CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of VIOLA DIANA CLARKE**
Citation:	**[2020] ACTCD 6**
Findings Date:	2 June 2020
Before:	**Coroner Lawton**
Decision:	See [25] – [28]
Catchwords:	**CORONIAL LAW** – cause and manner of death – aspiration pneumonia – no matter of public safety
Legislation applicable:	*Coroners Act 1997* (ACT) ss 13(1)(a), 52(1), 52(3)-(4)
Cases cited:	*Briginshaw v Briginshaw* (1938) 60 CLR 336 *R v Doogan; Ex Parte Lucas Smith & Ors* [2005] ACTSC 74 *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506 *Harmsworth v The State Coroner* [1989] VR 989
File Number:	CD 39 of 2016

Corrigendum

16 September 2020

Paragraphs 22-23 of the below decision have been amended to replace references to the 'Canberra Hospital' to 'Calvary Public Hospital'.

CORONER LAWTON:

Jurisdiction

1. A Coroner is required to hold an inquest into the manner and cause of death of a person who dies violently, or unnaturally, in unknown circumstances: see section 13(1)(a) of the *Coroners Act 1997* (ACT) ("the Act") as it was in force at the time [Reprint 37].

2. Mrs Clarke's death was referred to the Coroner on 22 February 2016 by Dr Carolyn Droste, who considered that an independent review was required into an allegation that Mrs Clarke was given the incorrect medication at Goodwin Ainslie, her nursing home, which caused or contributed to her death: see Ex. 1, Tab 4.

3. The matter was originally referred to the Chief Coroner who commenced a hearing on 29 April 2019. On 1 May 2019 the hearing was adjourned part-heard before the Chief Coroner until 16 September 2019.

4. Her Honour the Chief Coroner became unavailable to hear the balance of the hearing on 16 September 2019 as she was made an Acting Justice of the Supreme Court for 12 months from August 2019.

5. The matter was allocated to me for the continuation of the hearing. However, one party did not consent to the continuation of the hearing and as such, the hearing had to recommence with the recalling of witnesses. This required the hearing date to be vacated and the matter listed for hearing in March 2020.

6. I express my gratitude to Ms Baker-Goldsmith, Counsel Assisting, for her comprehensive work both in the courtroom and in her submissions.

7. I express my gratitude to Counsel who appeared for the other parties given leave to appear, for their assistance during the course of the hearing and in their written submissions.

Statutory Findings

8. Under subsection 52(1) of the Act, a Coroner holding an inquest must find, if possible:

    (a) the identity of the deceased; and

    (b) when and where the death happened; and

    (c) the manner and cause of death; …

    The Coroner must record his or her findings in writing: s 52(3).

9. At the relevant time, subsection 52(4) of the Act provided as follows:

    The coroner, in the coroner's findings—

    (a) must—

        (i) state whether a matter of public safety is found to arise in connection with the inquest or inquiry; and

        (ii) if a matter of public safety is found to arise—comment on the matter; and

    (b) may comment on any matter about the administration of justice connected with the inquest or inquiry.

Scope of the Inquest

10. The civil standard of proof applies in coronial matters. However, in making findings, the Coroner is to have regard to the principle laid down in *Briginshaw v Briginshaw* (1938) 60 CLR 336 as stated by Dixon J at 361-2:

    The truth is that, when the law requires the proof of any fact, the tribunal must feel an actual persuasion of its occurrence or existence before it can be found… The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which

must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal.

11. In *R v Doogan; Ex Parte Lucas Smith & Ors* [2005] ACTSC 74 (5 August 2005) the Full Court of the Supreme Court comprising Higgins CJ, Crispin and Bennett JJ stated in relation to the nature of the Coroner's inquiry:

> [12] *The task of a coroner is not to determine whether anyone is entitled to some legal remedy, is liable to another or is guilty of an offence. The Coroner's task is to inquire into the matters specified in the relevant section of the* Coroners Act 1997 *and make, if possible, the required findings and any comments that may be appropriate…*
>
> [15] *The [Coroners] Act is generally concerned with the resolution of relatively straightforward questions such as "what was the cause of this death?" or "what caused this fire?". It does not provide a general mechanism for an open ended inquiry into the merits of government policy, the performance of government agencies or private institutions, or the conduct of individuals, even if apparently related in some way to the circumstances in which the death or fire occurred.*

12. Their Honours go on at [28] to warn Coroners against the conduct of '*a wide-ranging inquiry akin to that of a Royal Commission*' and provide an example at [31] of the limits of enquiry:

> *… [A] coroner might well hear evidence suggesting that a cyclist's death had been caused not merely by a collision with a motor vehicle, but also by the antecedent conduct of the driver of that vehicle in failing to stop at a stop sign adjacent to an intersection. However, the limited jurisdiction conferred... would not authorise the coroner to inquire into any perceived failures in relation to general policy relating to the siting of stop signs or the*

