IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 004146

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Christine Anne Flanagan

Delivered On:	10 September 2024
Delivered At:	Melbourne
Hearing Dates:	10 September 2024
Findings of:	Coroner Leveasque Peterson
Counsel Assisting the Coroner	Courtney Davies
Keywords	In care death, complications of surgery

I, Coroner Leveasque Peterson, having investigated the death of Christine Anne Flanagan , and having held an inquest in relation to this death on - 10 September 2024,

at Melbourne

find that the identity of the deceased was Christine Ann Flanagan born on 15 May 1961

and the death occurred on 29 July 2023

at Maroondah Hospital

from:

1a: *Complications arising from elective laproscopic Hartman's Procedure for recurrent sigmoid volvulus and ileus (ileus and aspiration episodes)*

I find, under section 67(1) (c) of the ***Coroners Act 2008*** ('the Act') that the death occurred in the following circumstances:

INTRODUCTION

1. On 29 July 2023, Christine Flanagan was 62 years old when she passed away at Maroondah Hospital. Ms Flanagan was admitted to hospital from her supported living accommodation in Bayswater North. The supported living accommodation was operated by Scope Australia.
2. Ms Flanagan was born in Canberra with severe physical and intellectual disabilities. Her parents loved and cared for Ms Flanagan for many years however after moving from Canberra to Melbourne, Ms Flangan's parents reluctantly concluded that she needed a very high level of care. Ms Flanagan was placed in the state's care where she resided at Kew Cottages for some time. When that facility closed down Ms Flanagan moved to a group home at Glen Park, Bayswater where she continued to live amongst carers and co residents who were described as her second family.
3. In her 50s, Ms Flanagan developed gastroparesis, which is a condition that causes paralysis of the stomach muscles leading to a variety of complications. Her brother Michael reported that despite receiving high quality medical treatment and support, Ms Flanagan's general condition deteriorated over time.
4. Ms Flanagan subsequently began to experience pseudo bowel obstruction resulting in twists to her bowel. Clinically, Ms Flanagan's prognosis was poor without surgical intervention.
5. Ms Flanagan was subsequently admitted to Maroondah Hospital for surgical intervention.

THE CORONIAL INVESTIGATION

6. Ms Flanagan'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 was not unexpected or from natural causes.

7. Ms Flanagan was 'a person placed in …care ' within the meaning of section 4 of the Act, as she was a 'prescribed class of person'[1] due to her status as an SDA resident[2] residing in a SDA enrolled dwelling'[3].
8. I commenced an investigation into Ms Flanagan's death by reviewing relevant medical records. Based on the information I reviewed I was, at the time, and remain, satisfied that there were no circumstances of concern in respect of the care or treatment provided to Ms Flanagan.
9. Ms Flanagan's status, however, as a person in care immediately before her death requires that I must hold an inquest into her death unless I consider the death was due to natural causes. It also requires that I must, if possible, make a finding with respect to the circumstances in which the death occurred and publish the finding.

MATTERS IN RELATION TO WHICH A FINDING MUST BE MADE

Circumstances in which the death occurred

10. On 25 July 2023 Ms Flanagan was admitted to Maroondah Hospital for a laproscopic Hartman's procedure for recurrent sigmoid volvulus and ileus. A Hartman's procedure is a surgical resection of the colon used to treat a volvulus, which is a twist in the bowel that commonly occurs at the sigmoid colon. The condition can become life threatening.
11. Following the procedure Ms Flanagan was transferred to the ICU and on 27 July 2023 she was transferred back to a ward.
12. Although Ms Flangan's post operative status was uncomplicated, on 28 July 2024 she became diaphoretic and distressed and her abdomen was distended. Ms Flanagan was admitted back into the ICU for vasopressor treatment. She had increasing pain and distention with worsening peripheral perfusion - mottling of the lower limb skin.
13. After discussions with her family about Ms Flanagan's poor prognosis, a decision was made to provide comfort care rather than pursue further active treatment.
14. Ms Flanagan died peacefully on 29 July 2024 in the intensive care unit at Maroondah Hospital.

Identity of the deceased

15. On 29 July 2023, Christine Ann Flanagan, born 15 May 1961, was visually identified by her brother, Michael Flanagan.
16. Identity is not in dispute and requires no further investigation.

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[1] Section 4(20(j)(i) of the Coroners Act 2008 (Vic)

[2] An Specialist Disability Accommodation (SDA) resident includes a person who is an NDIA participant who is funded to reside in an SDA enrolled dwelling

[3] See *Residential Tenancies Act 1997* – section 498B

Medical cause of death

17. Forensic pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine conducted an examination on 31 July 2023 and provided a written report of his findings dated 1 August 2023.

18. The external examination of the body showed findings in keeping with the clinical history.

19. On the basis of the available history, external examination, and post mortem, CT findings at the time of completing this report, Dr Beer considered that the medical cause of death was 1(a) CAUSE OF DEATH I (a) COMPLICATIONS ARISING FROM AN ELECTIVE LAPAROSCOPIC HARTMANN'S PROCEDURE FOR RECURRENT SIGMOID VOLVULUS AND ILEUS (ILEUS AND ASPIRATION EPISODES).

20. I accept Dr Beer's opinion.

FINDINGS AND CONCLUSION

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

    a. The identity of the deceased was Christine Ann Flannagan, born 15 May 1961;

    b. The death occurred at the Maroondah hospital on 29 July 2023 from *complications arising from an elective laproscopic Hartman's procedure for recurrent sigmoid volvulus and ileus (ileus and aspiration episodes)*; and

    c. The death occurred in the circumstances described above.

COMMENTS

I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules and I direct that a copy of this finding be provided to the following:

The family of Christine Ann Flanagan;

Dr Yvette Kozielski, Eastern Health

Signature:

CORONER LEVEASQUE PETERSON

Date: 11 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 inquest. 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.