues that she was in pain and the pain management team continued to provide assistance to the treating team.
16. Around 5 October 2021, there were signs that the donor graft site had become infected, likely due to contamination from urine/faeces.
17. On 6 October 2021, further debridement was undertaken under GA and an indwelling urinary catheter inserted. Dr Aimee Khoo reported she had been unsuccessful in obtaining a nurse special to assist with Rachel's care (which required two staff) as she had been informed that the criteria for this level of care had not been met.⁸
18. Further wound debridement was undertaken under GA on 8 and 10 October 2021.
19. On 10 October 2021, the decision was made to undertake a staged amputation to reduce Rachel's pain and ongoing loss of tissue. However, there were difficulties in accessing an operating theatre due to the pandemic conditions.
20. A theatre became available at Footscray Hospital (**FH**) and Rachel was transferred on 14 October 2021. Although the SH pain management team provided a handover to FH, it does not appear that Rachel was given analgesia during her first night at FH.⁹
21. On 15 October 2021, Rachel underwent the first stage of a right below knee leg amputation (**BKA**).

⁸ Western Health EMR p.228/3562.

⁹ Ibid, p.2267/3562.

22. On 16 October 2021, Rachel was tachycardic and screaming during a PEG feed. She was reviewed by the pain management team who requested two-hourly pain assessment and use of PRN¹⁰ analgesia in addition to ongoing ketamine infusion, opioids and regional analgesia.
23. The second stage of the BKA was undertaken on 19 October 2021.
24. On 26 October 2021, new excoriation was noted under Rachel's right breast and between the toes on her left foot. A RiskMan report was made.
25. Rachel's ongoing care needs were overseen by FH occupational therapist (OT) Ann Cocking, who liaised with Joan, the SDA House Manager, FH physiotherapy team and Rachel's community-based OT. Post-discharge wound care was organised through Bolton Clarke.¹¹
26. On the morning of 8 November 2021, being the day of her planned discharge, nursing staff requested the treating team review Rachel as she '*sounded wet in the chest and gurgly*'.¹² On review, the treating team requested a speech pathologist address the matter but the request was denied as it was considered out of their scope of practice.¹³ Nursing staff obtained the advice of the treating team regarding the morning feed and were instructed to administer it, as usual, but Rachel was transferred home before this was able to take place.
27. Joan reported that Rachel dealt with the amputation well but, going forward, it impacted her *spirit*.¹⁴

Footscray Hospital admissions: December 2021 – November 2022

28. Rachel was readmitted to FH on 11 December 2021 with sepsis¹⁵ of unknown origin. During the admission she developed cardiac issues, had two aspiration events¹⁶, developed delirium and declining liver function.

¹⁰ The term "PRN" is a shortened form of the Latin phrase *pro re nata*, which translates roughly as "as the thing is needed". The term *prn* is used when prescribing medication, to direct that it be administered only as required e.g. for analgesia.

¹¹ Bolton Clarke provide at-home nursing support.

¹² Western Health EMR, p. 2710/3562.

¹³ It is not known if Rachel's symptoms were adequately assessed and appropriately managed, and if standard practice/protocol was followed.

¹⁴ Statement of Joan Winter, Coronial Brief, p.13/26.

¹⁵ Sepsis is a potentially life-threatening condition caused by the body's response to an infection. The body normally releases chemicals into the bloodstream to fight an infection. Sepsis occurs when the body's response to these chemicals is out of balance, triggering changes that can damage multiple organ systems.

¹⁶ The first aspiration event was following PEG flush on 12 December 2021 and a Code Blue was called. The second event occurred on 13 December 2021 while medications were being given and a MET Call was made.

