IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002611

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Danielle Meredith Noonan
Date of birth:	9 July 1972
Date of death:	12 May 2024
Cause of death:	1a: Chest sepsis in the setting of recurrent aspiration pneumonia, cerebral palsy, Lennox Gastaut Syndrome and other medical comorbidities
Place of death:	Eastern Health Wantirna Hospital 251 Mountain Highway Wantirna Victoria 3152
Keywords:	Death in care, aspiration pneumonia, natural causes

INTRODUCTION

1. On 12 May 2024, Danielle Meredith Noonan (**Ms Noonan**) was 51 years old when she passed away at Eastern Health Wantirna Hospital (**EHW**). At the time of her death, Ms Noonan lived in specialist disability accommodation (**SDA**) in Mooroolbark, Victoria, with disability support services provided by Melba Support Services (**Melba)**

2. Ms Noonan had a complex medical history including Lennox-Gastaut syndrome (epilepsy), cerebral palsy with spastic quadriplegia, intellectual disability, non-verbal communication, dislocated left hip, permanent suprapubic catheter and hyponatraemia.

3. From 2019, Ms Noonan received nutrition, hydration and medications via percutaneous endoscopic gastrostomy with jejunal extension (**PEG-J**).

4. Ms Noonan was a National Disability Insurance Scheme participant (**NDIS**) with a plan that funded 24-hour specialist disability accommodation for high physical support needs. She had been a resident with Melba for the past sixteen years.

THE CORONIAL INVESTIGATION

5. Ms Noonan'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 Noonan 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]

6. 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.

7. 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

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

[2] Pursuant to Reg 71(1)(d) of the Coroners Regulations 2019, a "*prescribed person of 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 Noonan resided at an address where the residents mee these criteria.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

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

9. This finding draws on the totality of the coronial investigation into the death of Danielle Meredith Noonan 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

10. On 19 March 2024, Ms Noonan attended the Austin Hospital Outpatient Clinic for replacement of her broken PEG-J. Staff noted that Ms Noonan had a low body temperature and conducted investigations. Blood results indicated high infection markers. A chest X-Ray demonstrated a chest infection for which antibiotics were prescribed.

11. Ms Noonan remained unwell despite completing two additional courses of antibiotics. Repeat chest X-Rays demonstrated persistent chest infection.

12. On Friday 26 April 2024, Ms Noonan was advised by her general practitioner to attend the local emergency department for consideration of a hospital admission for intravenous (**IV**) antibiotics.

13. On Saturday 27 April 2024, Ms Noonan presented to Maroondah Hospital Emergency Department (**ED**). Upon arrival, she was hypothermic and was reported to have been coughing thick white sputum and experiencing increased lethargy. An X-Ray demonstrated extensive consolidation of the lungs, indicative of chronic recurrent aspiration pneumonia. She was

[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.

admitted to the ward for a course of IV antibiotics with a view to altering the trajectory of the continuous respiratory decline of the past several weeks.

14. On Monday 29 April 2024, the medical team were informed by Ms Noonan's carer of her increased frequency of seizures and drowsiness. A referral was made to the Neurology team who provided a same day consultation. They recommended no changes, other than adding an intravenous dose of phenytoin 500mg, if the seizure activity were to increase further.

15. At 5:40pm that same day, a medical emergency treatment (**MET**) response was called as Ms Noonan experienced a choking event due to a sputum plug and she became cyanosed.[4] The MET team suctioned the airway, and high flow oxygen was commenced.

16. At 6:00pm, the medical registrar explained to Ms Noonan's mother that she was very unwell with pneumonia and ongoing aspiration. The risk of deterioration was discussed, and an agreement was made that Ms Noonan would not be for resuscitation if further deterioration occurred, and a palliative approach to care would be taken.

17. On Tuesday 30 April 2024, at 8:10am, another MET response was called due to low blood pressure of 81/54 mmHg.[5]

18. Shortly before midnight on Wednesday 31 April 2024, Ms Noonan continued to deteriorate with a re-accumulation of lung secretions, difficulty breathing and hypotension requiring a further MET call.

19. On Thursday 1 May 2024 at 1:20am, another MET response was called for low blood pressure of 60/40 mmHg. Blood test results demonstrated significant and wide-spread infection with a C-reactive protein (CRP) greater than 200mg/L.[6]

20. Later that same day, at 4:45pm, a Clinical Nurse Consultant from the Palliative and Supportive Care team assessed Ms Noonan in light of her progressive deterioration. Palliative care was initiated with all charted medications ceased and comfort care medications commenced.

21. At some point on Thursday 1 May 2024, an error in Ms Noonan's medication chart was detected in relation to the dosage of her anti-epileptic medication. The error was identified via pharmacy medication reconciliation processes which occurred five days after the initial

[4] A discolouration of the skin, as a symptom of insufficient oxygen in the blood.
[5] A reading of less than 90/60 mmHg is considered low.
[6] CRP normal range is typically less than 5 – 10 mg/L.

admission prescription. It was found that, from the date of Ms Noonan's admission, the carbamazepine dosage had been incorrectly calculated during the conversion of the liquid formulation (in millilitres) to the tablet formulation (in milligrams). Ms Noonan typically used a liquid formulation of carbamazepine which was not available upon her admission to hospital. Therefore, the carbamazepine was to be administered in crushed tablet formulation.

