CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Vakabauta Leone
Hearing date:	22 September 2021
Date of findings:	22 September 2021
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – natural causes death of a person in lawful custody – whether a 'not for resuscitation' directive was in place.
File number:	2019/ 84693
Representation:	Coronial Advocate assisting the inquest: Sergeant T O'Donnell International Health and Medical Services: Moray & Agnew. RN M Gapasin: Kennedys. RN Malla-Paudel: NSW Nurses and Midwives Association. Fairfield Nursing Home: Colin Biggers & Paisley Lawyers. SERCO: Corrs Chambers Westgarth.

Findings:	**Identity** The person who died is Vakabauta Leone. **Date of death**: Vakabauta Leone died on 15 March 2019. **Place of death**: Vakabauta Leone died at Liverpool Hospital, Sydney 2170. **Cause of death:** Vakabauta Leone died as a result of complications of rapidly progressing motor neurone disease. **Manner of death:** Vakabauta Leone died from natural causes, while she was in lawful custody.

1. Section 81(1) of the Coroners Act 2009 (NSW) [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

2. These are the findings of an inquest into the death of Vakabauta Leone.

Introduction

3. On 15 March 2019 Vakabauta Leone aged 47 years died in Liverpool Hospital, in south western Sydney.

4. Although Ms Leone had been living in an aged care home at the time of her death due to her terminal illness, she was in fact in immigration detention. She was therefore in lawful detention, and an inquest into the circumstances of her death is mandatory pursuant to sections 23 and 27 of the *Coroner's Act 2009*.

The role of the Coroner

5. The Coroner must make findings as to the date and place of a person's death, and the cause and manner of death.

6. In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

Ms Leone's life

7. Ms Leone was born in Fiji on 29 May 1971, the youngest of five children. Her father died when she was young and her mother raised the children with the help of relatives.

8. After her schooling Ms Leone completed a diploma of business studies. She spent some years working in Fiji until she and her husband Tavei Iliesa were granted visitors' visas to come to Australia. The couple arrived here on 19 July 2010. They did not have children, and they divorced in 2016.

9. On 16 January 2017 Ms Leone was convicted of an offence of setting fire to a hotel room in Tolland, Wagga Wagga. She was sentenced to twelve months imprisonment, and her Australian visa was cancelled on character grounds pursuant to the *Migration Act 1958*. It was thought that at the time of the offence Ms Leone was suffering a brief psychotic episode or the early stages of schizophrenia.

10. While awaiting deportation, on 20 January 2017 Ms Leone was transferred from Mulawa Correction Centre to custody in Villawood Detention Centre.

Ms Leone's medical treatment while detained at Villawood

11. The agency responsible for the medical care and treatment of detainees at Villawood is International Health and Medical Services.

12. When she went into custody Ms Leone had a documented history of hypertension, for which she used prescribed medication. Then in May 2017 she was diagnosed with Cushing's Syndrome, a metabolic disorder which causes the body to produce too much cortisol. She developed symptoms secondary to this condition, including memory loss. Surgery was performed in December 2017, and this improved her memory loss and her general physical and mental fitness.

13. During 2017 Ms Leone was required to take medication for diabetes, which is another condition associated with Cushing's Syndrome. Her blood sugar levels were regularly monitored and she stabilised on her medication. She was able to cease her medication in March 2018.

14. In October 2018 Ms Leone began to develop difficulties speaking and swallowing. She was also experiencing weakness in her upper arms. She was transferred to Bankstown Hospital and she underwent extensive neurological investigations. These resulted in the diagnosis in November 2018 of motor neurone disease. This is a devastating neurodegenerative condition. It causes rapidly progressing weakness in the muscles which allow a person to move, speak, swallow and breathe. It is incurable.

15. Ms Leone was discharged from hospital with treatment plans that included regular neurological review, speech pathology, respiratory and palliative

care. She was also placed on a soft diet due to her swallowing difficulties. As her condition progressed, it became impossible for her to take food and drink by mouth, and in December 2018 she was readmitted to hospital for a feeding tube to be inserted.

16. After this procedure Ms Leone did not return to Villawood Detention Centre. It was decided she would live at Fairfield Aged Care Home, where she could receive the 24 hour care which she now needed.

17. The evidence establishes that the medical care and treatment which Ms Leone received while she lived in Villawood Detention Centre was of an appropriate standard.

