IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 003276

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: PETER MALLIA

Delivered On:	20 August 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne Victoria
Hearing Date:	22 May 2013
Findings of:	CORONER K. M. W. PARKINSON
Representation:	Ms Amy Wood of counsel for Scope Victoria (Inc) instructed by DLA Piper Solicitors.
Police Coronial Support Unit Assisting the Coroner	Senior Constable Kelly Ramsey

I, K. M. W. PARKINSON, Coroner having investigated the death of **PETER MALLIA**
AND having held an inquest in relation to this death on 22 MAY 2013
AT MELBOURNE
find that the identity of the deceased was **PETER MALLIA**
born on 30 November 1963
and that the death occurred on 31 July 2011
at The Northern Hospital

from:

1(a) Severe Community Acquired Pneumonia;

1(b) Aspiration;

1(c) Critical Care Neuropathy;

2. Cerebral Palsy .

in the following circumstances:

1. An inquest was held into the death of Mr Peter Mallia on 22 May 2013. The following witnesses gave evidence in the proceedings: Ms Michelle Mallia; Ms Terry Martin Speech Pathologist; Ms Carmen Banfield, Ms Bronwyn Reeves and Mr Keith Strathdee, Disability Support Workers employed by Scope Victoria; Mr Gavin Cook, House Co-ordinator employed by Scope Victoria (Inc).

BACKGROUND AND CIRCUMSTANCES

2. Mr Peter Mallia was a 47 year old man who had a medical history of cerebral palsy with an intellectual disability. He also had anxiety and depression and behavioural disturbances. Peter resided at Corvey Road House, a disability services residential accommodation facility operated by Scope Victoria (Inc).

3. It initially appeared that the death occurred 'in care' and required reporting and a mandatory inquest. However it became apparent during the course of the proceeding that Peter was a recipient of privately arranged services and was not 'in care' as defined by s3 of the Coroners Act 2008. In those circumstances an inquest in this case was not mandatory and nor was

reporting of the death. There were however matters raised by family members as to the cause and circumstances of the death which required investigation.

4. Peter died at the Northern Hospital on 31 July 2011 and his death was certified by a medical practitioner as not unexpected and due to natural causes. The death was consequently not notified to the Coroner at that time.

5. The death was reported to the Coroner by Peter's sister, Ms Michelle Mallia, by way of a letter of concern dated 31 August 2011. The letter raised concerns relating to delay in transferring Peter to hospital and insufficient or inadequate management of his diet, failure to comply with speech pathologist recommendations and consequent resulting aspiration. Each of these factors were considered by family members to be contributory to the death.

6. There was no examination undertaken by a forensic pathologist, however it does not appear that any party contests the cause of death as described on the death certificate. The evidence including the medical records satisfies me that the cause of death is appropriately recorded in accordance with the death certificate as:

    1(a) Severe Community Acquired Pneumonia;

    1(b) Aspiration;

    1(c) Critical Care Neuropathy;

    2. Cerebral Palsy.

7. Peter had a medical history of cerebral palsy and aspiration. The cerebral palsy resulted in swallowing difficulties and he was prone to aspiration and consequent respiratory complications.

8. Peter was a resident at supported accommodation operated by Scope Victoria (Inc) at 11 Corvey Road in Reservoir. He had been a resident of Corvey Road for two years.

9. On Saturday 21 May 2011, he was detected to have flu-like symptoms, and over the successive days, staff had become concerned that his health was deteriorating, noticing shallow breathing and increasing weakness.

10. On 21 May, he had been in bed on account of feeling unwell. At approximately 3 pm., he was located by a staff member out of bed, crawling around on the floor. His breathing was noted to be laboured, which was not evident when he was in bed. It is believed Peter fell as he was getting dressed. Later that evening Peter was observed by staff to be lying on the floor and 'acting out' for five minutes before getting up by himself. At that time staff did not observe that he had sustained any injuries, including grazes or abrasions.

11. On Sunday 22 May, Peter was checked by a staff member at 7 a.m., in relation to his flu symptoms. At approximately 7.20 a.m., Peter fell on his way to the toilet. This was brought to staff attention by a fellow resident. He was found seated on the toilet, and on investigation, red marks were seen on the right side of his face and the left side of his forehead. Peter also had a grazed right knee, and inside left elbow. Staff believed that the abrasions resulted from carpet abrasion.

12. He was helped back to bed and suffered another fall in transit. Peter complained of being ill, with a sore throat and stomach. A doctor was contacted and attended at the facility. The doctor was a locum and not Peter's regular general practitioner. Management was focussed on Peter's chest infection. The doctor did not recommend transfer to hospital and advised rest and fluids.

13. At 7.40 p.m. that evening, Peter was found crawling on the floor from his bedroom to the hallway. He had not alerted staff of his need to go to the toilet, notwithstanding regular hourly checks. The Corvey Road resident coordinator was alerted and advised the staff to use a wheelchair to prevent Peter's crawling on the floor.

