CORONER'S COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the Death of PAMELA VANCE**
Citation:	**[2022] ACTCD 2**
Decision Date:	19 May 2022
Before:	**Coroner Archer**
Decision:	See [6], [31]-[32].
Catchwords:	**CORONIAL LAW** – cause and manner of death – natural cause of death – no criticism hospital or treating clinicians – no matters of public safety – delay in coronial processes
Legislation Cited:	*Coroners Act 1977* (ACT), s 3BA, s 13, S 34A, s 52
File Number(s):	**CD 259 of 2016**

CORONER ARCHER

Background

1. Mrs Pamela Vance died in the early hours of 3 November 2016. She was 83 years of age. She was last seen alive by her daughter in the evening of 2 November 2016 when she went to her mother's bedroom to attend to her care.

2. Mrs Vance was found unconscious by her daughter at about 3.00 a.m. on 3 November 2016. She called "000" and the operator gave instructions as her daughter administered CPR. That continued until the ambulance arrived. Police had also been called and they arrived at about 4:00 a.m. Mrs Vance did not exhibit signs of life and no attempt was made to perform further CPR or administer any drugs. A doctor came to the house and examined Mrs Vance. Her life was pronounced extinct on 3 November 2016 at 6:55 am.

3. Mrs Vance was born on 4 September 1933 in Queensland. She lived her early life in Queensland. In 1957 she went on working holiday to England where she met Richard Vance who was an Australian undertaking medical studies in England. They were engaged whilst still in England. They married in 1959 and moved to the Australian Capital Territory about that time. She had four children, the last born in May of 1969. It is clear from the evidence before me, and from their effective advocacy during the inquest process, that Mrs Vance was supported and loved by her family and that her passing was very deeply felt.

Jurisdiction

4. Mrs Vance's death was reported to the coroner because medical practitioners, who were approached by investigating police, were not prepared to give a certificate about the cause of Mrs Vance's death. Therefore, pursuant to section 13(1)(e)(e) of the *Coroners Act 1997* ("the Act"), the Coroner was required to hold an inquest into the manner and

cause of Mrs Vance's death and make the findings required by section 52 of the Act. That section of the Act relevantly provides:

> **52 Coroner's findings**
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> (1) A coroner holding an inquest must find, if possible—
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> (a) the identity of the deceased; and
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> (b) when and where the death happened; and
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> (c) the manner and cause of death; and
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> (d) in the case of the suspected death of a person—that the person has died.
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> (4) The coroner, in the coroner's findings—
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> (a) must—
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> (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

Evidence

5. The findings that follow are based on the evidence received during the inquest process. That material consisted of relevant medical records, a police investigation report, information provided to the Court by the family (in the form of emails and formal statements) an expert report from Professor David Bryant (a respiratory physician) and two reports from Dr Duflou, a forensic pathologist. Based on that information, I was satisfied, for the purposes of section 34A of the Act, that the manner and cause of Mrs Vance's death were sufficiently disclosed and, therefore, a hearing was unnecessary. My decision not to conduct a hearing and the reasons for that decision were provided to a member of Mrs Vance's immediate family in writing.

Formal Findings – Section 52(1) of the Act

6. An autopsy was conducted by Dr Johan Duflou on 6 November 2016. He found that Mrs Vance died of pneumonia with generalised atherosclerosis being a significant contributor to the death. In light of Dr Duflou's opinions, I make the following findings:

> Mrs Pamela Vance died on or about 3 November 2016 at 23 Scarborough Street Red Hill in the Australian Capital Territory as a result of pneumonia with generalised atherosclerosis as a significant contributor to the death.

The Obligations Imposed by Section 3BA of the Act

7. I make findings below in respect of the manner and cause of Mrs Vance's death.

8. Mrs Vance's family have raised a number of concerns regarding the treatment of Mrs Vance at the Canberra Private Hospital that in my view are not necessarily associated with the manner and cause of Mrs Vance's death. Section 3BA of the Act imposes obligations upon a Coroner conducting an inquest. The section requires a Coroner, amongst other things, to recognise that the family and friends of a deceased person have an interest in having all reasonable questions about the circumstances of the person's death answered. Whilst not without limits, the provision allows the inquest to explore

issues not necessarily directly associated with the manner and cause of death and, if appropriate to do so, publish reasons consistent with that power.

9. I make findings below that specifically address the matters the family have raised.

Mrs Vance's Health

10. I address those concerns against the background of Mrs Vance's deteriorating health.

11. During her life, Mrs Vance suffered a large number of medical disorders (including heart problems, cancer and asthma). She had an accident in May 2016 and fractured her scapula. A delay in the diagnosis of that condition caused her to live unnecessarily with the pain of that injury for a month. On 16 June 2016 she was hospitalised at the Canberra Private Hospital (CPH) to support her recovery. She was discharged on 30 June 2016. On 13 July 2016 she fell outside her home and was taken to the Canberra Hospital. She was found to have fractures of the nose, patella and at least one rib. During that admission Mrs Vance contracted pneumonia which required intubation for a period.

