IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 001991

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Betty Eileen Cliffe
Date of birth:	27 March 1938
Date of death:	16 April 2023
Cause of death:	1(a) Asphyxia due to upper airways obstruction by mucoid plugging of the upper airways on a background of cardiomegaly and heart failure.
Place of death:	Angliss Hospital 39 Albert Street, Upper Ferntree Gully, Victoria, 3156
Keywords:	In care, aged care, disability, natural causes death

INTRODUCTION

1. On 16 April 2023, Betty Eileen Cliffe was 85 years old when she died at Angliss Hospital after experiencing sudden respiratory distress. At the time of her death, Betty lived in specialist disability accommodation operated by Scope (Aust) Limited (**Scope**) at 44 Crusoe Drive, Lysterfield, Victoria, where she had resided for more than 30 years.

2. Betty was supported by Scope staff 24 hours a day in all aspects of daily living and relied on an attendant-propelled wheelchair. Due to chronic mild-to-moderate oropharyngeal dysphagia, she required a modified diet.[1]

3. Betty was non-verbal, but experienced carers were familiar with her facial expressions and body language and communicated with her in that way. Her medical history included intellectual disability, syncope, orthostatic hypotension, parastomal hernia, depression, skin cancer and complex bowel management including colostomy.[2] She was up to date with COVID-19 and influenza vaccinations.[3]

THE CORONIAL INVESTIGATION

4. Betty'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.

5. 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. Betty was residing in Specialist Disability Accommodation at the time of her passing, so her death is considered to be 'in care' as defined by section 3 of the Act, and thus subject to a mandatory inquest.[4] Having considered all of the evidence, I am however, now satisfied that her death was due to natural causes so pursuant to section 52(3A) of the Act, have determined not to hold an inquest.

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

[1] Statement of Dr Gabriel Wong, Coronial Brief.
[2] Statement of Ebony Lillee, Coronial Brief.
[3] Statement of Ebony Lillee, Coronial Brief.
[4] See Regulation 7(1)(d) of the *Coroners Regulations 2019*.

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

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Betty's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as carers, treating clinicians, the forensic pathologist, and my investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Betty Eileen Cliffe 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.[5]

10. In considering the issues associated with this finding, I have been mindful of Betty's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

11. On the morning of 9 April 2023, care staff noticed that Betty was wheezing when breathing out. Her symptoms were appropriately monitored and in the afternoon she was seen by a locum doctor. By the evening, staff were concerned that Betty was still unwell and her wheezing had continued, and called 000 to request an ambulance. Paramedics conveyed Betty to the Angliss Hospital in Upper Ferntree Gully, where she was admitted for more intensive management.[6]

[5] 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.

[6] Statement of Ebony Lillee, Coronial Brief.

12. After an initial assessment, Betty was diagnosed with aspiration pneumonia and dehydration, and commenced on intravenous fluids, antibiotics, and steroids, and nebulised bronchodilators.[7]

13. A speech pathology assessment was conducted on 10 April 2023, at which time she was deemed able to continue on her usual modified diet. At a second assessment on 12 April 2023, the speech pathologist considered that Betty's dysphagia had deteriorated since the initial assessment and that she was no longer safe for any oral intake until further assessment.[8]

14. On 14 April 2023, at a third speech pathology assessment, Betty suffered an aspiration (choking) event followed by respiratory distress and hypoxia. She was given oxygen and subcutaneous morphine, but her condition continued to deteriorate.[9]

15. After this incident, the consensus view of her treating team was that given Betty's baseline level of health, the irreversibility of the dysphagia, her limited improvement despite maximal medical treatment for five days and her acute deterioration, that any further active medical treatment would only prolong her distress.[10]

16. Following discussions with Betty's next of kin, she was transitioned to comfort care and passed away on 16 April 2023 at 10:10 pm.[11]

Identity of the deceased

17. On 2 May 2023, Betty Eileen Cliffe, born 27 March 1938, was visually identified by her carer, Lauren Thorpe.

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

Medical cause of death

19. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine conducted an autopsy on 3 May 2023 and provided a written report of his findings dated 14 June 2023.

[7] Statement of Dr Gabriel Wong, Coronial Brief.
[8] Ibid.
[9] Statement of Dr Gabriel Wong, Coronial Brief; E-Medical Deposition of Dr Gabriel Wong dated 16 April 2023.
[10] Ibid.
[11] Statement of Dr Gabriel Wong, Coronial Brief.

20. The autopsy showed upper airways obstruction by mucoid material with background changes of chronic aspiration in the lungs, but no acute inflammatory changes. There was cardiomegaly[12] with right and left heart failure.

21. Dr Beer found no injuries that may have caused or contributed to the death.

22. Whilst a small electrocardiogram[13] adhesive plastic tab was found in the oesophagus, presumably swallowed at some stage during the speech pathology assessment, there were no complications, such as perforation, seen to be arising from this.

23. Dr Beer opined that the only finding that might reasonably explain Betty's clinically sudden deterioration with acute respiratory distress was upper airways obstruction by the mucoid plugging.

24. There was no significant coronary artery atherosclerosis, but a sudden arrhythmia related to the cardiomegaly and myocardial fibrosis could be excluded. There was no pulmonary embolus.

25. Dr Beer provided an opinion that the medical cause of death was 1(a) asphyxia due to upper airways obstruction by mucoid plugging of the upper airways on a background of cardiomegaly and heart failure.

26. I accept Dr Beer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Betty Eileen Cliffe, born 27 March 1938;

    b) the death occurred on 16 April 2023 at Angliss Hospital 39 Albert Street, Upper Ferntree Gully, Victoria, 3156, from asphyxia due to upper airways obstruction by mucoid plugging of the upper airways on a background of cardiomegaly and heart failure; and

    c) the death occurred in the circumstances described above.

[12] Enlarged heart.
[13] A heart monitoring device.

28. Having considered all of the evidence, I am satisfied that Betty's care and medical treatment were reasonable and appropriate in all the circumstances.

I convey my sincere condolences to Betty's family 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.

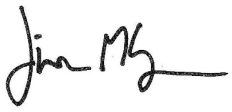
I direct that a copy of this finding be provided to the following:

Alana Wignell, State Trustees Victoria, Senior Next of Kin

Yvette Kozielski, Eastern Health

Leading Senior Constable Dale Mackie, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 30 August 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.