IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002788

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Jessica Nyla Louis
Date of birth:	27 December 1990
Date of death:	25 May 2023
Cause of death:	1(a) Perforation of the bowel 1(b) Constipation 1(c) Intellectual disability with picophagia
Place of death:	Frankston Hospital 2 Hastings Road, Frankston, Victoria, 3199
Keywords:	In care, pica, bowel obstruction

INTRODUCTION

1. On 25 May 2023, Jessica Nyla Louis was 32 years old when she died at Frankston Hospital. At the time of her death, Jessica resided in a high-level supported accommodation at 6 Woodlea Court, Frankston, Victoria.

2. Jessica was born with a rare genetic disorder known as Opitz Trigonocephaly Syndrome (also known as C Syndrome). She was non-verbal and both intellectually and physically disabled.[1] She required care and supervision for all daily activities and had lived in supported accommodation since the age of 18.

3. Jessica suffered from pica and compulsively swallowed non-food items. This had been a continual concern throughout her life in care. Her care, activities and accommodation had been conscientiously restricted and modified to minimise this known risk,[2] for which she had been hospitalised on three previous occasions.[3] She also suffered from chronic constipation which led to recurrent iron deficiency anaemia[4] and eventually necessitated regular iron and blood transfusions.[5]

4. After initially living with her parents, Jessica and her siblings lived in state care from a young age. Jessica's legal guardians from that time onwards were Julia and Peter Parke, and they maintained frequent and caring contact with her.[6]

5. Jessica's carers described her as caring and affectionate with the people that she knew, and spoke of her love of bright colours, sunlight, music, noises and movement.[7]

THE CORONIAL INVESTIGATION

6. Jessica'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 is from natural causes, but in such a case, there is no requirement to hold an inquest.[8]

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[1] Report of Dr Salvi Mililli, Coronial Brief.
[2] See Attachment 11, Behaviour Support Plan – Comprehensive, start date 23 December 2022, Coronial Brief.
[3] See Attachment 12, Functional Behaviour Assessment, 29 November 2022, Coronial Brief.
[4] Report of Dr Salvi Mililli, Coronial Brief.
[5] Statements of Julie and Peter Parke, Coronial Brief.
[6] Statements of Julie and Peter Parke, Coronial Brief.
[7] Statement of Harpreet Kaur, Statement of Bethany, Coronial Brief.
[8] Section 52(3A) of the *Coroners Act 2008*.

7. 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.

8. 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.

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

10. This finding draws on the totality of the coronial investigation into the death of Jessica Nyla Louis, 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.[9]

11. In considering the issues associated with this finding, I have been mindful of Jessica'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

12. On 18 May 2023, Jessica was attending one of her usual activities at Connecting2Australia in Frankston, when her carers noticed that she appeared to be unwell, holding her stomach and lacking her usual energy. Jessica look hot and flustered and soon after vomited clear fluids.[10]

[9] 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.

[10] Statements of Maurice Molella and Rehana Naz, Coronial Brief.

Jessica physically indicated she wished to continue with the activities, but when she continued to vomit a short time later her carers returned her to her accommodation.[11]

13. Once it was ascertained that she could not be satisfactorily monitored at the accommodation, an ambulance was arranged and Jessica was admitted to Frankston Hospital at 8.09 pm that day.[12]

14. On arrival at the Emergency Department, Jessica presented with abdominal distension, vomiting and pain, and was assessed as likely suffering from a bowel obstruction. A CT scan revealed severe faecal loading in her entire colon'[13] and Jessica was admitted to the Surgical Short Stay Unit.

15. On 19 May 2023, Jessica underwent an emergency evacuation of rectum under anaesthesia. The procedure was successful and on 20 May 2023 she was noted to be in stable condition, with no abdominal discomfort and clinical observations within normal limits. Jessica's treating team discussed with her guardians the options of oral laxative therapy but due to her poor oral intake and past difficulty with oral laxative therapy it was decided that Jessica would remain in hospital for observation.

16. On 22 May 2023 at 6:00am, Jessica had an episode of vomiting and was noted to have a low oxygen saturation of 80%. A chest X-ray was performed and showed indications of aspiration pneumonia. Following discussions with her guardians, it was decided that Jessica would receive only ward-based care and was not for invasive procedure due to her past difficulties tolerating such interventions.

17. On 23 May 2023, the Palliative Care Consultant met with Jessica's guardians and the decision was reached to transition her to comfort care.

18. On 25 May 2023, Jessica passed away at 1:08 pm.

Identity of the deceased

19. On 25 May 2023, Jessica Nyla Louis, born 27 December 1990, was visually identified by her guardian, Julie Parke.

[11] Statement of Bethany Laird, Coronial Brief.
[12] Statement of Benjamin McLaughlin, Coronial Brief.
[13] Statement of Dr Jonathan Loo, Coronial Brief; statement of Dr Senthilkumar Sundaramurthy dated 8 February 2023.

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

Medical cause of death

21. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine conducted an external examination on 26 May 2023 and provided a written report of his findings dated 29 May 2023.

22. The examination revealed findings consistent with the history given in the medical records. The bowels contained free gas, were severely distended and there was consolidation in the lungs and pleural fluid.

23. No other independent cause of death was identified.

24. Dr de Boer provided an opinion that the medical cause of death was 1 (a) perforation of the bowel in the context of 1(b) constipation and 1(c) intellectual disability with picophagia.

25. I accept Dr de Boer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Jessica Nyla Louis, born 27 December 1990;

    b) the death occurred on 25 May 2023 at Frankston Hospital, 2 Hastings Road, Frankston, Victoria, 3199, from perforation of the bowel; constipation and intellectual disability with picophagia; and

    c) the death occurred in the circumstances described above.

27. Having considered all of the circumstances, I am satisfied that Jessica's care was reasonable and appropriate in all the circumstances.

I convey my sincere condolences to Jessica'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:

Peter and Julie Parke, Senior Next of Kin

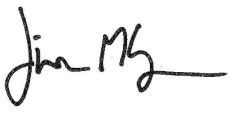
Amber Slater, Peninsula Health

Jonathan Lo, Frankston Hospital

Danielle Kelley, National Disability Insurance Scheme Quality and Safeguards Commission

Senior Constable Roy O'Hagan, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 24 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.