IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 003667

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Catherine Ann Collier
Date of birth:	11 August 1966
Date of death:	26 July 2018
Cause of death:	1(a) Aspiration in the setting of end stage down syndrome
Place of death:	Barwon Health, University Hospital, 272-322 Ryrie Street, Geelong, Victoria, 3220
Keywords:	Barwon Health, Department of Health and Human Services, DHHS, Department of Families, Fairness, and Housing, DFFH, Office of the Public Advocate, Down syndrome, dysphagia, disability, Disability Services Commissioner, DSC, Home@Scope

INTRODUCTION

1. On 26 July 2018, Catherine Ann Collier was 51 years old when she died at Barwon Health University Hospital in Geelong (**GUH**). At the time of her death, Catherine lived at in supported accommodation at 33 Talbot Street, Colac, a group home run by the Department of Health and Human Services (**DHHS**).[1]

2. Catherine's medical history included Down syndrome, epilepsy, hydrocephalus[2], dysphagia[3], hippocampal atrophy, osteoporosis, faecal and urinary incontinence, and a severe intellectual disability.[4]

3. At the time of her death, Catherine was prescribed valproate, lamotrigine, and midazolam (as required). She required high-level care and assistance with mobilising and eating and drinking and was non-verbal, using body language to communicate with group home staff and carers.[5]

4. Catherine resided in state care homes since the age of six months and lived in five different disability accommodation services throughout her life before eventually moving to the Talbot Street home on 20 June 2016. She had no contact with her family, and her brother, Robert Collier, had been told by their parents that Catherine had passed away many years before.[6]

5. Catherine enjoyed art, drives to the coast or country, and watching movies. Group home staff described Catherine as liking routine and being given time to perform tasks. Catherine was friendly and had a calm and easy-going manner.[7]

6. In 2014, Catherine began to exhibit tonic-clonic seizure activity which was well managed by medication until 2016 when her seizures began occurring with increasing regularity. Over the following two years, Catherine's health began to deteriorate.[8] In 2015, a neurologist assessed that Catherine may have been experiencing early onset Alzheimer's disease.[9]

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[1] Management of the Talbot group home was transferred to Home@Scope from the Department of Families, Fairness, and Housing (formerly known as the Department of Health and Human Services) on 13 October 2019.
[2] Excess fluid in the ventricles of the brain causing an increase of pressure.
[3] Difficulty with swallowing.
[4] Disability Service Commissioner (**DSC**) Report dated 15 June 2020, page 2.
[5] Coronial brief, statement of Dr Mohammad Gadi dated 28 June 2018, pages 9-10.
[6] DSC Report dated 15 June 2020, page 2.
[7] DSC Report dated 15 June 2020, page 2.
[8] DSC Report dated 15 June 2020, page 2.
[9] Disability Service Commissioner (**DSC**) Report dated 15 June 2020, page 2.

7. In June 2018, Catherine's neurologist reported that her hydrocephalus had progressed, leading to a worsening of her cognitive functioning and dysphagia.[10]

THE CORONIAL INVESTIGATION

8. Catherine'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.

9. 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.

10. 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.

11. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Catherine's death. The Coroner's 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.

12. This finding draws on the totality of the coronial investigation into the death of Catherine Ann Collier 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.[11]

[10] DSC Report dated 15 June 2020, pages 2-3.

[11] 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.

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

Circumstances in which the death occurred

13. On 25 July 2018, Catherine was being assisted with her evening meal when she began to cough, making an 'uncharacteristic gurgling sound'. She stopped breathing and became hypoxic shortly before progressing to a tonic-clonic seizure with an extended altered conscious state.[12]

14. Group staff contacted emergency services who attended the scene. Catherine was intubated by paramedics and transported her to GUH where she was placed on a ventilator to assist with her breathing.[13] During Catherine's time at GUH, clinical staff noted that it was likely that she had developed aspiration pneumonia and a probable hypoxic brain injury.[14]

15. Clinical staff liaised with the Office of the Public Advocate (**OPA**) who were Catherine's medical treatment decision makers. Following these discussions, the OPA approved the withdrawal of Catherine's ventilatory support.[15]

16. On 26 July 2018 at 1.55am, Catherine passed away.[16]

Identity of the deceased

17. On 26 July 2018, Catherine Ann Collier, born 11 August 1966, was visually identified by her carer, Greg Newton.

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

Medical cause of death

19. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 27 July 2018 and provided a written report of his findings dated 1 August 2018.