> *enforcement of traffic regulations. The particular siting and design of the relevant intersection may be a different matter. The application of the common sense test of causation will normally exclude a quest to apportion blame or a wide-ranging investigation into antecedent policies and practices.*

13. Their Honours endorsed, at [29], the 'common sense' test of causation laid down by the High Court in *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506, where it was said:

> *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… in the context of a coronial inquiry, [the common sense test of causation] 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.*

14. Further, in *Harmsworth v The State Coroner* [1989] VR 989 at 997, Nathan J discussed the ambit of the Coroner's power to comment as follows:

> *The power to comment arises as a consequence of the obligation to make findings… It is not free ranging. It must be comment 'on any matter connected with the death.' The powers to comment and also to make recommendations… are inextricably connected with, but not independent of the power to enquire into a death or fire for the purposes of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation. It arises as a consequence of the exercise of a coroner's prime function that is to make 'findings.'*

Consideration

15. The first two section 52 matters are uncontroversial. Mrs Clarke was declared life extinct at Calvary Private Hospital on 20 February 2016. No post-mortem examination was undertaken of Mrs Clarke. When she died, a Medical Certificate Cause of Death was written up for Mrs Clarke which described the cause of her death as aspiration pneumonia: Ex. 1, Tab 3. No alternative cause of death was proffered by any other witness, nor any party during the hearing.

16. Determination of the manner of Mrs Clarke's death, and specifically the cause and timing of the aspiration that led to aspiration pneumonia, is much more difficult. In submissions Counsel Assisting suggested several possibilities as to how, when and where Mrs Clarke aspirated.

17. Counsel Assisting submitted that the task for me as Coroner properly construed does not require exclusion of all but one possibility, but rather an assessment of what is the most likely cause of events, or alternatively the making of an open finding if the evidence in support of any likely cause of events does not rise to a level of comfortable satisfaction.

18. I have reviewed the evidence and submissions of the parties several times.

19. I will not recount the narrative leading to Mrs Clarke's death, but note Counsel Assisting provided as part of her submissions a comprehensive timeline of which all parties have had the benefit.

20. I am unable to be comfortably satisfied as to when and where in that narrative Mrs Clarke aspirated or whether it was a single aspiration or several aspirations at different times that lead to her developing aspiration pneumonia.

21. As Mrs Clarke's death was referred to the Coroner by Dr Droste, it is important to consider the issue of the medication error. Although Mrs Clarke was given the wrong medication on the evening of 9 February 2016 at Goodwin Aged Care Facility in

Ainslie, the error was immediately detected and a protocol followed to notify her family, her general practitioner and other medical practitioners to deal with the consequences.

22. Mrs Clarke's condition worsened on the afternoon of 10 February 2016 and she was admitted to the Calvary Public Hospital. At the time of her admission she was also suffering from several other vulnerabilities and co-morbidities, including congestive heart failure, chronic obstructive pulmonary disease, acute on chronic renal failure, gastric reflux, and dysphagia.

23. It was possible that she aspirated before being given the wrong medication; after being given the wrong medication but before being admitted to the Calvary Public Hospital; or after she was admitted to the Calvary Public Hospital.

24. Ultimately I am unable to be comfortably satisfied that the erroneously-given medication caused or contributed to the aspiration that led to Mrs Clarke developing aspiration pneumonia as I cannot be comfortably satisfied as to when that aspiration (or aspirations) occurred, and therefore cannot be comfortably satisfied that the aspiration occurred during the time period in which the medication would have had an effect upon Mrs Clarke.

Findings

25. I make the following findings

    1. Viola Diana Clarke died at Calvary Private Hospital, Mary Potter Circuit, Bruce, on 20 February 2016.

    2. The cause of her death was aspiration pneumonia.

    3. I cannot make a finding to about what caused the aspiration pneumonia nor when the onset of Mrs Clarke's aspiration pneumonia occurred.

    4. No matter of public safety arises in relation to this inquest.

Recommendations

26. These findings are being released during the COVID-19 Pandemic. The aged care system will need to consistently expand to meet the increase in demand upon it as our population grows and ages.

27. I make the following recommendations:

    a. Steps should be taken to promote the aged care industry as an attractive career option for graduate nurses, including considering practical support for aged care facilities to institute graduate programs allowing for attainment of speciality in geriatric care.

    b. The Commonwealth Government reconsider the scope of practice of EENs within aged care, to increase and align the scope of practice with that for other sub-acute settings.

28. I extend my condolences to Mrs Clarke's family.

J T Lawton

Coroner

2 June 2020

I certify that the preceding twenty-eight [28] numbered paragraphs are a true copy of the Reasons for Decision of his Honour Magistrate Lawton

Associate: James Harris

Date: 2 June 2020