IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 004650

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Maria Presti
Date of birth:	19 January 1961
Date of death:	21 August 2023
Cause of death:	1(a) Aspiration pneumonia 1(b) Cerebral palsy
Place of death:	Werribee Mercy Hospital, 300-310 Princes Highway, Werribee, Victoria, 3030
Keywords:	Death in care, aspiration pneumonia, natural causes

INTRODUCTION

1. On 21 August 2023, Maria Presti was 62 years old when she passed away at the Werribee Mercy Hospital (**WMH**). At the time of her death, Ms Presti lived in specialist disability accommodation (**SDA**) in Altona Meadows, Victoria.

2. Ms Presti had a complex medical history, which included cataracts, cerebral palsy, depression, dysphagia, gastro-oesophageal reflux disease (**GORD**), intellectual disability, osteoarthritis, and osteoporosis. She was non-verbal, could not stand independently and required full assistance for all transfers. She required support for all daily living activities including meal preparation, personal care, and medication administration.

THE CORONIAL INVESTIGATION

3. Ms Presti'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 Presti was a "*person placed in custody or care*" pursuant to the definition in section 4 of the Act, as she 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 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 Presti's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

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[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 from the NDIS that Ms Presti 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 Maria Presti 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. Ms Presti's carers noted that she was generally well in early-2023, although often had bruises and blisters from "*hooking her arms under the bed rails and wheelchair arms as a sign of her frustration with communication*". She experienced an episode of aspiration pneumonia in early-July 2023 and was treated in hospital. She appeared to recover from this episode of illness and was discharged.

9. On 29 July 2023, a carer at Ms Presti's SDA observed that she "*appeared weak*", although she ate her dinner that afternoon without any difficulty. At about 6.15pm that evening, a carer observed that Ms Presti appeared weak and out of breath, although was still able to vocalise. The carer called 000 for paramedics to attend. Paramedics transported Ms Presti to WMH with a query of possible pneumonia or sepsis.

10. Initial investigations at WMH showed elevated inflammatory markers consistent with infection and consolidation in the left upper and mid zones of her chest x-ray, consistent with pneumonia. She received intravenous antibiotics and oxygen via high flow nasal prongs. She was also noted to be hypovolaemic (dehydrated) associated with severe hypernatremia and acute kidney impairment. She received IV fluids which were effective. Over the first few days of her treatment for pneumonia, Ms Presti's condition improved.

11. On 3 August 2023, Ms Presti's condition deteriorated due to an acute aspiration event. A Medical Emergency Team (**MET**) call occurred, and Ms Presti received oxygen and IV morphine and midazolam. A repeat chest x-ray demonstrated worsened severe consolidation of the left lung. Despite an increase in treatments and supports, Ms Presti demonstrated ongoing clinical deterioration and became increasingly more agitated and distressed.

[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.

12. The next day, a multidisciplinary team meeting occurred between clinicians, who agreed that given there was only a minimal response to ward-based care, ongoing deterioration was expected. They noted that due to Ms Presti's ongoing distress and agitation, it would be in her best interests to transition to comfort care. Ms Presti's family were unhappy with this decision and wanted to continue with ward-based care. Clinicians continued with antibiotics in hospital at the family's request, however Ms Presti continued to deteriorate and was ultimately referred to the palliative care team for end-of-life care.

13. Ms Presti was transferred to the palliative care unit on 7 August 2023 and received ongoing comfort care. At her family's request, clinicians continued to administer subcutaneous fluids, and Ms Presti was referred for a second opinion. A respiratory physician confirmed that comfort care was the most appropriate option.

14. Ms Presti was commenced on a syringe driver on 11 August 2023, with ongoing breakthrough morphine and midazolam for breathlessness and distress. Subcutaneous fluids were ceased the next day, due to the pain and distress they were causing to Ms Presti. She continued to deteriorate and passed away on 21 August 2023.

Identity of the deceased

15. On 21 August 2023, Maria Presti, born 19 January 1961, was visually identified by her brother, Raymond Presti.

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

Medical cause of death

17. Forensic Pathologist Dr Paul Bedford, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 24 August 2023 and provided a written report of his findings dated 1 September 2023.

18. The post-mortem examination revealed findings consistent with the reported circumstances.

19. Examination of the post-mortem CT scan showed changes consistent with aspiration pneumonia.

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

21. Dr Bedford provided an opinion that the medical cause of death was "*1(a) Aspiration pneumonia* secondary to "*1(b) Cerebral palsy*" and that the death was due to natural causes.

22. I accept Dr Bedford's opinion.[4]

FAMILY CONCERNS

23. Ms Presti's older brother, Raymond Presti, raised some concerns regarding her care and medical treatment in a statement which forms part of the coronial brief. He felt that she should have been transferred to Footscray Hospital from the SDA as that was her family's preference. He felt that the outcome would have been better at that hospital as she was admitted there previously, and it was closer to her family and it would have been easier to visit her there. He was also concerned about the timing of his sister's transition to palliative care and whether it occurred too early. He acknowledged that everyone involved in his sister's care was trying to help her.

CPU REVIEW

24. As part of my investigation, I referred this matter to the Coroners Prevention Unit (**CPU**),[5] for an independent review of the medical treatment and care provided to Ms Presti. I specifically requested a review as to whether the decision to palliate Ms Presti was appropriate and reasonable in the circumstances.

25. The CPU explained that a next of kin/family member cannot refuse palliative treatments, when provided to manage distress by a non-competent person. They explained that the small doses of palliative medications were given to manage evidence of significant distress and that there was no evidence that the palliation involved the introduction of high dose terminal sedation, for the purposes of hastening death.

26. The CPU also noted that Ms Presti's goals of care were changed from active aggressive (curative) treatment on admission to comfort care on 4 August 2023. However, active treatment, including IV therapy for hydration and antibiotics were continued at the family's

[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.

[5] 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.

request, despite the change in her goals of care. The CPU noted that Ms Presti's condition was already deteriorating in the months before her passing, which was evidenced by her inability to swallow safely, functional withdrawal, hypernatremia, and her very low body mass index (**BMI**). The CPU concluded that the decision to palliate was appropriate and reasonable in the circumstances. I accept their advice.

27. Based on the CPU advice, I am satisfied that Ms Presti received appropriate care and treatment at WMH. There was nothing that could be done to reverse her decline, which was due to natural causes, and the outcome could not have been avoided. I acknowledge Mr Presti's concern that his sister should have been taken to a different hospital in accordance with family wishes, but considering my finding that there was no deficiency in her care and treatment at WMH, that issue is not relevant to the coronial investigation and requires no further investigation.

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 Maria Presti, born 19 January 1961;

    b) the death occurred on 21 August 2023 at Werribee Mercy Hospital 300-310 Princes Highway, Werribee, Victoria 3030, from aspiration pneumonia secondary to cerebral palsy; and

    c) the death occurred in the circumstances described above.

I convey my condolences to Ms Presti's family for their loss. I wish to specifically acknowledge Mr Presti's long standing devotion to his sister and her care, and his grief at her passing.

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:

Raymond Presti, Senior Next of Kin

First Constable Lliam Hanns, Victoria Police, Coroner's Investigator

Signature:

Coroner Catherine Fitzgerald

Date : 11 October 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.