CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into death of JULIE ANN HERMANS**
Citation:	**[2020] ACTCD 4**
Findings Date:	20 February 2020
Before:	**Coroner Morrison**
Decision:	See [36]-[42].
Catchwords:	**CORONIAL LAW** – cause and manner of death – whether submissions raise questions as to cause of death – application of human rights legislation – "common sense" test of causation – whether public hearing necessary – whether matter of public safety arises
Legislation cited:	*Coroners Act 1997* (ACT), s 13(1)(d), 34, 34A, 52 *Human Rights Act 1997* *Medical Treatment (Health Directions) Act 2006*
Cases cited:	*The Queen v Coroner Maria Doogan; ex parte Australian Capital Territory* [2005] ACTSC 74 *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506 *Inquest into the death of Tanya Day*, ruling of 25 June 2019, acting Victorian State Coroner English *Momcilovic v The Queen* (2011) HCA 34 *Inquest into the death of Jamie Mitchell* [2018] ACTCD 18
File Number:	CD 177 of 2019

CORONER MORRISON:

1. On 13 August 2019 the Coroner's Court received an email from Ms Vanamali (also known as Mali) Hermans, the daughter of Julie Ann Hermans, reporting the death of Mrs Hermans to the ACT Coroner and requesting a post-mortem examination. The basis on which the report of death was made was that Mrs Hermans died after having undergone an operation or procedure and in circumstances that should be better ascertained, thus invoking section 13(1)(d) of the *Coroners Act 1997* (the Coroners Act).

2. The relevant history provided by Ms Hermans was that Mrs Hermans had passed away on 10 August 2019, at The Canberra Hospital (TCH). Mrs Hermans was an indigenous woman aged 54 years old who lived with acquired quadriplegia from Guillain-Barre Syndrome, which caused dysphagia, and diabetes. To treat her dysphagia Mrs Hermans had had a percutaneous endoscopic gastrostomy (PEG) fitted, which is a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. Patients receive complete or supplemental feeding – known as parenteral feeds – through the PEG.

3. Mrs Hermans was said to have been in and out of hospital in late July 2019. She was admitted to TCH on 23 July 2019 and discharged the following day. Mrs Hermans was then readmitted to TCH on 25 July 2019 with sepsis and stayed in in the Intensive Care Unit (ICU) until 1 August 2019 when she was transferred to Ward 7B (General Medicine). It was there that Mrs Hermans passed away apparently from complications of a lung infection said to have been acquired in hospital.

4. I agreed to accept jurisdiction in the matter but after taking advice from Professor Johan Duflou, the coronial pathologist, I declined to order a post-mortem examination on the basis that there would be no benefit to conducting an autopsy in the particular circumstances of this case, and that a review of records of treatment would be sufficient. This was accepted and agreed to by Ms Hermans. I directed that Mrs Hermans' records be obtained from The Canberra Hospital. I then directed Professor Duflou to review the records of Mrs Hermans' treatment, having regard to the communications received from and on behalf of Mrs Hermans' family, and report to me as to the manner and cause of Mrs Hermans' death, and to express an opinion in relation to the family's concerns.

5. Professor Duflou's report was received at the Court on 6 September 2019. Having considered that report, I directed that Mrs Hermans' family be contacted and advised of my preliminary view that the matters raised by the family were not within the scope of an enquiry into the manner and cause of Mrs Hermans' death. I indicated that I intended to dispense with a hearing and make findings as to manner and cause of death in accordance with Professor Duflou's opinion, and state that a matter of public safety was not found to arise in connection with inquest. Mrs Hermans' family were also advised that I would (with their permission) send copies of relevant communications to the Quality and Safety Unit of ACT Health with a request that the Unit communicate with the family direct about the matters raised. I also invited further submissions on whether a public hearing should be held, should objection be taken to my proposed course.

6. By way of submissions via her legal representative received at the Court on 29 November 2019, Ms Hermans submitted that a public hearing should be held. Those submissions raised three distinct points said to be in favour of the holding of a hearing:

    a. That the investigation of whether systematic disability discrimination was a factor in the manner and cause of Mrs Hermans' death is compatible with the application of the *Human Rights Act 1997* (ACT) ('HR Act') to this Inquiry (sic);

    b. That the investigation of parenteral feeds is critical to determining the cause of the hospital-acquired pneumonia which was the identified cause of Mrs Hermans' death; and

    c. That the investigation of whether Mrs Hermans' death received a high-risk and specialist response during her admissions at the Canberra Hospital, as a patient with complex conditions is central to the manner and cause of her death.

