IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005546

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Ms N[1]
Date of birth:	[redacted] 1959
Date of death:	6 October 2023
Cause of death:	1(a) COVID-19 and aspiration pneumonia in a woman with cerebral palsy
Place of death:	Bendigo Health Care Group, 100 Barnard Street Bendigo Victoria
Key words	*In care; COVID-19; aspiration pneumonia*

At the direction of Coroner Sarah Gebert, the name of the deceased and her family members have been replaced with pseudonyms to protect their identities. Identifying details have also been redacted.

INTRODUCTION

1. On 6 October 2023, [redacted] (Ms N) was 64 years old when she died at the Bendigo Hospital following a deterioration in her health.

2. At the time of her death, Ms N lived at Sternberg House, which is specialist disability accommodation in Kennington operated by Golden City Support Centres.

THE CORONIAL INVESTIGATION

3. Ms N'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. 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.

4. 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.

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 Senior Constable Daniel Masson to be the Coronial Investigator for the investigation of Ms N'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.

7. This finding draws on the totality of the coronial investigation into the death of Ms N 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.[1]

BACKGROUND

8. Ms N was born in 1959 to parents [redacted]. She had two younger siblings, Ms H and Mr J and was raised on a sheep and wheat farm in [redacted], Victoria.

9. Ms N was born with Cerebral Palsy requiring the use of a wheelchair and was largely nonverbal. She had a happy childhood and enjoyed watching old movies and listening to music from the 1950s and 1960s. She also enjoyed walks with her family and playing with the dogs on the family farm.

10. Growing up Ms N's mother was her primary carer and assisted with her food, drinks, bathing, clothing and toileting needs. In 1993 Ms N's father passed away from a heart attack and in 1997, when Ms N was 38 years old, her mother passed away from breast cancer.

11. Around the time of her mother's death, Ms N's brother Mr J had taken over the family farm and with the increased responsibilities was unable to provide the intensive care which Ms N required. In 1998, Ms N moved to live at Sternberg House in Kennington, a suburb within the greater Bendigo area, where she remained until her death.

12. Ms N's carers affectionally remembered her as having a wicked and quirky sense of humour, as well as being a very patient and caring person. She enjoyed having a cup of sweet black tea, reading magazines, watching the Bold and the Beautiful, leisurely walks and being outside in nature. She also had a keen eye for fashion and enjoyed outings shopping for clothes. In a statement provided for the coronial brief, Ms N's sister Ms H expressed great appreciation for the care Ms N received from the staff at Sternberg House.

13. In the years leading up to her death, Ms N's health steadily deteriorated with frequent chest infections and wound breakdown. From May 2021, Ms N was managed by General Practitioner (**GP**) Dr Amin Pourzahed Gilani of the Sandhurst Medical Practice in Bendigo. Her medical diagnoses included spastic cerebral palsy, recurrent aspiration pneumonia, gastro-oesophageal

[1] 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.

reflux disease, dysphagia (difficulty swallowing), asthma, chronic constipation and recurrent urinary tract infections.

14. Between August 2023 and her death, Ms N had six separate admissions to the Bendigo Hospital. Her penultimate admission occurred on 14 September 2023 with hypothermia and drowsiness before being discharged to Sternberg House on 16 September 2023.

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

Circumstances in which the death occurred

15. On 18 September 2023, Ms N presented to the Bendigo Hospital Emergency Department (**ED**) with fever and hypoxia. A COVID-19 PCR test returned a positive result and subsequently Ms N was commenced on antiviral therapy (remdesivir and dexamethasone). The initial clinical impression was that Ms N may have sepsis. She received fluid resuscitation and anti-bacterial therapy at that time.

16. Over the coming days Ms N's condition improved although she still required one to two litres of oxygen support. On 27 September 2023, Ms N was medically cleared for discharge due to a clinical improvement no longer requiring oxygen support. However, due to a COVID-19 outbreak in her residential accommodation, Ms N was kept in hospital.

17. Later that day, Ms N developed fevers and her oxygen saturation levels again deteriorated. She also had an elevated heart rate and her treating team considered she likely had another episode of infection. Ms N was commenced on intravenous anti-biotics (ceftriaxone and azithromycin). Investigations on 1 October 2023 showed elevated inflammatory markers and an ongoing fever with elevated heart rate despite intravenous therapy.

18. Ms N's condition continued to deteriorate with spike temperatures on intravenous ceftriaxone and suspected recurrent aspiration pneumonia episodes. On 4 October 2023 she was transitioned to intravenous piperacillin-tazobactam however her condition did not approve.

19. Her treating team considered that Ms N's recurrent episodes of aspiration pneumonia and ongoing decline reflected a deterioration in her baseline function which was unlikely to be reversible.

20. Following discussions with the Palliative Care Team and Ms N's family, on 5 October 2023 Ms N was transferred to palliative care prioritising comfort care. Ms N was kept comfortable until she passed away and was formally pronounced deceased at 11.55am on 6 October 2023.

Identity of the deceased

21. On 6 October 2023, Ms N, born [redacted] 1959, was visually identified by her sister, Ms H, who signed a formal 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, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 9 October 2023 and provided a written report of his findings dated 10 October 2023.

24. The post-mortem examination showed no obvious signs of injury and no unexpected signs of trauma.

25. Dr Young provided an opinion that the medical cause of death was *1(a) COVID-19 and aspiration pneumonia in a woman with cerebral palsy* and considered the death was due to natural causes.

26. I accept Dr Young's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Ms N, born [redacted] 1959;

    b) the death occurred on 6 October 2023 at Bendigo Health Care Group, 100 Barnard Street Bendigo Victoria, from COVID-19 and aspiration pneumonia in a woman with cerebral palsy; and

    c) the death occurred in the circumstances described above.

28. Ms N'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. Section 52 of the Act requires an inquest to be held, except in circumstances where the death was due to natural causes. I am satisfied that Ms N died from natural causes and that no further investigation is required.

I convey my sincere condolences to Ms N's family and carers for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published (in redacted form) 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:

Ms H, Senior Next of Kin

Bendigo Health

Dr Amin Pourzahed Gilani c/- MDA National

Senior Constable Daniel Masson, Victoria Police Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date : 10 September 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.