29. Rachel had a 1:1 nurse special on 13 December 2021. That day, FH arranged for Rachel's carers to provide care cover for night shift and other timeslots, when available, up until 17 December 2021.
30. Joan advocated for palliative care should Rachel's condition continue to deteriorate and become not reversible. Medical staff sought to minimise distressing medical interventions for Rachel and delayed/withheld a CAT scan, insertion of central venous line and cardiac monitoring.
31. By 17 December 2021, Rachel had recovered to close to baseline, and she was discharged on 21 December 2021.
32. Rachel was admitted to FH on several more occasions over the next 11 months,¹⁷ mostly for sepsis of unknown origin, and actively treated with antibiotics. During these admissions, Rachel's carers or a nurse special were occasionally documented as providing 1:1 care.
33. During the November 2022 episodes of care, dieticians documented on multiple occasions¹⁸ that Rachel's PEG feeds were to be delivered via pump over one hour and Rachel was to remain upright for one hour post feed.
34. On 30 November 2022, Rachel's 8am PEG feed was delivered via syringe rather than pump¹⁹. A RiskMan report was made, and medical staff, nurse-in-charge, dietitian and Joan were notified. It was agreed that Rachel's carers would subsequently be in charge of her feeds. Rachel was monitored for regurgitation with no issues documented.

THE CORONIAL INVESTIGATION

35. Rachel's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008 (the Act)*. Specifically, Rachel was immediately before her death 'a person placed in custody or care', as she was an SDA resident residing in an SDA enrolled dwelling. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.
36. 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

¹⁷ Admission dates were 28 December 2021 – 31 December 2021, 31 March 2022 – discharged same day, 2 November 2022 - 5 November 2022, 25 November 2022 – 1 December.

¹⁸ 3 November 2022, 4 November 2022 and 29 November 2022.

¹⁹ Western Health, EMR, p.2771/3562.

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.

37. 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.
38. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Rachel'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.
39. This finding draws on the totality of the coronial investigation into the death of Rachel Frances Piskun. 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.²⁰

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

Circumstances in which the death occurred

40. On 11 December 2022 Rachel was readmitted to FH with another episode of sepsis, the third in around five weeks. In consultation with Joan, she was provided active treatment with antibiotics. Joan and Rachel's carers provided her with 1:1 care.
41. At the morning round on 12 December 2022, a medical officer noted no signs of aspiration on admission.²¹ The ward nurse documented that feeds were to be delivered via pump and this was to be undertaken by Rachel's carers.
42. On 14 December 2022, a medical officer reported that a stool sample had not been taken as requested and no PRN analgesia had been given overnight.²² The medical officer requested

²⁰ 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.

²¹ *Ibid*, p. 2470/3562.

²² *Ibid*, p.2479/3562.

three-hourly pain assessments and instructed staff to consider loud screaming a sign that Rachel was in pain.

43. On 16 December 2022, a medical officer documented that the stool sample had still not been taken after three days of requests and advised that a RiskMan report be made as Rachel's discharge was dependent on the outcome of stool cultures.²³

44. That day, Rachel's 8am PEG feed was given via syringe instead of slow pump.²⁴ The nursing notes stated:

*Regime written by dietician team did not indicate rate of feeds/flush. Feeds prescribed 3 times a day 0800/1200/1700 - 50mls pre flush with 200mls and post feed flush 50mls. Prior to administering feeds, double checked with NIC [Nurse-in-Charge] and RN colleague if feed regime is pump or via syringe. Nil pump rate documented on PEG feed regime form.*²⁵

45. A Riskman report was made. No aspiration, regurgitation or clinical deterioration was noted following the incident.

46. At 7am on 16 December 2022, a Scope carer arrived at FH to support Rachel. At 8am, the carer asked nursing staff to provide a giving set so they could give Rachel her PEG feed. The carer was informed a giving set could not be located and nursing staff would administer the PEG feed through a syringe. According to the carer, nursing staff informed them Rachel had been receiving PEG feeds using this method of delivery. The carer did not query the information.²⁶

47. Rachel's midday feed was also delivered by syringe. At around 2pm Joan arrived, and the carer informed her that the two meals on that shift had been delivered by syringe. A RiskMan entry was made and the NIC and dietitian notified. No issues with regurgitation or side effects were reported on the shift.

48. On the morning of 17 December 2022, a MET call was made as Rachel was distressed, tachycardic and tachypnoeic. That evening Rachel was again reviewed for tachycardia.

²³ Ibid, p.2489/3562.

