IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 004137

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Gaye Marie Darby
Date of birth:	10 February 1965
Date of death:	29 July 2023
Cause of death:	1(a) Aspiration Pneumonia Contributing Factors: Malnutrition, Trisomy 21 and Alzheimer's Dementia
Place of death:	St. Vincent's Hospital Melbourne 41 Victoria Parade Fitzroy Victoria 3065
Keywords:	In Care; Natural causes

INTRODUCTION

1. On 29 July 2023, Gaye Marie Darby was 58 years old when she died at St Vincent's Hospital Melbourne from natural causes.

2. At the time of her death, Ms Darby lived in Supported Disability Accommodation (**SDA**) in Hawthorn, Victoria, 3122 with five other participants. This arrangement was funded under Ms Darby's National Disability Insurance Scheme (**NDIS**) plan.

3. Ms Darby had a close relationship with her family who were very supportive and visited her accommodation regularly. This included her parents, Malcolm and Bev, two sisters Raylene and Sue, brother Mark, and their partners and children.

THE CORONIAL INVESTIGATION

4. Ms Darby's 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.

5. This is because, immediately before death, Ms Darby was a person "in care", meaning that she was an SDA resident residing in an SDA enrolled dwelling. The death of a person "in care" is a mandatory report to the Coroner even if the death appears to have been from natural causes.

6. Generally, the Coroner must hold an inquest into the death of a person "in care". However, under section 51(3A) and (3B) of the Act, the Coroner is not required to hold an inquest if the Coroner considers that the death was due to natural causes, on the basis of a report from a medical investigator which includes an opinion as such.

7. In this instance, I am satisfied on the basis of a report from Forensic Pathologist Dr Brian Beer of the Victorian Institute of Forensic Medicine (**VIFM**) dated 1 August 2023 that Ms Darby's death was due to natural causes and therefore that an inquest is not required. The report of Dr Beer is discussed further below in relation to the medical cause of death.

8. 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.

9. 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.

10. In this matter, taking into account the circumstances of Ms Darby's death, I conducted investigations including by obtaining and reviewing a copy of the Medical Deposition, Police Report of Death, and information from the National Disability Insurance Agency (**NDIA**).

11. This finding draws on the totality of the coronial investigation into the death of Gaye Marie Darby. Whilst 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

12. On 16 July 2023, Ms Darby presented to St Vincent's Hospital Melbourne with a three-week history of worsening anorexia and dysphagia and a suspected aspiration event five days preceding the presentation (choking, gurgling) with likely secondary aspiration pneumonia.

13. Family members reportedly described a notable decline in her function and quality of life in the previous two months, and longstanding difficulties relating to progressive dysphagia.

14. Ms Darby was initially treated with intravenous (**IV**) ceftriaxone for aspiration pneumonia and intravitreal therapy (**IVT**) for dehydration. She demonstrated initial clinical and biochemical improvement (CRP 208 -> 74).

15. In discussions with family, treating clinicians noted Ms Darby's improvement but emphasised that her dysphagia was ongoing, her swallow was likely to decline further, and she was likely to have ongoing aspiration events in the future with little reversibility possible, noting that she was already on the maximum modified diet and no further modifications were available.

[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.

16. In discussion with Ms Darby's family, it was determined that nasogastric tube feeding was not in her best interests and that risk feeding was appropriate in order to support quality of life. Risk feeding commenced on 20 July 2023.

17. On 21 July 2023, a further decision made in collaboration with family that Ms Darby was not for further parenteral antibiotics or fluid.

18. Over the weekend of 22-23 July 2023, Ms Darby deteriorated further and was noted to have apnoeic breathing and agitation.

19. In discussion with family, it was determined to shift treatment to palliative care.

20. Ms Darby later died on 29 July 2023.

Identity of the deceased

21. On 2 August 2023, Gaye Marie Darby, born 10 February 1965, was visually identified by her brother, Paul Darby.

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

Medical cause of death

23. On 31 July 2023, Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination and reviewed a post mortem CT scan, the Medical Deposition, and the Police Report of Death (Form 83). Dr Beer provided a written report of his findings dated 1 August 2023.

24. After reviewing the post mortem CT scan, Dr Beer noted findings of:

    a) Bilateral hip replacements.

    b) No acute fractures.

    c) Head – cerebral atrophy and moderate hydrocephalus.

    d) No intracranial haemorrhage.

    e) Chest - Extensive bilateral lower lobe consolidation with some upper lobe changes.

    f) Abdomen – nil significant.

25. The external examination showed findings in keeping with Ms Darby's known clinical history.

26. Dr Beer provided an opinion that the death was due to natural causes and a reasonable formulation for the medical cause of death was:

    1 (a) Aspiration Pneumonia

    Contributing factors: Malnutrition, Trisomy 21 and Alzheimer's Dementia.

27. I accept Dr Beer's opinion.

FINDINGS AND CONCLUSION

28. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Gaye Marie Darby, born 10 February 1965;

    b) the death occurred on 29 July 2023 at St. Vincent's Hospital Melbourne 41 Victoria Parade Fitzroy Victoria 3065, from aspiration pneumonia, with contributing factors of malnutrition, Trisomy 21 and Alzheimer's dementia; and

    c) the death occurred in the circumstances described above.

29. Having considered all of the circumstances, I am satisfied that Ms Darby died of natural causes and have not identified any concerns in relation to the care provided in the period proximate to her death.

I convey my sincere condolences to Gaye's 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:

Malcolm & Beverley Darby, Senior Next of Kin

Donna Filippich, St Vincent's Hospital Melbourne

Signature:

Coroner Leveasque Peterson

Date : 13 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.