12. On 5 August 2016 Mrs Vance was transferred to the John James Hospital. She remained there until 6 October 2016. During that admission she suffered several further episodes of pneumonia requiring ventilatory assistance. She was transferred to the CPH on 6 October 2016 for ongoing rehabilitative care. She remained there until discharged on 1 November 2016.

Mrs Vance's Treatment at Canberra Private Hospital

13. Mrs Vance's co-morbidities made her vulnerable to other serious illnesses. The length of her admissions to various hospitals after the July fall and the pneumonia she contracted on several occasions speak of her medical vulnerability. Professor Bryant, who from the standpoint of his expertise and having reviewed relevant medical notes, expressed the view that by the time Mrs Vance was admitted to the CPH, her prognosis was guarded. It was not clear to Professor Bryant that any treatment was capable of improving Mrs Vance's underlying ventilatory function. The various conditions she had suffered from had in his opinion:

> *"resulted in physical deconditioning, some loss of ventilatory function, some mild residual tendency to aspiration and recurrent pneumonia and an increased tendency to oxygen desaturation."*

14. The autopsy findings of Dr Duflou confirmed the existence of damage caused by pre-existing lung disease.

15. The medical records and the information provided by her family make clear that Mrs Vance had, for a significant period, suffered from asthma and Chronic Obstructive Pulmonary Disease (COPD). Those conditions were appropriately treated with medications during her admission to CPH. Mrs Vance's sleep apnoea was treated by using continuous positive airway pressure (CPAP) therapy. Mrs Vance found it difficult and unpleasant to use her nasal CPAP device and was hesitant to use it, particularly following the experience of being intubated after an episode of pneumonia. The hospital notes indicate variable oxygen saturations during Mrs Vance's admission. Improvements were noted after being given oxygen (2 litres of oxygen per minute) and oxygen was routinely given overnight to also help Mrs Vance sleep.

Mrs Vance's Discharge from Hospital

16. It is against this background that the matters the family have raised in relation to their mother's discharge from CPH on 1 November 2016 fall to be assessed.

17. Whilst ultimately it was for medical staff to determine whether it was medically appropriate for Mrs Vance to be discharged, that responsibility was subject to Mrs Vance's own wishes.

18. Planning for Mrs Vance's discharge was not rushed – it was spread over an extended period and involved consultation with the family. There is no evidence that her discharge was opposed by the family although issues concerning a cough, a possible urinary tract infection and the provision of oxygen therapy at home were raised by them. Mrs Vance was looking forward to going home as she had been in hospital for approximately four months. Mrs Vance was described by her daughter as being anxious to go home. Dr Duflou expressed the view that if Mrs Vance could be safely cared for in the community, it was desirable and consistent with clinical best practice for that to happen. Staying in hospital exposed Mrs Vance to the on-going risk of infections, particularly in relation to pneumonia. The Klebsiella bacteria identified in Mrs Vance's lungs at autopsy is known to be acquired in hospital settings.

(A) Lack of Oxygen at Home

19. The family have also expressed concerns about the lack of arrangements that were made for oxygen supplementation to be available at home and whether the failure to provide oxygen was relevant to Mrs Vance's death.

20. At a meeting held with the family to discuss post discharge care arrangements a question was asked by the family about the provision of oxygen after release. The notes suggested that "nursing would f/u [follow up]". At discharge Mrs Vance had been given her nasal CPAP machine. The evidence suggests that oxygen was not made available to Mrs Vance at the time of discharge.

21. Professor David Bryant opined that it would have been appropriate for the CPH to have assessed Mrs Vance's respiratory status and daytime oxygen requirements in greater detail and to have provided oxygen for Mrs Vance to use at home. Whilst I accept that opinion, arrangements had been made prior to her discharge for Mrs Vance to visit the Sleep Clinic on 2 November 2016 the day after her discharge and to visit her GP on 3 November 2016. Those arrangements were reasonable and would have allowed doctors or other health care providers to facilitate access to oxygen therapy if immediate access to oxygen was clinically indicated.

22. Professor Bryant expressed the view that, presuming the *absence* of pneumonia, and given Mrs Vance's refusal to use CPAP therapy, the availability of oxygen at home may have "reduced [Mrs Vance's] tendency to hypoxia" and that, therefore, "her death may have been avoided or delayed". Whilst theoretically this may be so, I find that in the period immediately before her death Mrs Vance *was* suffering from pneumonia. Dr Duflou found that, on its own, the presence of oxygen therapy would not have prevented the onset of pneumonia. Further, in his view, whilst the use of oxygen might have been used in treating Mrs Vance's pneumonia, other interventions such as antibiotics and ventilatory support may have been required in a hospital setting.