²⁴ Ibid, p.2786/3562.

²⁵ Ibid, p.2786/3562. Other evidence suggests that the dietician did specify the rate of 200ml per hour over one hour, via pump.

²⁶ The Scope Incident Report indicated that the house manager subsequently raised with the carer that Scope staff do have the right to speak up in the hospital setting if a patient's safety is at risk.

49. A dietitian spoke with Joan on 19 December 2021 about the incorrect PEG feed delivery method used on 16 December. Joan indicated she was concerned about the wording of the bed chart feeding instructions as she believed use of the word ‘bolus’ may have been interpreted as ‘deliver quickly’ by nursing staff. The dietitian indicated the hospital did not have a bed chart that aligned with Rachel's unique feeding regime but *minor adjustments* were made to improve the clarity of the instructions for nursing staff.²⁷
50. Rachel continued to be distressed due to pain, the cause of which was unclear but may have been related to bowel and/or hip and spine issues. In consultation with Joan, priority was given to managing Rachel’s pain and on 21 December 2022, the Palliative Care Team (PCT) commenced a pain relief regime with a syringe driver delivering morphine, midazolam and haloperidol. Rachel settled overnight.
51. On 23 December 2022, Joan noticed a port on one of the two syringe drivers was dislodged, meaning that Rachel may not have been receiving maximum dose of medication, including analgesia.²⁸ The medical team were informed and a RiskMan report made. A second subcutaneous butterfly needle was inserted to ensure reliable administration of medication.
52. That afternoon, Rachel developed a fever, tachycardia and agitation. A medical officer informed Joan that that *aspiration events unlikely avoidable* and even with active treatment, the team may not be able to change Rachel’s trajectory.²⁹ In consultation with Joan, who did not want Rachel to suffer further cycles of antibiotics with limited gain, the decision was made to commence palliative care and Rachel was transferred to the SH Palliative Care Unit on 24 December 2022.
53. On the afternoon of 24 December 2022, the palliative care ward nursing staff noted an error in the prescription and possible dispensing of Rachel’s syringe driver that had occurred at FH.³⁰ The consultant, Dr Maria Coperchini, had wanted Rachel to have hyoscine butylbromide (Buscopan), morphine and midazolam³¹ via syringe driver but the orders were for hyoscine hydrobromide (Scopolamine)³². It was confirmed that Rachel had in fact been

²⁷ Western Health, EMR, p.1880/3562.

²⁸ Ibid, p. 2038/3562.

²⁹ Ibid, p.2519/3562.

³⁰ Ibid, p.2522 and 2813/3562.

³¹ Hyoscine butylbromide (decrease chest secretions, reduce colic), morphine (pain relief) and midazolam (sedation) are often used in combination as part of palliative care.

³² Hyoscine hydrobromide is used to treat motion sickness and postoperative nausea and vomiting. It can also be used in palliative care to reduce respiratory secretions.

administered the correct medication, though the incorrect medication was recorded as being dispensed. Joan was informed, an entry made in RiskMan and education provided to staff.

54. Rachel died on 11 January 2023.

Identity of the deceased

55. On 11 January 2023, Rachel Frances Piskun, born 9 March 1980, was visually identified by her mother, Joan Winter, who completed a Statement of Identification.

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

Medical cause of death

57. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination of the body of Rachel Piskun on 13 January 2023. Dr Bedford considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (CT) scan and E-Medical Deposition Form from Sunshine Hospital and provided a written report of his findings dated 17 January 2023.

58. The post mortem CT scan showed cerebral atrophy, bilateral lung changes and right below knee amputation.

59. Dr Bedford provided an opinion that the death was due to natural causes and ascribed the medical cause of death as 1(a) PNEUMONIA, 1(b) SEVERE CEREBRAL PALSY.

REVIEW OF CARE

60. I requested the Coroners Prevention Unit (CPU)³³ review Rachel's case and advise me as to whether her below knee amputation in September 2021, and the PEG feeding by syringe on 16 December 2022 were causal to her death. In doing so, the CPU conducted a comprehensive review of Rachel's care at Sunshine Hospital and Footscray Hospital.