14. On Monday 23 May 2011, at approximately 1 p.m., Peter was seen at Corvey Road, by his regular general practitioner, Doctor Richard McClelland. Doctor McClelland noted the carpet burns on Peter's face. Doctor McClelland managed his respiratory presentation with antibiotics and bed rest. He directed that if symptoms did not improve or there was a deterioration, Peter should be medically reviewed by his GP, or transferred to the hospital emergency department.

15. The evidence is that on the evening of 23 May, Peter was communicating by telephone with a relative overseas and that he did not appear to have deteriorated. Staff continued to supervise and manage his condition in accordance with the doctor's instructions.

16. The following morning at approximately 8.30 a.m., Tuesday 24 May 2011, Peter was found lying in a wet bed. Staff became concerned at his lack of response in not moving or helping staff to sit up in bed. Advice was sought from senior managers as to his care, and permission obtained to manually handle Peter, to make him comfortable, and assist him physically until he was well. Staff were advised, if he did not improve, to call for medical assistance.

17. At 3.30 p.m., Peter was again reviewed and found unable to respond verbally, and looked unwell. A decision was made to transfer Peter to hospital however, an ambulance was not called until approximately 4.30 p.m.

18. Peter was transferred by ambulance to the Northern Hospital, where he was admitted to the intensive care unit. Intensive treatment was initiated and ultimately when there was no sustained improvement to his condition, palliative measures were provided. Peter died on 31 July 2011.

EVIDENCE AS TO CARE AND MANAGEMENT OF PETER'S RESPIRATORY CONDITION AND DECLINE

19. Family members were concerned that there had been a delay in the transfer of Peter to hospital for treatment when his respiratory condition declined and that this may have caused or contributed to his death. They were also concerned that inadequate diet management may have contributed to his aspiration and thus contributed to death.

20. Family members were also concerned in relation to the grazes and bruising identified when Peter was hospitalised and as to their origin. Family members stated that they had not had any experience of Peter falling onto the ground or dragging himself along the ground as a behavioural issue and were concerned therefore as to how the injuries occurred.

21. The evidence is that staff had experience of a number of difficulties with management of Peter's behaviour and that it was not unusual for him to fall onto the floor or refuse to move.

Peter had some behavioural difficulties, which staff managed as best they were able. These included lying on the floor and refusing to co-operate with staff and kicking and hitting out at staff on occasions. On occasions, Peter had refused to get up and dress to attend work or other activities, and the staff approach was to encourage him to do so. It was difficult for staff to identify on every occasion whether there was actual illness attenuating the refusal. From time to time staff enlisted the assistance of medical advisors in managing these aspects of his care.

22. Dr McClelland had treated Peter since 2004 and he stated that his general health was reasonable in view of his long-term problems of cerebral palsy, epilepsy and depression. He was prescribed Valium, Effexor and Sodium Valproate.

23. Dr McClelland reported:

> "Peter had significant motor difficulties secondary to his cerebral palsy, and this meant that walking was difficult, as was speech and swallowing. His psychological health was dominated by depression, and he had attempted suicide in 1991, which required hospitalisation, and a tracheotomy. In the years that he attended Oakhill Clinic, he was constantly trying to limit his daily routine, so that he did not have to leave his residential facility to go to work. There were frequent references from the staff that he was difficult to manage, that he would become agitated, abusive, and resistant.
>
> He had been referred to specialist help for his behavioural problems in 2001 and 2003. I was notified that Peter was admitted to the Northern Hospital on 6 April 2011 with behavioural issues. As part of his investigations, he was to have a fluoroscopy of his swallowing, and I was contacted on 16 May 2011 to provide information about his medications.
>
> I last saw Peter around 1 p.m., on 23 May 2011 at 11 Corvey Road Reservoir, which was his residence. He was attended by a staff member, who told me that Peter was being non-compliant with medication, and eating, and toileting. All these issues had been problems in the past.
>
> When I examined Peter, I was concerned that he was not well, with evidence of a possible respiratory tract infection. His breathing was erratic, and I had observed that before to be part of his cerebral palsy. He had a blocked nose, and was drooling, another effect of his cerebral palsy. Despite the drooling, I thought he may have been slightly dehydrated. He was flushed and restless, but alert and responding to speech.
>
> He was afebrile, and his chest was clear, but auscultation was difficult as he was lying in a daybed, or beanbag, on the floor of the day room. Chest auscultation was also difficult because of the drooling and erratic breathing. He had what appeared to be carpet burns on his head, and I was told these were due to him rolling on the floor and being resistant to attention from the staff. I considered the possibility of him having had a seizure recently, but the staff member was not able to confirm that this had happened.