23. The absence of oxygen therapy available at home was not, as I find below, relevant to Mrs Vance's death.

(B) Adjustment of the CPAP machine

24. The family have also expressed concerns about the CPAP machine being incorrectly adjusted when their mother was discharged, and that nursing staff seemed untrained in their use.

25. It is likely that the CPAP machine required adjustment at the time of Mrs Vance's discharge given that adjustments to the CPAP machine were made at the Sleep Clinic during the consultation that occurred during the morning of 2 November 2016. However, appropriate arrangements had been made for matters relevant to the treatment of Mrs Vance's sleep apnoea to be addressed at the Sleep Clinic, the day after Mrs Vance's discharge. It might reasonably have been expected that clinicians at the Sleep Clinic who were trained and/or experienced in the calibration of these machines, would ensure that the machine was adjusted appropriately.

26. It is likely that hospital staff were unaware of the willingness of her respiratory physiotherapist to come to the hospital to adjust the CPAP machine. It is beyond the scope of this inquest to determine whether there is a general issue as to whether nursing staff at CPH or other hospitals are sufficiently trained in the adjustment of CPAP machines.

(C) Was Mrs Vance Suffering Pneumonia when Discharged?

27. The family have also raised the possibility that Mrs Vance was suffering pneumonia at the time of her discharge. Whilst this is certainly a possibility, I am unable to be satisfied that this was so. Professor Bryant found that the medical notes do not describe symptoms that would lead to a presumptive diagnosis of pneumonia. The family noted a productive cough, and this was brought to the attention of medical staff close to the time of discharge. Mrs Vance was also complaining about a shortness of breath. However, neither Professor Bryant nor Dr Duflou were able to conclude to any reasonable level of satisfaction that Mrs Vance was suffering pneumonia at the time when she was discharged. As Dr Duflou noted, early pneumonia, especially in the setting of chronic lung and heart disease in an elderly patient, can be difficult to diagnose by clinical examination alone. Although Mrs Vance died as a result of pneumonia against a background of generalised atherosclerosis Dr Duflou was of the view that the condition may have developed after Mrs Vance left the hospital.

28. Even if Mrs Vance was exhibiting signs of illness consistent with pneumonia when discharged, a structure was in place that allowed Mrs Vance to be appropriately assessed and returned to hospital if necessary. During the Sleep Clinic consultation that occurred on 2 November 2016, no diagnosis of pneumonia was made although concern was expressed about Mrs Vance's respiratory levels and a call was made to Mrs Vance's own respiratory physician. He advised that Mrs Vance "probably should go back to hospital". It was indicated by him that oxygen would be available at Mrs Vance's home the next day. The situation was discussed with Mrs Vance. She said she did not want to go back to hospital. It was agreed with the sleep clinic physiotherapist that Mrs Vance would use the CPAP machine at home a few times during the afternoon for an hour. The plan was for Mrs Vance to see her GP the following day and organise for oxygen to be used at home. Mrs Vance was reported by her daughter to have been more energetic in the afternoon. Returning to hospital was discussed a "few times" and Mrs Vance clearly stated she did not want to go back there. Given her recent long admissions in hospitals, Mrs Vance's reluctance to return to a hospital setting was completely understandable. She was with her family and in her home.

29. Although Mrs Vance went to bed quite early in the evening of 2 November 2016, and she was observed to be restless, there was nothing to indicate the likelihood of her sudden death.

30. In these circumstances, I do not consider that criticism should be made of anyone. Decisions were made by clinicians and by Mrs Vance that in my view were completely reasonable. Mrs Vance was loved by her family, and they were very conscientious in ensuring she was well cared for and that appropriate arrangements for medical assessments were in place. In the end Mrs Vance chose not to return to hospital. Even

if she returned to hospital her prognosis was guarded and recovery was not inevitable. Her family could do no more than they did.

31. The evidence does not rise to a level where any adverse comment or finding against CPH, any medical practitioner or nurse is warranted.

Finding as to Matters of Public Safety

32. I find that no matters of public safety arise in connection with the inquest into Mrs Vance's death.

Apology to the Family

33. The disposition of the inquest into Mrs Vance's death has taken an inexcusably long period of time.

34. Section 3BA of the Act requires inquests to be carried out in way that recognises that the death of a person and an inquest into the person's death, has a significant impact on the person's family and friends. That statutory obligation has not been discharged in this case.

35. On behalf of the Coroner's Court an apology is made to the family for that delay and the poor levels of communication with them as to the progress of the inquest.

I certify that the preceding [35] numbered paragraphs are a true copy of the Reasons for Decision of his Honour Magistrate Archer

Associate:

Date: 19 May 2022