IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 000067

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: LORRAINE THERESE PATRICK

Delivered On:	18 September 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne
Hearing Dates:	18 September 2012
Findings of:	HEATHER SPOONER, CORONER
Police Coronial Support Unit	Leading Senior Constable Nadine Harrison

I, HEATHER SPOONER, Coroner having investigated the death of LORRAINE PATRICK
AND having held an inquest in relation to this death on 18 September 2012
at Melbourne

find that the identity of the deceased was LORRAINE THERESE PATRICK
born on 15 April 1965
and the death occurred on 5 January 2011
at Box Hill Hospital, Nelson Road, Box Hill, Victoria 3128

from:

1a. ASPIRATION PNEUMONIA

in the following circumstances:

1. Ms Patrick was aged 45 when she died. She lived in a community residential care unit situate at 4 Regan Street, Box Hill. This unit was managed by the Department of Human Services (DHS). Ms Patrick had a past medical history that included Downs Syndrome, epilepsy and non verbalisation

2. A police investigation was conducted into the circumstances surrounding the death. As Ms Patrick was 'a person placed in care' of DHS as defined in S.3 *Coroners Act 2008* a mandatory inquest was convened pursuant to S.52(2)(b) of the Act.

3. A summary of the investigation was produced and read to the Court:

> *"Ms Patrick was a 45 year old female. Ms Patrick lived at a Department of Human Services (Disability Accommodation Services) house at 4 Regan Street, Box Hill. This was a high care facility.*
>
> *On 2 January 2011, Ms Patrick had cold and flu symptoms. In the early hours of 3 January, Ms Patrick was breathing noisily. She was seen by a locum who advised she be admitted to hospital. She was admitted to Box Hill Emergency Department at 0509 hours on 3 January 2011 as she was suffering from aspiration pneumonia. Staff tried non-invasive ventilation which was unsuccessful. Ms Patrick was still coughing with noisy breathing and had high-grade fever. Ms Patrick had low blood pressure (hypotensive), high heart rate (tachycardic) and low oxygen level (hypoxic). Ms Patrick was given antibiotics – ceftriaxone and metronidazole.*

Ms Patrick was admitted to Intensive Care Unit (ICU) 0800 on 4 January as her condition had not improved. Ms Patrick still had low oxygen level and widespread coarse crackles in lungs. Ms Patrick's family was consulted and still wanted full active management. Staff tried a non-invasive mask which was successful. The family was again consulted at 1840 on 4 January and informed that Ms Patrick's condition was worsening. Ms Patrick looked uncomfortable, was agitated and distressed.

A decision was agreed upon that further invasive therapies were inappropriate for Ms Patrick. Ms Patrick was suffering discomfort with laboured breathing and was in distress. Staff gave her morphine and medaziacent to relieve pain. Ms Patrick's condition continued to deteriorate. Family was consulted and it was agreed full comfort care would be given. Ms Patrick was certified deceased at 2310 on 5 January 2011."

4. An external examination and inspection was performed by Dr Woodford, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr Woodford formulated the cause of death and commented in part in his report:

"The deceased was a 46 year old female who lived at a DHS facility in Box Hill (high level care) and had a history of Down's syndrome, epilepsy and nonverbalization. On the 2nd January, 2011 she reportedly experienced cold and flu-like symptoms and was seen by a locum the following day. She was transported to Box Hill Hospital where she was diagnosed with aspiration pneumonia. Non-invasive ventilation was attempted at first but as this was unsuccessful she was transferred to Intensive Care (hypoxic, hypotensive and febrile). She was intubated and received broad spectrum antibiotics. Despite these treatment measures there was no improvement in her condition and after further discussions with family members she received palliative care. She died on the 5th January, 2011 at 2310 hours. According to a medical deposition, her history also included a right total knee replacement.

Examination of a postmortem CT scan shows the presence of a metal prosthesis in the right hip. There are opacities at the left lung base and bilateral pleural fluid. The brain appears atrophic (moreso in the occipital lobes and in the cerebellar hemispheres).

External examination of the body shows findings consistent with the history.

According to the medical deposition, an opinion as to the cause of death was 'aspiration pneumonitis'. There were no specific issues to be addressed at autopsy."

5. Although there were no care issues identified at the time of initial family contact, some concerns were raised in a statement from Mrs Carmel Peterson, Ms Patrick's sister and guardian. These concerns were referred to the Health and Medical Investigation Team (HMIT).[1] After reviewing the statements and medical records it was noted that the statements from the facility supervisor and the person feeding Ms Patrick on 2 January 2011 did not indicate a particularly dramatic episode of choking during the meal but rather an episode of coughing while eating, noting some food in the product of the cough. The HMIT review concluded that the facility workers response appeared reasonable including contacting the locum service. There was quite a wait from 6.30pm to 4.00am until the locum arrived and recommended sending Ms Patrick to hospital by ambulance. It was also noted that there is often a wait for locums and that nonetheless there did not appear to be great urgency at the time.

6. It is apparent that Ms Patrick unfortunately died from aspiration pneumonia. Although there was an apparent wait involved in the attendance of the locum service, Ms Patrick's overall management in the period leading up to her demise did not appear unreasonable.

I direct that a copy of this finding be provided to the following:

The family of Ms Lorraine Patrick;
Investigating Member, Victoria Police;
Interested parties.

Signature:

HEATHER SPOONER
CORONER
Date: 18 September 2012

[1] The role of the Health and Medical Investigation Team (HMIT) is to assist the Coroner's investigation into the nature and extent of deaths, which occurred during the provision of healthcare and identify potential system factors in healthcare related deaths. HMIT personnel comprise of practising Physicians and Clinical Research Nurses who draw on their medical, nursing and research experiences, skills and knowledge, to independently evaluate clinical evidence for the investigation of reportable healthcare deaths and to assist in identifying remediable factors that may assist in prevention and risk management in health services settings.