FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 5801/08

Inquest into the Death of EILEEN MAY HOWELL

Delivered On:	20th May, 2010
Delivered At:	Coroners Court of Victoria at Melbourne Hearing Room Level 1, 436 Lonsdale Street Melbourne Victoria 3000
Hearing Dates:	12th May, 2010
Findings of:	PARESA ANTONIADIS SPANOS
Representation:	N/A
Place of death:	Western Hospital, 176 Furlong Road, St Albans 3021
Appearances:	Senior Constable Kelly RAMSEY State Coroners Assistants Unit

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In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

Details of deceased:

Surname:	HOWELL
First name:	EILEEN
Address:	Community Residential Unit 1a First Avenue, Melton, Victoria 3338

AND having held an inquest in relation to this death on 12th May, 2010

at Melbourne

find that the identity of the deceased was EILEEN MAY HOWELL born on the 24th August, 1940

and death occurred on the 27th December, 2008

from: 1(a) INTRACEREBRAL HAEMORRHAGE

in the following circumstances:

1. Ms Howell was a sixty-two year old woman who resided in the care of the Department of Human Service. Ms Howell was born with an intellectual disability which meant she had limited language and communications skills and required full time care for her whole life. During her teenage years, while still living with her family, she was maimed when three of her fingers were caught in a plough. Ms Howell remained in the care of her family until they were no longer able to care for her and she came into the care of the Department of Human Services (DHS). Since 1993, she had resided at the above Community Residential Unit (CRU).

2. Other than her intellectual disability and the injury to her fingers referred to above, Ms Howell enjoyed good general health and had no major health concerns until 2004 when she had a cerebral haemorrhage which required surgery. As a result she lost control of the right side of her body, was wheelchair bound and required more assistance with all the activities of daily living.

The prognosis was that it was likely that she would have another stroke within five years of the first.

3. Ms Howell received regular visits from her brother and sister-in-law. On 25th December 2008 she went to her brother's house in Melton West for Christmas lunch. While seated in her wheelchair in the rear courtyard, she had a collapse which was witnessed by her brother and sister-in-law. They called emergency services and Ms Howell was taken to Western Hospital where a CT scan of the brain revealed a haemorrhage. Ms Howell was admitted to the Intensive Care Unit where she was treated conservatively until her death at 6:53am on 27th December, 2008.

4. Neither Ms Howell's carers nor her family members had noticed anything to raise concerns about her health in the period preceding her collapse on 25th December, 2008. According to family members there had been nothing to indicate major illness, apart from Ms Howell being slightly slower and quieter during the two weeks preceding her death.

5. There was no autopsy as I allowed the family's objection to autopsy pursuant to section 29 of the *Coroners Act 1985*. However, Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine performed an external examination in the mortuary, reviewed the circumstances as reported by the police and post-mortem CT scanning of the whole body and advised that it would be reasonable to attribute the cause of death as *"intracereral haemorrhage"*.

6. I find that Ms Howell died from an intracerbral haemorrhage and find no evidence to support a finding of any causal connection or contribution between her death and her status as a person in the care of DHS when she died.

Signature:

PARESA ANTONIADIS SPANOS
Coroner
Date: 20th May, 2010