20. The post-mortem computed tomography scan revealed marked brain atrophy/hydrocephalus and coronary calcification.

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[12] DSC Report dated 15 June 2020, page 3; GUH Medical E-Deposition dated 26 July 2018, page 1.
[13] DSC Report dated 15 June 2020, page 3; GUH Medical E-Deposition dated 26 July 2018, page 1.
[14] GUH Medical E-Deposition dated 26 July 2018, page 1.
[15] DSC Report dated 15 June 2020, page 3.
[16] DSC Report dated 15 June 2020, page 3.

21. Toxicological analysis of ante-mortem samples identified the presence of morphine, lamotrigine, valproic acid, midazolam, and ketamine.[17]

22. Dr Burke provided an opinion that the medical cause of death was 1 (a) aspiration in the setting of end stage down syndrome.

23. Upon review of Dr Burke's report, I requested that he provide elucidation as to whether Catherine's death could be from natural causes. Dr Burke explained that, in the purest sense, an episode of aspiration is an unnatural event, however, aspiration can be viewed as a natural progression of a long term serious medical condition, such as end-stage dementia.

24. Therefore, upon consideration and subject to section 52 (3A) and (3B) of the Act,[18] I am satisfied that Catherine's death resulted from natural causes and should be classified as such.

DISABILITY SERVICES COMMISSIONER INVESTIGATION

25. On 31 July 2018, the Disability Services Commissioner (**DSC**) commenced an investigation into the disability services provided to Catherine by DHHS (now the Department of Families, Fairness, and Housing (**DFFH**), pursuant to section 128I of the *Disability Services Act 2006* (Vic). As a result of this investigation, several issues were identified pertaining to her care.

Management of Catherine's dysphagia

26. In April 2016, following an increase in the frequency of Catherine's seizures, she was assessed by a community speech pathologist in relation to her dysphagia who identified that Catherine was at risk of aspiration and recommended a trial of thickened fluids.[19]

27. In May 2016, Catherine was assessed by a hospital speech pathologist who noted that she was 'tolerating extremely thick fluids and a puree diet' but had 'severe oral and moderate pharyngeal dysphagia with inconsistent signs of aspiration on moderately thick fluids and high risk of aspiration on thinner consistencies.' A recommendation was made for Catherine to be 'monitored infrequently by speech pathology for tolerance of current recommendations and any change in swallow status.'[20]

[17] These drugs are consistent with therapeutic use and were likely administered during the course of Catherine's medical treatment.
[18] Subject to section 52 (3A) and (3B) of the Act, a Coroner is not required to hold an inquest into the death of an individual placed in custody or care if the coroner considers that the death was due to natural causes.
[19] DSC Report dated 15 June 2020, page 4.
[20] DSC Report dated 15 June 2020, page 4.

28. In response to a request for a copy of Catherine's most recent mealtime assistance plan, DFFH submitted a copy of a generic mealtime planning guide that was not developed specifically for Catherine. Whilst the instructions contained within this guide may have assisted group home staff to prepare fluids for residents, there was no evidence that a mealtime assistance plan had been developed specifically for Catherine.[21]

29. In response, DFFH advised: 'Ms Collier was assessed by a speech pathologist in the final year of her life, during an admission to the University Hospital of Geelong. Furthermore, that Ms Collier's Specific Health Management Plan - Dysphagia and Swallowing Difficulty of 27 December 2017 was considered appropriate to her needs and for that reason, remained in place and unchanged.'[22]

30. Given Catherine's increase in swallowing difficulties due to her continuing seizures and increased cognitive deficit (as identified by her neurologist in June 2018), it is reasonable to conclude that a specific mealtime assistance plan should have been developed for Catherine and that speech pathologist reviews should have occurred more frequently.

