



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Ena Ann Bentley

Find, pursuant to Section 28(1) of the Coroners Act 1995, that

- a) The identity of the deceased is Ena Ann Bentley;
- b) Miss Bentley was born on 1 April 1938 and was aged 82 years at her death. She was born with cerebral palsy with epilepsy, spastic tetraplegia and blindness. She was unable to speak, was virtually immobile and required full time care. Her later medical history included osteoporosis, fractured neck of femur and fracture of the osteo pubis. Miss Bentley had been a long-term client of Multicap Tasmania Inc. and resided at the shared home facility known as “Emily 7” at Somerset. All aspects of Miss Bentley’s care at the facility were provided by Multicap carers and support workers. She was also under the regular care of doctors. In February 2021, a palliative care review of Miss Bentley found her to be frail and deteriorating in her condition and oral intake. She was also less mobile and less responsive.

On the evening of 21 March 2021, staff of the facility contacted an ambulance for Miss Bentley as her breathing and temperature had changed, she had not passed urine as expected and she appeared to be suffering pain. Ambulance paramedics conveyed her to the North West Regional Hospital, where she was diagnosed with aspirational pneumonia. Her prognosis was poor and she was admitted to the medical ward of the hospital for end of life care. She was provided with comfort care and passed away on March 28, one week after her admission to hospital.

- c) Miss Bentley died of natural causes, being aspiration pneumonitis. In his report, the State Forensic Pathologist who conducted the autopsy upon Miss Bentley commented that aspiration pneumonia occurs when foreign debris (such as food or gastric contents) are inhaled into the airways and alveoli (air sacs). This process can cause death by preventing normal breathing. Aspiration and aspiration

pneumonitis are common in elderly and disabled individuals and it is a common cause of death in this group of people. The State Forensic Pathologist noted that Miss Bentley's cerebral palsy contributed to her death and he also discovered at autopsy that she had suffered a recent myocardial infarct (heart attack). He further stated that there were no injuries to Miss Bentley suggestive of poor treatment or abuse. I accept his opinions, which accord with the evidence in the investigation.

- d) Ms Bentley died on 28 March 2021 at the North West Regional Hospital, Burnie, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into Miss Bentley's death. The evidence includes:

- The police and hospital reports of death for the coroner;
- Affidavits confirming life extinct and identification;
- An opinion of the State Forensic Pathologist who conducted the autopsy;
- The results of toxicological analysis of blood samples taken at autopsy;
- Affidavit and subject report of Detective Senior Constable Luke Negri, investigating officer;
- Affidavit of a Forensic Services officer, together with photographs;
- Affidavits and interviews of Kelly Hite, Gwyneth Pyke, Anthony Tabart, Leander Griffiths and Maxine Munting, staff members of Emily 7;
- Multicap Tasmania Inc. records relating to Miss Bentley;
- Records from the National Disability Insurance Scheme;
- Records from Ambulance Tasmania;
- Records from Tasmania Health Service; and
- Review by the Coronial medical consultant, Dr A J Bell.

Comments and Recommendations

The death of Miss Bentley was due to natural causes and was not an unexpected death, particularly in the context of her recent deterioration in health. On this basis, her death was not one reportable to the coroner. In fact, a death certificate was properly issued by a treating doctor immediately following her death.

However, the day after Miss Bentley's death, the National Disability Insurance Scheme notified the Coroner's Office that an incident report on the Multicap reporting system had been made by a staff member at the facility. The staff member alleged in the report that another staff member of the facility had, on 16 March 2021 (12 days before Miss Bentley's death), forcefully fed Ms Bentley's sustagen drink to her, which may have contributed to her aspiration pneumonia and death.

On the basis that this report may have had some veracity, police officers investigated the case on my behalf. As a result of the investigation, I am satisfied that the incident report alleging inappropriate feeding of Miss Bentley has no substance whatsoever. I am further satisfied that the carer who fed Miss Bentley, and who was the subject of the allegation, was an experienced and professional staff member who had been appropriately caring for Ms Bentley for nine years. It would appear that the motivation for the incident report against that staff member related substantially to particular work grievances.

It is clearly important in the care of vulnerable persons that genuinely concerning incidents are brought to the attention of management or authorities. However, this was not such a matter and, most unfortunately, has resulted in a prolonged and unnecessary coronial investigation and distress for the staff member who was the subject of the report.

The circumstances of Miss Bentley's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act 1995*.

I extend my appreciation to investigating officer, Detective Senior Constable Luke Negri for his investigation.

Dated: 19 August 2022 at Hobart Coroners Court in the State of Tasmania.

Olivia McTaggart
Coroner