Observations on Scope of Jurisdiction

7. I made some observations about the powers of a Coroner in the context of public hearings in the recent matter of *Inquest into the death of Jamie Mitchell* [2018] ACTCD 18. I will reiterate and expand on those observations here.

8. In the ACT the role of the Coroner is defined in the Coroners Act. Primarily it is to determine the manner and cause of a person's death where the person has died in circumstances prescribed by the legislation.

9. The decision on whether or not to hold a hearing depends, in large part, upon whether or not a hearing is necessary to determine the manner and cause of death. That in turn depends upon what evidence is already available to the Coroner, without a hearing, about the manner and cause of death.

10. The evidence before me as to the direct cause of the death of Ms Hermans is the expert opinion expressed by Professor Duflou in his report dated 6 September 2019 reviewing the records of Ms Hermans' treatment. Although the letter on behalf of Ms Hermans commences by joining issue on both manner and cause of Mrs Hermans' death, at paragraph 24 and with reference to Professor Duflou's report it states:

"It is accepted that the cause of death is 'multiple organ failure, due to pneumonia in a patient with Guillain-Barre syndrome with quadriplegia, diabetes mellitus, chronic pain and recurrent infections' ."

11. The ACT Supreme Court has considered the approach to be taken to what is the 'cause' of an event for coronial purposes. In *The Queen v Coroner Maria Doogan; ex parte Australian Capital Territory* [2005] ACTSC 74 ("Doogan"), the Court said this:

> *A line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative. The point where such a line is to be drawn must be determined not by the application of some concrete rule, but by what is described as the "common sense" test of causation affirmed by the High Court of Australia in* March v E & MH Stramare Pty Ltd *(1991) 171 CLR 506. The application of that test will obviously depend upon the circumstances of the case and, in the context of a coronial inquiry, it may be influenced by the limited scope of the inquiry which, as we have mentioned, does not extend to the resolution of collateral issues relating to compensation or the attribution of blame.*

12. The expert evidence, by way of the opinion expressed in the report of Professor Duflou at paragraph 14, points clearly to the cause of Ms Hermans' death as being multiple organ failure, due to pneumonia in a patient with Guillain-Barre syndrome with quadriplegia, diabetes mellitus, chronic pain and recurrent infections. There is no evidence suggesting any different conclusion about the manner and cause of death. I note also that Professor Duflou's opinion as to cause of death accords with that recorded by Mrs Hermans' treating doctors when completing the Medical Certificate Cause of Death, although the Professor has provided more detail in his description of the cause of Mrs Hermans' death.

13. Professor Duflou comments further in his report:

    a. *"It is my opinion that all reasonable investigations were done in this case, taking in account the patient's co-morbidities and her expressed wishes."* at paragraph 13a.

    b. *"In the days leading up to [Mrs Hermans'] death, she had been gradually deteriorating despite appropriate treatment for her various medical conditions."* at paragraph 13f.

    c. "*I am of the view that [Mrs Hermans] was investigated, treated and cared for at a high level, with all necessary investigations performed."* at paragraph 13h.

Applicability of the Human Rights Act – Systemic Discrimination

14. It was submitted that I should investigate whether systemic disability discrimination formed part of the manner and cause of Mrs Hermans' death. This approach, it was said, is compatible with the application of the HR Act. It was noted in the submissions that *Doogan* clearly excludes consideration of policy, the conduct of individuals and broader concerns from a Coroner's investigation. However, as I understood the submissions, it was suggested that *Doogan* may be distinguished on two bases:

    a. Firstly, the HR Act had not been enacted at the time of *Doogan*; and

    b. Secondly, Mrs Hermans' peculiar attributes as an Aboriginal woman and someone living with a disability were "*fundamental reasons to engage the application of the HR Act when conducting the inquest into her death*".

15. There is no ACT case law, either from a Coroner or the Supreme Court, dealing with the specific question of the relationship between the HR Act and the Coroners Act.

16. There is no submission made that the Coroners Act is incompatible with the HR Act. Rather, the thrust of the submissions appears to be that in conducting the investigation directed by the Coroners Act it would be appropriate to interpret the requirement to make a determination on manner and cause of death as requiring an examination of whether Mrs Hermans' death was the "*result of a failure to enjoy her human rights without discrimination*": at paragraph 15 of the submissions.