Management of communication needs

31. Under section 5(2)(f) of the *Disability Services Act 2006* (Vic), 'a person with a disability has the same right as other members of the community to access information and communicate in a manner appropriate to their communication and cultural needs'. I note that this is reflected by section 15 of the *Charter of Human Rights and Responsibilities 2006* (Vic).

32. During the course of the investigation into the care provided to Catherine, it was identified that her communication support information on file was undated and appeared to have been completed many years prior to her passing. Furthermore, no evidence was identified that indicated that Catherine had ever had a speech pathologist communication assessment.[23]

33. In response, DFFH advised that 'While Ms Collier's cognitive functioning was reported to have declined, the Operations Manager of the service advised that her communication methods from 2016 to 2018 had not significantly changed.'[24]

[21] DSC Report dated 15 June 2020, page 4.
[22] DSC Report dated 15 June 2020, page 5.
[23] DSC Report dated 15 June 2020, page 6.
[24] DSC Report dated 15 June 2020, page 6.

34. As Catherine had complex communication needs, it is reasonable to expect that a communication assessment and the development of an up-to-date communication plan should have taken place. Alternative or augmentative communication methods may have also been beneficial given Catherine's non-verbal communication requirements.

Investigation outcomes

35. As a result of the DSC investigation, a Notice to Take Action (**NTTA)** was issued to DFFH with the following requirements:

    i. DFFH to work with the new service provider, Home@Scope, to share the findings and subsequent recommendations for service improvement detailed in this investigation with staff at 33 Talbot Street, Colac.

    ii. DFFH to work with the new service provider, Home@Scope, to ensure that residents with dysphagia, who demonstrate a change in their health and/or mealtime supports, are reviewed by a speech pathologist, and have a current mealtime assistance plan in place.

    iii. DFFH to work with the new service provider, Home@Scope to ensure that non-verbal residents have a speech pathologist communication assessment and a current communication support plan in place. Residents' communication plans should be updated if they experience cognitive decline due to health or other challenges.[25]

DFFH Response

36. In response to the DSC NTTA, the DFFH undertook several specific remedial actions, including:

    i. A review of the nutrition and swallowing issues for all residents was undertaken by a speech pathologist. New mealtime plans for all residents were developed and implemented by August 2020.

    ii. A review of the communication and health support requirements (including specific health care plans) for all the residents of Talbot Street who are non-verbal and/or complex in their communication was undertaken. In September 2020, Home@Scope

[25] DSC Report dated 15 June 2020, page 7.

reported that all the residents had up-to-date Communication Plans, and Specific Health Management Plans. This was completed in September 2020.[26]

37. The DFFH also noted that continuing work undertaken regarding addressing and implementing strategies to minimise swallowing and choking risks, falls prevention, responding to deteriorating health, and supporting residents in hospital.[27]

FINDINGS AND CONCLUSION

38. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[28] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.
39. Catherine's death reflects the inherent difficulties faced by those with high-level care needs, as well as those that care for them. Whilst her death is tragic occurrence, I am satisfied that the investigation into the care provided to Catherine and subsequent NTTA issued to the DFFH will assist in avoiding similar episodes in the future and, therefore, I do not intend to make any formal comments or recommendations in this matter.
40. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Catherine Ann Collier, born 11 August 1966;

    b) the death occurred on 26 July 2018 at Barwon Health, University Hospital, 272-322 Ryrie Street, Geelong, Victoria, 3220, from *aspiration in the setting of end stage down syndrome*; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Catherine's family for their loss.

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[26] Statement of Carley Northcott dated 8 April 2022, page 8.
[27] Statement of Carley Northcott dated 8 April 2022, pages 9-10.
[28] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

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:

Robert Collier, Senior Next of Kin

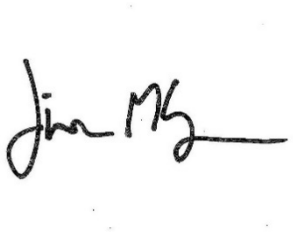
Lorraine Judd, Barwon Health

Arthur Rogers, Disability Services Commissioner

The Honourable Anthony Carbines, MP, Minister for Disability, Ageing, and Carers

Senior Constable Joshua West, Victoria Police, Coroner's Investigator

Signature:



CORONER SIMON McGREGOR

CORONER

Date: 6 July 2022

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.