22. This error had the effect of Ms Noonan receiving 1000mg of carbamazepine three times a day (**tds**), instead of 200mg tds since 27 April 2024. At the time of the error being identified, this medication had already been ceased in line with a palliative approach to care.

23. On 2 May 2024, Ms Wen Tee (**Ms Tee**), Clinical Director of General Medicine, documented that open disclosure of the medication error was provided to Ms Noonan's parents and a Melba carer.

24. On 3 May 2024, phenobarbital, morphine and midazolam administered via a continuous IV were effectively reducing Ms Noonan's respiratory distress. She was assessed by the palliative care team to be comfortable. She required suction for an ongoing productive cough and oxygen saturation was 85% on room air. Ms Noonan had one period of alertness during which she became restless and was administered additional morphine and midazolam.

25. At 6:30pm that same day, it was documented that further investigations were to be undertaken including a chest X-ray and blood tests. Later that night, after discussion with Ms Noonan's parents, antibiotics were reinstated.

26. On 4 May 2024, the Neurology team noted that Ms Noonan had a reasonable amount of alertness and responsiveness, although she did not have an effective cough, and oxygen levels were suboptimal despite supplemental oxygen via nasal prongs. They formulated the opinion that Ms Noonan would have difficulty recovering from this significant deterioration. A certain level of anti-epileptic medication was recommended to be recommenced.

27. At 2:30pm that same day, Ms Noonan was unable to cough and clear sputum. Clinicians formed an impressed that returning to her usual baseline was unlikely and a family meeting was planned to discuss the likely trajectory.

28. At 5:40pm, the medical team were informed that Ms Noonan was to recommence a palliative approach to care. Antibiotics, IV fluids and anti-epileptic medications were ceased and continuous IV morphine and midazolam recommenced.

29. On 5 May 2024, Ms Noonan was transferred to the palliative care unit at Eastern Health Wantirna Hospital.

30. On 12 May 2024, Ms Noonan passed away in the early hours of the morning.

Identity of the deceased

31. On 12 May 2024, Danielle Meredith Noonan, born 9 July 1972, was visually identified by her carer, Kate Mallick.

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

Medical cause of death

33. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 13 May 2024 and provided a written report of her findings dated 27 May 2024.

34. The post-mortem examination revealed findings in keeping with the clinical history.

35. Examination of a post-mortem computed tomography (**CT**) scan showed increased lung markings suggestive of aspiration pneumonia, thoracic kyphoscoliosis, PEG tube without evidence of complication and suprapubic catheter in situ without evidence of complication.

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

37. Dr Francis provided an opinion that the medical cause of death was "1(a) Chest sepsis in the setting of recurrent aspiration pneumonia, cerebral palsy, Lennox Gastaut Syndrome and other medical comorbidities".

38. Dr Francis noted that "carbamazepine administration cannot be completely excluded as a contributing factor to the death". However, on the information available, she was of the opinion that "the death was mostly likely due to natural causes in the setting of underlying medical conditions and recurrent aspiration pneumonia episodes".

39. I accept the expert opinion of Dr Francis.[7]

[7] Pursuant to section 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.

INTERNAL REVIEW

40. On 1 July 2024, Eastern Health's Serious Incident Review Committee (**the committee**) conducted a root cause analysis into the medication error and produced a report dated 3 July 2024.

41. The committee reported the following:

    a) in the absence of an electronic prescribing system, a human error was made in the calculation of the carbamazepine dose when converting the usual liquid dose in millilitres to a tablet formulation in milligrams.

    b) by the time this error had been identified, the carbamazepine, along with other medications, had already been ceased in line with the goals of care being palliative in nature.

    c) on 1 May 2024, the carbamazepine level was 20 mg/L. This level is not ordinarily associated with lethality.[8] On 3 May 2024, carbamazepine levels had returned to a range within normal limits, at 5 mg/L.

    d) Ms Noonan's clinical status showed no improvement following the cessation of carbamazepine.

    e) at the time of the Ms Noonan's presentation to hospital, her respiratory function was on the precipice of collapse, and the prospects of averting the trajectory towards pulmonary shutdown and death were slender.

42. I accept Eastern Health's conclusions that the medication error, whilst it should not have occurred, did not contribute to Ms Noonan's death.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Danielle Meredith Noonan, born 9 July 1972;

    b) Ms Noonan's death occurred on 12 May 2024 at Eastern Health Wantirna Hospital, 251 Mountain Highway, Wantirna, Victoria 3152, from 1(a) Chest sepsis in the setting of

[8] Levels greater than 40 mg/L are associated with coma, seizures and cardiac conduction abnormalities.

recurrent aspiration pneumonia, cerebral palsy, Lennox Gastaut Syndrome and other medical comorbidities; and

c) her death occurred in the circumstances described above.

44. Having regard to the diagnosis of chronic recurrent aspiration pneumonia in the context of Ms Noonan's medical comorbidities, Ms Noonan's significant deterioration in respiratory function over several weeks, the lack of improvement with repeated courses of antibiotics, and the expert evidence of Dr Francis that the death was most likely due to natural causes , I am satisfied on the balance of probabilities that the medication error was not a causative factor in Ms Noonan's passing.

I convey my sincere condolences to Ms Noonan's family and carers 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:

Mr Terrence Noonan & Mrs Lynn Noonan, Senior Next of Kin

Eastern Health

Leading Senior Constable James Tarrant, Victoria Police, Coronial Investigator

Signature:

Coroner Catherine Fitzgerald

Date: 23 July 2026

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 dayon which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.