Ms Leone's medical treatment at Fairfield Aged Care Home

18. Ms Leone's motor neurone disease progressed quickly, and by the time she went to live at Fairfield Aged Care Home she was losing the ability to speak. She communicated with her carers by using her hands or writing on a whiteboard. Because of her feeding tube she needed regular oral suctioning due to the build up of saliva in her mouth. She also required a large number of medications.

19. While she was living at the Aged Care Home Ms Leone received regular visits from her sister, Pasepa Vodivodi.

20. Ms Leone was taken to Liverpool Hospital for fortnightly reviews of her condition. Her last hospital admission was on 27 February 2019, after which she was discharged back to the Aged Care Home on 4 March 2019. The hospital records noted the rapid progression of her motor neurone disease, and indicated that hospital staff had discussed with Ms Leone her care needs as follows:

'*Discussed with patient ceiling of care – when develop aspiration pneumonitis/pneumonia, not for antibiotics, but for escalation crisis meds ...'*

21. On her return from hospital Ms Leone wrote on her whiteboard that she had been told she only had a couple of weeks to live. She decided she wanted to be baptised, and on 7 March 2019 a baptism ceremony was held at the Aged Care Home.

The night of 14 March 2019

22. On the night of 14 March 2019 Registered Nurse Marilou Gapasin was caring for Ms Leone. At 10.40pm and 11.30pm RN Gasparin checked on her, and on both occasions she saw that Ms Leone was awake and lying on her bed. Ms Leone gave her a 'thumbs up' indicating she was alright.

23. At about 1.00am on 15 March 2019 Ms Leone's buzzer rang for assistance. Sharon Neeson, who was at that time an Assistant in Nursing, responded and saw Ms Leone walking towards the bathroom and then

sitting on a chair inside the bathroom. On a whiteboard Ms Leone wrote: '*I am not feeling too well'*. Ms Neeson called on RN Gapasin for assistance. Ms Leone then wrote: '*I need to be suction'*. This was due to the build up of saliva in her mouth.

24. Both carers helped Ms Leone back to her bed and proceeded to suction her. RN Gapasin then attempted to carry out vital sign observations. At this point Ms Leone slumped backwards and her blood pressure readings fluctuated wildly. RN Gapasin ran to call for an ambulance. While putting Ms Leone into the recovery position Ms Neeson saw that she had stopped breathing. She ran from the room to get help from Registered Nurse Rama Malla-Paudel, but on their return a few minutes later they found Ms Leone unresponsive and without a pulse. Her pupils were fixed and dilated.

25. RN Malla-Paudel did not commence CPR. In her statement she said that according to her understanding, when Ms Leone entered palliative care at the Aged Care Home she had said she did not wish to be resuscitated. She asked RN Gapasin to cancel the ambulance, but at that point the ambulance crew arrived. According to NSW Ambulance records, it was now 1.14am. This was several minutes after Ms Leone's collapse and loss of breathing, during which time she had not been administered CPR.

26. When the ambulance paramedics asked to see a copy of Ms Leone's 'not for resuscitation' order, none could be found. The paramedics commenced CPR and eventually achieved a return to spontaneous circulation, which was maintained with adrenaline.

27. Ms Leone was then transported to Liverpool Hospital. She was intubated and placed on a ventilator. However after a neurological assessment the next day and discussions with her family, her life support was removed and she was pronounced deceased at 3.22pm.

The post mortem report

28. An external examination of Ms Leone's body was performed by forensic pathologist Dr Kendall Bailey. On the basis of her examination and the Liverpool Hospital records, Dr Bailey concluded that the cause of Ms Leone's death was the complications of rapidly progressing motor neurone disease. Dr Bailey noted that respiratory distress is a common mechanism of death where a person suffers motor neurone disease.

Had Ms Leone made a 'Do Not Resuscitate' directive?

29. Overall the care and treatment which Ms Leone received at the Fairfield Aged Care Home appears to have been appropriate. One issue however required further examination at the inquest. This was the question why nursing staff did not attempt to resuscitate Ms Leone on the night of 14 March 2019, prior to the arrival of the ambulance.

30. The evidence is not entirely clear why the nurses who were on duty that night did not commence CPR when they noticed that Ms Leone was not breathing. RN Malla-Paudel appeared to have had the impression that Ms Leone had verbalised a wish not to be resuscitated. RN Gapasin simply stated that she would not expect to commence CPR if a resident had an advanced care directive in place advising resuscitation was not to be performed.

