FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 3359/09

Inquest into the Death of DONNA LAVINIA NARELLE VICKY FAURE

Delivered On:	9th December 2010
Delivered At:	Melbourne Magistrates Court
Hearing Dates:	4th November 2010
Findings of:	Coroner PARESA ANTONIADIS SPANOS
Representation:	Sergeant Tracey WEIR, Police Coronial Support Unit, to assist the Coroner

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In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

Details of deceased:

Surname: FAURE

First name: DONNA LAVINIA

Address: 79 Telopea Crescent, Mill Park, Victoria 3082,

AND having held an inquest in relation to this death on 4 November 2010,

at Melbourne

find that the identity of the deceased was DONNA LAVINIA FAURE also known as DONNA LAVINIA NARELLE VICKY FAURE born on the 20th March, 1970

and that death occurred on the 8th July, 2009

at Broadmeadows Health Service Palliative Care Unit, 35 Johnstone Street, Broadmeadows 3047

from: 1(a) NEUROLOGICAL DISORDER OF UNKNOWN CAUSE
1(b) RIGHT AXILLA ABSCESS

in the following circumstances:

1. Ms Faure was a thirty-nine year old woman with a neurological disorder first diagnosed when she was six years old but of unknown cause despite extensive investigations during her life. She also suffered from hypertension, recurrent aspiration pneumonia, cholelithiasis and visual impairment. Ms Faure required 24 hour care, assistance with all the activities of daily living including feeding, could not communicate verbally and, during the last years of her life, was wheelchairbound.

2. Since 15 May 1993, Ms Faure resided at 79 Telopea Crescent, Mill Park, a group home managed by the Department of Human Services where 24 hour care was available. Her previous

residence had been the Lonsdale Nursing Home in Northcote. When she was otherwise well, Ms Faure participated in a day programme three times a week. Ms Gwendoline Faure, Ms Faure's mother, remained her legal guardian throughout her life.

3. On 17 June 2009, staff at Telopea Crescent found Ms Faure unwell and noticed a lump in her armpit. They made an appointment for her to be seen by her GP Dr Al Mullah on 18 June 2009. He diagnosed an infection, prescribed antibiotics and paracetamol and requested a follow-up appointment for the next day. Later that day, Ms Faure was febrile (39°) and appeared generally unwell. She was seen by a Locum early on the morning of 19 June 2009 and later in the day by Dr Mullah who found her comfortable and did not change her medication regime.

4. On 21 June 2009, Ms Faure's right armpit was dark red in colour and felt hot to touch. Staff felt that she was generally unwell with lethargy, difficulty swallowing, a rattly chest, elevated temperature (39.5°), cyanosed lips and protruding tongue. Her mother was notified and an Ms Faure was taken by ambulance to the Northern Hospital Emergency Department. Ms Faure was admitted with a diagnosis of right axillary abscess and admitted to a ward.

5. On 22 June 2009, blood cultures grew Proteus mirabilis and mixed anaerobes. Antibiotic therapy and hydration continued, drainage of the abscess was attempted with limited success due to Ms Faure's anatomy, and her diet was modified to thick fluids and pureed diet to minimise the risk of aspiration. Ms Faure was reviewed by the Surgical Registrar who advised that surgical drainage of the abscess would be extremely difficult due to her anatomy. The Infectious Diseases unit also reviewed her and advised as to the appropriate antibiotics in light of the blood culture results. Mrs Gwendoline Faure was kept informed as to her daughter's treatment. On 26 June 2009 she agreed to a Limitation of Treatment Order to the effect that PEG or nasogastric feeding would not be appropriate in the event of further deterioration in Ms Faure's ability to swallow.

6. When further attempts at drainage of the abscess were unsuccessful on 30 June 2009, Mrs Faure agreed to a Palliative Care referral for her daughter. Ms Faure was reviewed by a Palliative Care Consultant who agreed that her transfer to the Palliative Care Unit was appropriate. Oral antibiotics were ceased on 2 July and the transfer to the Palliative Care Unit made on 3 July 2009. Ms Faure was treated palliatively thereafter until 8 July 2009 when she

passed away in the presence of her mother who had remained by her side for the last few days of her life.

7. There was no autopsy as Forensic Pathologist Dr David Ranson from the Victorian Institute of Forensic Medicine conducted an external examination in the mortuary, reviewed the relevant medical deposition and records, and advised that it would be reasonable to attribute the medical cause of Ms Faure's death to a *"neurological disorder of unknown cause and right axilla abscess"*.

8. Ms Faure's death was not initially reported to the coroner as the treating medical staff were under the impression that her death was not reportable. Her death was subsequently reported on the basis that she was a person "*held in care*" of the Department of Human Services.[1] In my view, Ms Faure's death was appropriately reported to the coroner. As a person held in care, her death was reportable irrespective of the cause, and the legislation mandates an inquest as part of the coronial investigation of the death. In this way, the legislation recognises the vulnerability of people in State care, the appropriateness of transparent and independent investigation of their death by the coroner, and implicitly invites appraisal of the relevance of their status and the adequacy of the care provided to them, to their death.

9. I find that Ms Faure died from the combined effects of a neurological disorder of unknown cause and right axilla abscess. I find no evidence of any want of clinical care or management on the part of the staff of, or the Secretary to, the Department of Human Services, or the medical and nursing staff of the Northern Hospital including the Broadmeadows Health Service Palliative Care Unit.

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 9th December, 2010

[1] See definition of a person held in care in section 3 of the *Coroners Act 1985* which applied at the relevant time. Ms Faure was immediately before her death "*a person under the control, care or custody of the Secretary to the Department of Human Services*", despite her mother remaining her legal guardian throughout her life.