IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002843

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Denise Lucina Roberts
Date of birth:	22 March 1960
Date of death:	Between 14 and 28 May 2023
Cause of death:	1(a) Combined features of bronchopneumonia, emphysema and ischaemic heart disease on a background of a probable long lie period on the ground with hypothermia in a malnourished woman
Place of death:	408/2 Cooke Court, Richmond, Victoria
Keywords:	Missed appointment – Patient follow-up – Notification protocol

INTRODUCTION

1. On 28 May 2023, Denise Lucina Roberts was 63 years old when she was found deceased at home. At the time of her death, Ms Roberts lived alone in Richmond.

BACKGROUND

2. Ms Roberts' medical history included depression, anxiety, liver cirrhosis and gastro-oesophageal reflux disease. She had a history of illicit drug use, namely heroin, methamphetamine and marijuana, and had become dependent on Valium (diazepam) and Panadene forte (codeine).

3. Ms Roberts first attended North Richmond Community Health (**NRCH**) in July 2012 and attended infrequently throughout 2014. From February 2016, she became a regular patient of the clinic for treatment of her diazepam dependence, hepatitis B and C, and podiatric issues. Ms Roberts' previously consulted general practitioner Dr Gloria Moscattini on a regular basis, but Dr Hamish Scott became her regular treating doctor at the clinic from November 2022.

4. In her statement to the Court, Ms Roberts' daughter, Elysia Roberts, explained that their relationship was occasionally strained due to her mother's drug and alcohol use. Elysia recalled that their bond was stronger during her mother's periods of abstinence from illicit drugs, and Ms Roberts reportedly acknowledged the trauma she had experienced throughout her life as a result of heroin use.

5. Approximately 11 years prior to her death, Ms Roberts ceased using heroin regularly and only had it "*once in a blue moon over the years*". At around this time, Elysia moved to Richmond, living in the block beside her mother, and they grew increasingly close. Elysia recalled that her mother used methamphetamine infrequently at this time, often on weekends or close to her pay day, but she was "*still functional*" despite her prescription medication use. Ms Roberts was able to attend social gatherings and outings with her grandson, Elysia's son, Jason, several times a week; however, Elysia would not see her mother or allow her to see Jason when she was drug affected.

6. When Elysia later moved house, she observed a change in her mother's demeanour but they maintained contact and Ms Roberts continued to regularly visit the shopping centre with Jason. In her statement to the Court, Elysia recalled that at their last family gathering on 6 March 2021, her mother "*looked great, she was happy*" despite still using illicit drugs.

Ms Roberts' drug use apparently increased throughout Covid-19 lockdowns in Melbourne, which placed further strain on her relationship with Elysia.

7. According to Elysia, Ms Roberts was "*still looking great and happy*" when they saw each other briefly in April 2022; however, Elysia began to receive abusive text messages from her mother at all hours in around May 2022.

8. On 8 May 2022, Elysia received a text message from her mother saying, "*she was in pain and couldn't walk and she needs her medication (Valium)*". She recalled that her mother suffered anxiety regarding a much-needed surgery for her feet, which resulted in multiple missed appointments.

9. Growing concerned about her mother's drug use and its impact, Elysia confronted her in around December 2022. She recalled their conversation was positive and Ms Roberts expressed a fear of dying and being unwell. Ms Roberts reportedly advised her daughter that she would consult a doctor. Elysia recalled that her mother was also smoking marijuana throughout this time.

10. By end the of December 2022, Elysia had ceased contact with her mother due to her abusive messages and phone calls.

11. On 3 January 2023, Elysia contacted Dr Scott, who reportedly advised that her mother was "*fine…is there every week same time and there is nothing to worry about*". Ms Roberts' medical records confirm that Elysia conveyed her concerns to Dr Scott regarding Ms Roberts' drug use and that she had posted on social media to the effect that she wanted to be with her deceased father and sister.

THE CORONIAL INVESTIGATION

12. Ms Roberts' death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

13. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

14. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

15. This finding draws on the totality of the coronial investigation into Ms Roberts' death, including evidence contained in medical records from North Richmond Community Health (**NRCH**), and statements provided by Elysia Roberts and Practice Manager Clara Titus on behalf of NRCH. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

16. At approximately 9.00am on 8 May 2023, Ms Roberts' left a voice message for Elysia, however the message was indecipherable as her speech was slurred.

17. On 9 May 2023, Ms Roberts attended a consultation with Dr Scott to collect her diazepam prescription and provide a blood sample for routine pathology. A further routine appointment was booked for 16 May 2023, however she did not reattend. Ms Roberts' failure to attend the appointment does not appear to have been recorded within her NRCH records.

18. On 14 May 2023, Ms Roberts sent a text message to Elysia, however the message was not successfully transmitted due to insufficient funds.

19. On 28 May 2023, Elysia requested that Victoria Police conduct a welfare check for her mother as she had not heard from her since the voice message on 8 May 2023.

20. At approximately 1.00pm, members from Victoria Police and from Fire Rescue Victoria attended Ms Roberts' apartment and forced entry via the front door. They observed Ms Roberts on the floor at the front door, lying in a curled-up position on her left-hand side. It was evident that Ms Roberts had been deceased for some time.

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

21. Police inspected the apartment and identified that the front door and security door were both locked from the inside. They observed multiple prescription medication packets near where Ms Roberts was located, including doxepin, diazepam, codeine, meloxicam and omeprazole. Police described the apartment as clean and undisturbed and did not identify any suspicious circumstances or third-party involvement in Ms Roberts' death.