31. The evidence is that Ms Leone had not documented a 'not for resuscitation' directive. Further, there is no evidence as to whether she expressed any such wish to staff at the Aged Care Home, or whether staff ever encouraged her to make her wishes known in this regard. This is not to say that such discussions did not take place. If they did, they were not documented.

32. At the request of those assisting the inquest, a statement was obtained from Ms Jennifer O'Connell, who is the NSW Director of Quality and Education for the company which owns and manages the Fairfield Aged Care Home. She advised that at the time of Ms Leone's admission to the Aged Care Home, the following policies were in place:

- when a resident was admitted, a comprehensive care plan was developed. It included a section regarding the resident's palliative care preferences and end of life care preferences

- the resident and their family were encouraged to discuss with their doctor, and to document, a care directive which expressly states the resident's preferences regarding resuscitation, in the event the resident experienced a change to their health status

- registered nurses were expected to be aware of residents' resuscitation plans and orders. A copy of the care plan and resuscitation directive was kept in the Registered Nurse's office

- however, residents could not be compelled to complete or to express a care directive regarding resuscitation

- if a resuscitation directive was not in place, nurses would be expected to exercise their individual clinical judgement as to whether to administer CPR.

33. The evidence at inquest indicated that on the night Ms Leone collapsed, nursing staff were unclear if she had a 'not for resuscitation' directive, either in document or verbal form. While I accept that the involved nurses acted at all times in good faith, their uncertainty on this point appears to have been contrary to the policy at the Aged Care Home.

34. In fairness to the involved nurses however, it is clear that Ms Leone knew that she was in the advanced stages of a terminal illness, and that her condition was deteriorating rapidly. It is entirely possible she did not wish for resuscitation that night.

35. Furthermore, the Aged Care Home's policy provided that, in the absence of a resuscitation directive, nurses were expected to exercise individual judgement as to whether to administer CPR. I accept that when Ms Leone commenced living at the Fairfield Aged Care Home, her death was recognised as a natural progression of her disease's process. There was no prospect of a cure, her condition was deteriorating, and she was not expected to live much longer. Given this, I do not think it would have been unreasonable for RN Malla-Paudel to have concluded, on the night of 14 March 2019, that it was not appropriate to attempt her resuscitation.

36. For these reasons, I do not criticise the nursing staff at Fairfield Aged Care Home for not attempting to resuscitate Ms Leone.

37. Nevertheless the circumstances that night do give rise to some concern about the lack of clarity among staff as to Ms Leone's resuscitation status. There was uncertainty as to whether she had documented or expressed a 'not for resuscitation' directive. On the incorrect assumption that she had, the nurses did not commence resuscitation. When the nurses were unable to provide ambulance officers with evidence of it, this led to a significantly delayed resuscitation effort. It is not known if the delay had any effect on Ms Leone's prospects for surviving her collapse that night.

38. There was a need for greater clarity that night as to Ms Leone's resuscitation status.

39. Ms O'Connell advised that since Ms Leone's death, she has become the convenor of a Working Group which will develop clear policies regarding the circumstances in which CPR would be expected to be administered to residents. Staff will then be trained in these policies, as well as in policies for developing care plans and resuscitation directives, and how to engage in discussions with residents and families about these. The work which is planned to be done in this area is commendable, and it obviates the need for me to make recommendations in this area, arising out of this inquest.

Cause and manner of death

40. The cause of Ms Leone's death is able to be established as complications of rapidly progressing motor neurone disease. The manner of her death is natural causes, while she was in lawful custody.

Conclusion

41. I express to Ms Leone's family my sincere sympathy for their loss.

42. I thank Coronial Advocate Timothy O'Donnell for his assistance in the preparation and conduct of this inquest. I thank also the Officer in Charge of the coronial investigation, Senior Constable Yen Tran, for her preparation of the brief of evidence.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity
The person who died is Vakabauta Leone.

Date of death:
Vakabauta Leone died on 15 March 2019.

Place of death:
Vakabauta Leone died at Liverpool Hospital, Sydney 2170.

Cause of death:
Vakabauta Leone died as a result of complications of rapidly progressing motor neurone disease.

Manner of death:
Vakabauta Leone died from natural causes, while she was in lawful custody.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner
Lidcombe

22 September 2021