Leg injury

³³ 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.

61. The CPU examined the serious adverse event in September 2021 that led to Rachel having a right BKA and considered that while the episode likely reduced Rachel's resilience, it occurred more than a year before her death from a respiratory-related event, thus making it difficult to draw causal connections between the event and her death.
62. SH promptly explained to Joan that Rachel had suffered a serious adverse event while in their care. Western Health (WH) conducted an internal review and invited Joan's participation. WH staff and Joan are seen discussing the internal investigation in a video on the *Safer Care Victoria* website where they indicate a range of issues were identified and recommendations made for improvements, including referral of specialist services, transfer of information between departments, visiting patients, team interactions and staff interactions with a patient with a disability.³⁴
63. The CPU noted that these issues broadly align with the issues they identified in reviewing Rachel's care:
- a) Carers of a highly vulnerable person were not allowed to stay with them on the ward during the pandemic-conditions operating at the time within Victorian public hospitals.³⁵
 - b) Lack of continuity of important patient information on transfer between the ED and the ward.
 - c) Inadequate assessment and management of pain in a person who was non-verbal.
64. Rachel also experienced multiple issues associated with the pandemic conditions including difficulty in accessing specialist staff to insert intravenous lines and take blood (leading to repeated distressing attempts by non-specialist staff and delays in receiving intravenous antibiotics), and delays in access to operating theatres and anaesthetists. The pressure on the health workforce and health service resources during the pandemic are well documented, though the impact this had on the most vulnerable of patients is exemplified by Rachel's case.

PEG feeding

³⁴ See *Safer Care Victoria* website: <https://www.safercare.vic.gov.au/report-manage-issues/managing-adverse-events>

³⁵ The Department of Health/SH policies regarding hospital visitors at this point during the pandemic are unknown. However, as noted above, there is evidence that, after the adverse event occurred, the SH DLO informed carers that they were permitted to visit patients with a disability to provide care and support

65. The CPU advised me that it was difficult to definitively link the use of an incorrect delivery method on 16 December 2022 to the development of pneumonia (and Rachel's subsequent death), as there were no signs of regurgitation or serious side-effects that day. The next morning, Rachel did become distressed, tachycardic and tachypnoeic and require emergency assistance. However, this was following the morning PEG feed, so it may have been this feed that led to an aspiration event.
66. Although a medical officer noted that Rachel showed no signs of aspiration on her admission on 12 December 2022, meaning aspiration likely happened at FH, it was not possible to untangle which specific feed/s might have contributed to the development of aspiration pneumonia.
67. The CPU noted that this incident occurred during Rachel's final admission which was the third in around five weeks for sepsis; although the origin of each episode was not always apparent, aspiration pneumonia was a possible cause. By 23 December 2022, a medical officer noted that aspiration events had likely become unavoidable for Rachel. Hence, although the delivery of two feeds by syringe on 16 December 2022 was a failure to follow the plan written in the nursing progress notes and the bedside feeding plan may not have been sufficiently clear, Rachel did not appear to regurgitate after these feeds and the risk of aspiration remained very high, even when feeds were delivered as planned.

Other care concerns

68. The review conducted by CPU identified a number of additional concerns with the overall quality of care provided to Rachel by FH during her multiple admissions between 11 December 2021 and 24 December 2022, when she was transferred to SH for palliative care:
- d) Two aspiration events associated with the delivery of medications and flushing of the PEG feeding tube (12 and 13 December 2021)
 - e) Failure to follow instructions for PEG feed and delivered by syringe rather than slow pump (30 November 2022)
 - f) Failure to adequately assess and manage pain (on several occasions during most admissions)
 - g) Lengthy delay in actioning pathology request delaying discharge (December 2022)

