IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 2068

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MICHELLE HODGSON, CORONER**
Deceased:	**JEAN ELIZABETH TANTS**
Date of birth:	9 June 1936
Date of death:	4 May 2018
Cause of death:	1(a) CONGESTIVE HEART FAILURE
Place of death:	70 Lowe Street, Ararat, Victoria

HER HONOUR:

Background

1. Jean Elizabeth Tants was born on 9 June 1936. He was 81 years old when she died on 4 May 2018 from congestive heart failure.

2. At the time of her death, Ms Tants was under the care of the Department of Health and Human Services. She had a moderate intellectual disability.

3. Ms Tants lived with her mother for as long as possible before living with her sister and family until they were no longer able to care for her. Ms Tants subsequently lived in supported care accommodation for 15 years until her health significantly deteriorated.

4. In February 2018, Ms Tants moved to an Aged Care Residential Facility in Ararat following a decline in her mobility and function. At this time, she was diagnosed with progressive vascular dementia. Feeding became difficult and her communication decreased.

5. Ms Tants suffered from a number of medical conditions, including congestive cardiac failure/ cardiomyopathy.

6. Ms Tants's niece, Jenny Baker, visited her regularly and provided assistance when needed.

7. In the weeks before her death, Ms Tants's health declined rapidly.

The coronial investigation

8. Ms Tants's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Ms Tants's death was reportable because she was in the care of the State immediately before the time of her death.[1] Deaths of persons in the care of the State are reportable to ensure independent scrutiny of the circumstances surrounding their deaths. If such deaths occur as a result of natural causes, a coronial investigation must take place but the holding of an inquest is not mandatory.

9. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to

[1] See section 4(2)(c) of the *Coroners Act* 2008 (Vic).

the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[2]

10. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

11. 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.

12. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Ms Tants's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses, and submitted a coronial brief of evidence.

13. After considering all the material obtained during the coronial investigation, I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

14. 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.

Identity of the deceased

15. Ms Tants was visually identified by Jazmin Riana Sabo, nurse, on 4 May 2018. Identity was not in issue and required no further investigation.

Medical cause of death

16. On 8 May 2018, Dr Sarah Parsons, Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of the body of Ms Tants and reviewed a post mortem computed tomography (CT) scan.

17. Dr Parsons noted that she found nothing to suggest Ms Tants's death was due to anything other than natural causes.

[2] In the coronial jurisdiction facts must be established on the balance of probabilities 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.

18. After reviewing toxicology results, Dr Parsons completed a report, dated 18 May 2018, in which she formulated the cause of death as "*1(a) Congestive cardiac failure*". I accept Dr Parsons's opinion as to the medical cause of death.

Circumstances in which the death occurred

19. On 2 May 2018, Ms Tant's health began to rapidly decline and she became less responsive.

20. Over the following days, Ms Tants was reviewed by medical practitioners and provided with appropriate medical treatment and comfort care.

21. She was last attended to at 1.00am on 4 May 2018.

22. Ms Tants passed away peacefully between 1.00am and 1.30am that morning.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was Jean Elizabeth Tants, born 9 June 1936;

(b) Ms Tants died on 4 May 2018 at 70 Lowe Street, Ararat, Victoria, from congestive heart failure;

(c) her death was due to natural causes; and

(d) the death occurred in the circumstances described above.

Publication

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

I convey my sincere condolences to Ms Tants's family.

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

Jim Tants, Senior Next of Kin
Senior Constable Toni Chegwin, Coroner's Investigator, Victoria Police

Signature:

MICHELLE HODGSON
CORONER
Date: 7 December 2018.