17. To the extent that the submission is to the effect that such an examination is required in every case, I reject it. I was referred to a ruling by acting Victorian State Coroner English of 25 June 2019, in the *Inquest into the death of Tanya Day*. There is nothing in the decision in *Day* to that effect.

18. When there is evidence which, if accepted, may realistically link the manner and cause of death of a person with discrimination, conduct incompatible with a human right, or a decision made without proper consideration of a human right, then such an examination may properly fall within the ambit of a coronial enquiry.

19. The facts surrounding the death of Ms Day as reported by acting Victorian State Coroner English are very different to the circumstances of Mrs Hermans' death. Mrs Hermans died during a course of hospitalisation to receive treatment for illnesses consequent upon her disabilities. The submissions do not particularise the ways in which it is said Mrs Hermans was discriminated against by TCH. They do not go beyond her status as a member of the specific groups stated.

20. The fact that Mrs Hermans identified as an Aboriginal woman was recorded on the TCH medical records in multiple locations and patient progress entries. There were also a number of visits to Mrs Hermans by TCH Aboriginal Liaison staff recorded in the notes. Professor Duflou provided supplementary commentary to his report that in his view, there was no indication of discrimination on this basis or otherwise against Mrs Hermans. There is no evidence to suggest that Mrs Hermans was discriminated against, systematically or otherwise, on any basis while at TCH. The evidence which is before me does not warrant the holding of a public hearing.

Parenteral Feeds

21. The next submission I am asked to consider is that the investigation of parenteral feeds is critical to determining the cause of the hospital-acquired pneumonia which was the identified cause of Mrs Hermans' death. It is suggested that Mrs Hermans was fed mildly thickened fluids while in TCH (rather than thickened fluids), causing her to aspirate, which then resulted in the pneumonia that ultimately caused her death.

22. This submission calls for consideration of whether the questions raised go to matters too remote to be considered as causative. That determination must be made in the context of the limited scope of a coronial enquiry and the

unchallenged evidence that the cause of death was in part the consequence of Mrs Hermans' multiple comorbidities.

23. Professor Duflou, quite rightly, indicated that he had no expertise on the various types of parenteral feeds or the indications for those feeds. He did however comment that the records of treatment record (at paragraph 13d):

> *… extensive discussion between appropriate health personnel in relation to the patient's airway, her feeding, and the risk of aspiration. Overall, the consensus view reached was that although the patient had multiple episodes of fluctuating consciousness, she was able to adequately maintain her airway, and that intubation was therefore not warranted. Added to this was the decision that the patient was not to be re-admitted to the ICU, where the patient would need to be admitted should intubation and ventilation take place.*

24. I note also that Professor Duflou did not find that Mrs Hermans' death was as the result of aspiration of gastric contents. All that the medical records document is a diagnosis of hospital-acquired pneumonia.

25. There is an obvious, but superficial argument that a causal connection exists simply because Mrs Hermans would not have developed hospital-acquired pneumonia had she not been in hospital, and Mrs Hermans died from that condition. Such a line of reasoning would however run contrary to the decision of the High Court in *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506 and impliedly adopted in this jurisdiction in *Doogan* that the 'but for' or 'causa sine qua non' test is not a definitive test of causation.

26. The evidence which is before me does not justify a finding that parenteral feeds Mrs Hermans received at TCH were not appropriate or that they contributed to her death, or that a matter of public safety arises around that treatment. Given the limited role of a Coroner, further investigation is not warranted.

Patient with complex conditions

27. The submissions ask that I consider investigating whether Mrs Hermans received a high-risk and specialist response during her admissions at the Canberra Hospital, as it is said this is central to the manner and cause of her death.

28. Issue is taken with part of paragraph 13h of Professor Duflou's report, where he noted that recorded in the medical records were accounts of conversations with Mrs Hermans and her family, on multiple occasions, where Mrs Hermans

expressed her wishes for no admission to the ICU and No CPR orders. It is submitted that (at paragraph 25.2):

> *… a central issue in determining the manner and cause of Mrs Hermans' death is to further investigate what, if any high risk or critical response teams were involved in the treatment plan leading up to her death. Doing so, would confirm whether Mrs Hermans received specialist healthcare as required for patients with comorbidities rather than the provision of ordinary medical treatment in circumstances which required an alternative response. If Mrs Hermans was provided with only responsive medical treatment to her symptoms as they arose as Professor Duflou's report suggests, it is proximate to the manner and cause of her death that failing to apply high risk or critical medical treatment contributed to the manner and cause of Mrs Hermans' death.*

29. It is well recognised in the ACT and elsewhere that competent patients have the right to decline further medical treatment, including if that further treatment would save their life or provide better wellbeing. In the ACT, the provisions of the *Medical Treatment (Health Directions) Act 2006* and the HR Act apply.