- h) Syringe driver port incorrectly positioned meaning analgesia may not have been delivered as prescribed (23 December 2022)
 - i) Incorrect prescription for syringe driver (24 December 2022).
69. While concerning, most of these issues were unlikely to have had an impact on Rachel's outcome. Of these matters, the most concerning to the CPU was the ongoing struggle by clinical staff to identify when Rachel was in pain and to adequately manage it.³⁶ Rachel was unable to tell clinical staff when she was in pain, but even when information was gleaned from Rachel's mother and carers about how Rachel communicated pain, there are multiple entries in the record of her loudly and persistently screaming that were not identified as likely pain. Rachel's pain did not appear to be well controlled until the involvement of the pain management team and subsequently, palliative care team.
70. Western Health advised that pain assessment and management posed significant challenges during Rachel's admission due to her non-verbal status and complex medical condition, meaning staff were relying on atypical behavioural patterns to infer pain. They noted that analgesia was prescribed regularly and as needed, and an internal review had identified the same.
71. Western Health have advised that they have implemented several measures aimed at enhancing patient safety and care quality. An Electronic Medical Record project was initiated to improve the clarity, accessibility, and precision of nursing and midwifery documentation, including enteral feeding regimes and pain assessment protocols. Processes have been strengthened to ensure the involvement of family members and carers in care planning, pain assessment and daily management discussions. Further, pain assessment protocol adherence is subject to clinical audits, with the findings to be reviewed by the Medication Safety Committee and all deviations from prescribed care protocols trigger formal reporting via RiskMan and prompt clinical review.

³⁶ Failure to identify and treat pain can have significant consequences for quality of life. An *NDIS Practice Alert: Pain Management* (November 2022) notes that people who cannot communicate their pain do so in ways that are specific to them (usually behaviourally), but often not well understood by others (<https://www.ndiscommission.gov.au/sites/default/files/2022-11/Practice%20Alert%20-%20Pain%20management%20-%20November%202022%20-%20accessible.pdf>). Thus, obtaining knowledge of the person and active observation are essential to guide appropriate management. Scales exist to assess and monitor pain in this cohort, including for people with cerebral palsy [see Lotan & Icht, (2023) Diagnosing pain in individuals with intellectual and developmental disabilities: Current state and novel technological solutions. *Diagnostics*, 13, 401].

COMMENTS

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

1. Although I have not identified any opportunities for prevention, the overall care provided to Rachel by Western Health during multiple admissions to Sunshine Hospital and Footscray Hospital between September 2021 and her death in January 2023 was not ideal. The care appears reflective of a comment made in the Final Report (2023) of the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (**the Royal Commission**) that:

People with cognitive disability are subject to systemic neglect in the Australian health system... health services are not designed for people with disability... health workers do not have sufficient disability knowledge and skills” such that “too often, people with disability have received poor care, the wrong care or no care.”³⁷

2. The Victorian Government *State Disability Plan 2022-2026*³⁸ (**the Plan**) includes actions to improve the quality of care delivered to people with a disability when they enter hospital. Although the Plan sits within the Department of Families, Fairness and Housing, it is a whole-of-government agreement to prioritise systemic reform in six priority areas, one of which is health. Some of the health-related actions have relevance to Rachel’s experience and should ensure people with similar vulnerabilities are better cared for in the future:

2.1.3 Develop ‘disability champion/lead’ models in each health service partnership to promote/guide knowledge, professional development and capacity-building services

2.1.4 Support health services to enhance referral pathways at key intake points to recognise and respond to the needs of people with disability

2.1.7 Look for opportunities to develop e-learning and other training packages and courses that are co-designed with people with disability and which promote inclusion, foster a culture of respect and change attitudes towards people with disability

³⁷ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (September 2023), *Final Report, Volume 6, Enabling autonomy and access*, p. 321.

<https://disability.royalcommission.gov.au/publications/final-report-volume-6-enabling-autonomy-and-access>

³⁸ Department of Families, Fairness and Housing (March 2022) *Inclusive Victoria: State Disability Plan 2022-2026*. <https://www.vic.gov.au/sites/default/files/2023-03/Inclusive-Victoria-state-disability-plan-2022-2026.pdf>

2.1.8 Leverage broader work around community attitude campaigns and Disability Liaison Officers (DLOs) in health services to include a focus on attitudes towards people with disability in health settings

2.1.9 Working with relevant peak bodies to promote workforce development strategies

2.1.10 Investigating opportunities for training to be included in pre-service qualifications.

3. However, as indicated by the Royal Commission's Final Report, Victoria is not the only jurisdiction in Australia that has a health system poorly designed to care for people with a disability. The Royal Commission made a number of recommendations that go much further than the *State Disability Plan 2022-2026* in providing a way forward for improved health service care. Those specific to Rachel's experience are:

Recommendation 4.1: Establish a Disability Rights Act

The Australian Government should commit to the enactment of a Disability Rights Act and take the necessary steps to introduce the legislation into Parliament and support its enactment.