Identity of the deceased

22. On 1 June 2023, Denise Lucina Roberts, born 22 March 1960, was identified via fingerprint identification.

23. Identity is not in dispute and requires no further investigation.

Medical cause of death

24. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine conducted an autopsy on 31 May 2023 and provided a written report of his dated 16 July 2023.

25. At autopsy, Dr Beer observed evidence of significant natural disease in the form of ischaemic heart disease, myocardial fibrosis and emphysema. Dr Beer noted widespread bronchopneumonia, and evidence of hypothermia and a possible prolonged lie.

26. Dr Beer did not observe any evidence of injuries that would have caused or contributed to the death but commented that Ms Roberts was markedly underweight.

27. Toxicological analysis of post-mortem samples detected the presence of codeine, doxepin, benzodiazepines (diazepam, nordiazepam, oxazepam), and paracetamol. Dr Beer noted that codeine was detected at a raised but non-lethal level, and antidepressant doxepin was detected at overlapping toxic and low lethal levels. He commented that the process of decomposition may increase the detected levels of certain substances and he did not consider either drug to have contributed to Ms Roberts' death.

28. Dr Beer also noted the absence of alcohol and excluded the possibility of acute ethanol toxicity as a contributing factor. Toxicological analysis did not detect any acetone, which excluded the effects of alcohol withdrawal (alcoholic ketoacidosis).

29. Dr Beer surmised that Ms Roberts' widespread bronchopneumonia and background of chronic lung disease likely precipitated her collapse on the ground, and that the effects of hypothermia coupled with her significant ischaemic heart disease and malnourishment also played a role in her death.

30. Dr Beer provided an opinion that the medical cause of death was 1(a) Combined features of bronchopneumonia, emphysema and ischaemic heart disease on a background of a probable long lie period on the ground with hypothermia in a malnourished woman.

31. I accept Dr Beer's opinion.

FAMILY CONCERNS

32. During the course of the coronial investigation, Elysia raised concerns about the lack of contact she received from NRCH staff after her mother failed to attend an appointment on 16 May 2023 as scheduled. Elysia advised the Court that she had understood she would be contacted by the clinic in the event her mother did not attend an appointment as she was considered a "*high risk*" patient.

FURTHER INVESTIGATION

33. In light of Elysia's concerns, I considered that further information was required from NRCH in order to better understand the circumstances of Ms Roberts' death.

34. In particular, NRCH was asked to outline any steps taken to follow up with Ms Roberts after she failed to attend an appointment following her consultation on 9 May 2023; and to confirm whether there was any agreement or policy in place for NRCH staff to contact a patient's Next of Kin in the event of a failure to attend for an appointment.

35. In a statement on behalf of NRCH, Practice Manager Ms Titus referred to the clinic's work instructions for "*Client Access to Care*", specifically "*4.6 Clients Who Fail to Attend*". Ms Titus explained that in circumstances where Ms Roberts was scheduled for a routine appointment, it was at the doctor's discretion to follow-up or to advise the administration team to do so. Further, the administration team would only contact a patient's Next of Kin and/or Emergency Contact where a consent was recorded in the patient's notes to make contact when an appointment is missed. Ms Titus confirmed that Ms Roberts' NRCH records did not contain any such consent.

36. Ms Titus advised that the clinic conducted an internal investigation following receipt of a complaint from Elysia via its online portal. Elysia advised NRCH that there had been an agreement in place with her mother's former treating doctor, Dr Moscattini, to contact Elysia in the event of a missed appointment. The NRCH internal investigation identified that the agreement with Dr Moscattini was in fact verbal and that Ms Roberts' records did not contain any documentation to this effect.

CONCLUSION

37. While I am satisfied that the clinic's approach to missed appointments is reasonable and appropriate, I consider that the agreement between Ms Roberts and her former treating doctor, whereby the clinic would contact her Next of Kin in the event she failed to attend an appointment, ought to have been formally documented in her records.

38. Ms Roberts' recent treating doctor, Dr Scott, would therefore have been alerted to the earlier agreement with Dr Moscattini and an attempt would have been made to contact Ms Roberts after she failed to attend her appointment on 16 May 2023. In circumstances where it was not unusual for Ms Roberts to consult other NRCH doctors on an ad hoc basis, whether due to the unavailability of her regular doctor or otherwise, it was all the more important that any arrangements be prominently displayed in Ms Roberts' patient file.

FINDINGS AND CONCLUSION

39. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Denise Lucina Roberts, born 22 March 1960;

    b) the death occurred between 14 and 28 May 2023 at 408/2 Cooke Court, Richmond, Victoria, from combined features of bronchopneumonia, emphysema and ischaemic heart disease on a background of a probable long lie period on the ground with hypothermia in a malnourished woman; and

    c) the death occurred in the circumstances described above.

40. The investigation has not revealed the precise timing of Ms Roberts' collapse, nor the period of time she may have been on the floor prior to her death. Accordingly, I am unable to conclude that a notification to Elysia on 16 May 2023 from NRCH would have prevented Ms Roberts' death.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation:

(i) That North Richmond Community Health review its practice to ensure that arrangements made between clinicians and a patient's next of kin regarding notification in the event of a patient's non-attendance at appointments are recorded in the patient's records.

I convey my sincere condolences to Ms Roberts' family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Elysia Roberts, Senior Next of Kin

Lyndsey Wagstaff, Australian Health Practitioner Regulation Agency (AHPRA)

Sergeant David Bower, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 15 May 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.