> I concluded that Peter had a respiratory tract infection that was aggravated by his poor airway secondary to his tracheostomy, and his cerebral palsy. Further, that his resistant behaviour had lead to a degree of dehydration, and increased agitation. I ordered some antibiotic, Rulide, to be commenced and that his fluid be encouraged. I asked Peter to be cooperative with the staff, that it was important to comply with fluids, and his medication. As a routine, I said that if he was no better over the succeeding 24 hours, Oakhill Clinic should be called, or an ambulance to take him to hospital. I felt that if he did not improve, a chest X-ray may help in the diagnosis."

Conclusion as to the circumstances in which abrasions and grazing injury was sustained

24. I accept the evidence of staff members as to the circumstances in which the injuries were sustained and that it is consistent with the history provided by and to the treating General Practitioner.

25. I am satisfied that there were no suspicious circumstances and that the abrasions and grazing which were observed by family members, were sustained during the course of Peter placing himself on the floor of the facility and dragging himself along the floor.

26. I am not satisfied that the abrasions or grazing apparent in the photographs taken by Ms Mallia were matters contributory to Peter's death or that they were evidence of any lack of care by the facility or evidence of any physical violence directed by staff towards Peter.

Conclusion as to the timing of the transfer to hospital and medical management between 21 May and 24 May 2011

27. Peter was transferred to hospital by ambulance on 24 May 2011. This was within 3 days of the respiratory condition arising and after there had been two consultations with medical practitioners arranged and occurring at the facility. On each of those occasions, the staff complied with the directions and requirements of the general medical practitioners regarding rest, review and medication. During this time, Peter was being treated with antibiotic therapy, which may have been expected to take some effect in that period.

28. The time elapsing between the observation on 24 May that Peter was not improving and was in fact declining, was a period of hours. Whilst an earlier transfer might have been arranged in the morning of 24 May, the evidence does not support a conclusion that this period of hours

was significant in terms of the deterioration of his condition, or in relation to the capacity of the hospital to intervene and to attempt to treat the respiratory illness once he was admitted.

29. Peter was hospitalised on 24 May 2011 and actively treated for a period of two months prior to his death on 31 July 2011. During the course of his illness, there were improvements and then further decline in his condition. The evidence does not support a conclusion that earlier admission to hospital would have resulted in a different outcome. I am satisfied that the medical and personal care provided was reasonable and appropriate.

Management of his dietary requirements and speech pathologists recommendations

30. Peter had a number of complicating factors arising from the cerebral palsy, which pre-disposed him to complication including respiratory illness. These were discussed by the speech pathologist, Ms Terry Martin. Ms Martin stated that results of video fluoroscopy in 2008 confirmed that Peter had moderate to severe dysphagia affecting his mouth and throat. He had difficulty with lip closure and co-ordination when eating and drinking as well as reduced co-ordination, strength and accuracy of chewing. Peter had reduced control and co-ordination of his tongue and his swallowing reflex was delayed and poorly co-ordinated with breathing. These factors led to Peter's airway being poorly protected which increased the risk of laryngeal penetration, that is, food or drink entering his airways and therefore an increased risk of aspiration – namely food or drink entering his lungs. Further, food or drink was likely to remain in Peter's throat after he swallowed with the risk of spillage into his airways and therefore an increased risk of aspiration. Ms Martin made certain recommendations as to food preparation and supervision of meals, which were adopted.

31. A further video fluoroscopy was conducted in April 2011 when he was hospitalised and findings again recommended soft cut up food and mildly thick fluids with close monitoring of Peter's eating and drinking to reduce the risk of aspiration and consequent risk of chest infection. Ms Martin developed another mealtime profile, which she provided to staff, Mr Cook and Ms Strathdee. Ms Martin also discussed the recommendations with Peter.

32. Ms Martin stated that she was satisfied that the meals he was provided and their supervision was appropriate and in accordance with her advice. There is no evidence to suggest that the meals were not appropriate or were not supervised in the manner recommended.

33. Ms Martin's evidence was that whilst such a meal plan is designed to reduce risk arising from a person's poor swallowing, it is not possible to remove the risks posed by the dysphagia.

34. I am satisfied that the facility provided appropriate care and supervision of food and drinks in accordance with the recommendations of the speech pathologist and that despite these measures Peter remained at risk of the aspiration due to dysphagia and consequent infection which occurred in this case.

FINDING AS TO CAUSE OF DEATH

35. I find that Mr Peter Mallia died on 31 July 2011 and that the death was due to Severe Community Acquired Pneumonia; Aspiration; and Critical Care Neuropathy in a man with Cerebral Palsy.

36. I find that Mr Peter Mallia died of natural causes and that no person caused or contributed to his death.

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

    The family of Mr Mallia;
    The interested parties;
    The Investigating Member

Signature:

CORONER K. M. W. PARKINSON
Date: 20 August 2013

Coroners Court of Victoria