Recommendation 6.31: Embed the right to equitable access to health services in key policy instruments:

(a) The Australian Commission for Safety and Quality in Health Care (ACSQHC) should:

- amend the Australian Charter of Healthcare Rights to incorporate the right to equitable access to health services for people with disability and align with the scope of this proposed right in the Disability Rights Act (see recommendation 4.1)
- review and revise the National Safety and Quality Health Service Standards and the National Safety and Quality Primary and Community Healthcare Standards to provide for the delivery of safe and high-quality health care for people with disability and align with the scope of the proposed right to equitable access to health services in the Disability Rights Act
- as part of this review, consider how the national standards support equal access to health services for people with disability throughout life, including (but not limited to) prevention and health promotion, diagnosis and early intervention and rehabilitation services.

- (b) The Australian Government Department of Health and Aged Care and state and territory counterparts should review all policies and protocols to ensure people with disability are permitted to be accompanied by a support person in any health setting. This should apply at all times, including when in-person healthcare restrictions are in place, such as during COVID-19.
4. The Royal Commission also recommended that states and territories should each establish or maintain an independent ‘one-stop shop’ complaint reporting, referral and support mechanism to receive reports of violence, abuse, neglect and exploitation of people with disability (Recommendation 11.3). This is an important step forward in ensuring the safety of people with a disability, but Rachel’s case illustrates that neglect can arise when a person with a disability is non-verbal and cannot directly communicate their needs to clinicians in the hospital setting and likely nor to an independent complaint reporting body.
5. What was striking to me about Rachel’s experience was the number of errors and incidents that occurred across the admissions (most of which were reported on RiskMan), yet there appeared to be nothing to flag a potential systemic problem with the care delivered to people with severe disability at Western Health. I consider that part of the solution to improving the quality of care for this vulnerable cohort when admitted to hospital, is to explore the capacity to use existing monitoring mechanisms such as RiskMan to identify systemic problems in the care delivered to this cohort. I intend to make a recommendation in this regard.

RECOMMENDATIONS

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

- (i) With the aim of promoting public health and safety and preventing like deaths, I recommend that Western Health explore the use of their existing monitoring and reporting mechanisms such as RiskMan to identify systemic problems in the care delivered to people with disabilities.

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 Rachel Frances Piskun, born 09 March 1980;
- b) the death occurred on 11 January 2023 at Sunshine Hospital, Furlong Road, St Albans, Victoria, 3021;

- c) I accept and adopt the medical cause of death ascribed by Dr Paul Bedford and I find that Rachel Frances Piskun, a women with severe cerebral palsy, died from pneumonia;
2. AND, although I have identified several shortcomings in the care provided to Rachel Frances Piskun by Western Health from September 2021 to her death, I am unable to find that those shortcomings were causal to her death;
3. AND FURTHER, I have determined to apply section 52(3A) of the Act to this matter and finalise the matter without Inquest as I accept that Rachel Frances Piskun's death was from natural causes.

I convey my sincere condolences to Rachel'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:

Joan Winter, Senior Next of Kin

Walter Piskun, Senior Next of Kin

Western Health

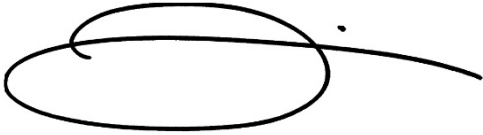
Safer Care Victoria

Australian Department of Health

Australian Commission for Quality and Safety in Health Care

Senior Constable Brent Beer, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 17 October 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.