30. The submissions made on behalf of Ms Hermans do not go so far as to suggest that her mother was not competent to make her own decisions, but as I understand them, appear to suggest that there should have been more involvement from other, specialist practitioners as part of Mrs Hermans' treatment plan, and that a failure to provide specialist treatment contributed to Mrs Hermans' death. The submission is not supported by any evidence. The evidence which is before me, by way of the report of Professor Duflou, is relevantly to the following effect (at paragraph 13a):

> *There is no doubt that [Mrs Hermans] had a number of diseases which together made treatment of the patient highly challenging. The clinical presentation of [Mrs Hermans] was not typical of either urinary tract or respiratory infection, and as a result very extensive investigations of [Mrs Hermans] were performed by a multidisciplinary team.*

31. Having regard to that evidence, and against the background of Mrs Hermans' wishes expressed on multiple occasions about limits on life-prolonging treatment, further investigation of this issue, by way of public hearing or otherwise, is not warranted.

Matter of Public Safety

32. The submissions received on behalf of Ms Hermans suggested that a matter of public safety might arise in this case if I was to find that Mrs Hermans' death was the result of, in part, the improper administration of parenteral feeds.

33. As I commented in my findings in the *Mitchell* inquest, if, in the course of holding an inquest (either with or without a hearing), a Coroner is satisfied that a matter of public safety is found to arise then the Coroner must report upon that matter of public safety at the conclusion of the inquest. It is important to recognise however that the authority to report on matters of public safety is an incidental power. It is triggered only if "a matter of public safety is found to arise in connection with the inquest" – and does not of itself require the holding of a hearing, if it is not otherwise necessary to do so.

34. In this context I have considered two questions. The first is whether, on the basis of the evidence before me, I can find that any matter of public safety arises. The second is whether in all the circumstances it is appropriate to hold a public hearing to determine whether such a finding can be made despite a hearing not being necessary to determine the manner and cause of death.

35. I have concluded that, in relation to each of the issues raised in the submissions on behalf of Ms Hermans, the state of the evidence which is before me does not justify a finding that a matter of public safety arises, and further, in each case, that the holding of a public hearing to determine whether such a finding should be made is not justified. I accept the general proposition that inappropriate hospital treatment may result from systemic deficiencies and give rise to a matter of public safety. However, that is not the case here.

Conclusions

36. On the basis of the material before me, I am satisfied that the manner and cause of Mrs Hermans' death, for the purposes of section 52 of the Coroners Act, is established by the evidence comprising the expert opinion of Professor Duflou and that no public hearing is necessary for the purpose of making that determination.

37. I also conclude that questions raised in submissions on behalf of the Hermans family go to matters too remote to be considered as causative for the purposes of a coronial inquest. It follows that further investigation of those matters by way

of a public hearing for the purpose of determining any contribution by them to the cause of death is not justified.

38. Accordingly, I find as follows:

> Julie Ann Hermans died on 10 August 2019 at The Canberra Hospital, Dann Close, Garran in the Australian Capital Territory. The manner and cause of Mrs Hermans' death is multiple organ failure, due to pneumonia in a patient with Guillain-Barre syndrome with quadriplegia, diabetes mellitus, chronic pain and recurrent infections.

39. I have made these findings as to the manner and cause of death without the need to further investigate or determine to finality the questions raised in the submissions made on behalf of Mrs Hermans' family.

40. I make no adverse findings against any person.

41. I make no finding that a matter of public safety has been found to arise.

42. I make no recommendations.

43. The submissions on behalf of Ms Hermans' state that *"[i]t is difficult to consider Mrs Hermans' death in vacuum that separates her lived experience of disability to the events that led to her death*": paragraph 22. Insofar as this is intended to be a reference to Mrs Hermans' apparent difficulties with the National Disability Insurance Scheme (NDIS), I have concluded that investigation of this subject is beyond the scope of this inquest as being too remote from the cause of Mrs Hermans' death. I note that there are multiple avenues available to the Hermans family to have other concerns investigated, including the ACT Disability and Community Services Commissioner.

44. I direct that these findings be published in due course on the Coroner's Court website, together with any responses I might receive.

45. I extend my condolences to Mrs Hermans' family and friends.

DATED 20 February 2020

P J MORRISON
CORONER