IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 4985

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**JUDITH FAYE MYORS**
Date of birth:	18 June 1955
Date of death:	20 October 2016
Cause of death:	Intracerebral haemorrhage
Place of death:	A Department of Health and Human Services managed residential service in Kew, Victoria
Catchwords:	Deceased person in custody or care; natural causes.

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HER HONOUR:

BACKGROUND

1. Judith (Judy) Faye Myors (**Ms Myors**) was a 61-year-old woman who resided at a Department of Health and Human Services (**DHHS**) managed residential service in Kew at the time of her death.

2. Ms Myors was a long-term resident in DHHS care, requiring care from age 12. Ms Myors was diagnosed with an intellectual disability from birth. She had a medical history of epilepsy, visual impairment, a diagnosis of Parkinson's disease in 2015, and an acute myocardial infarction in 2016. Ms Myors used a wheelchair for mobility, and required assistance with all activities of daily living.

3. Ms Myors received care from general practitioner Dr Stephen Bennie for more than 20 years. Dr Bennie noted that other than her admission to St Vincent's Hospital in June 2016 due to an acute myocardial infarction, Ms Myors was otherwise reasonably well and was only seen by him on three occasions between her admission to hospital and her death for referrals and minor medical matters.[1]

THE PURPOSE OF A CORONIAL INVESTIGATION

4. The role of a coroner is to investigate reportable deaths to establish, if possible, the identity, of the deceased, the medical cause of death and, with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame, or determine criminal or civil liability.[2]

5. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[3] The *Coroners Act 2008* (Vic) (**the Act**) provides for a system whereby reportable deaths are independently

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[1] Coronial brief, statement of Dr Stephen Bennie, dated 4 May 2017, 2.

[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.

[3] Section 89(4) *Coroners Act 2008.*

investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[4]

6. Ms Myors' death constituted a '*reportable death*' under the Act, as the death occurred in Victoria and, at the time of her death, she was a person considered to be "*a person placed in custody or care.*"[5]

7. The Act provides that a coroner must hold an inquest into all deaths which occurred while a person is "*in custody or care*",[6] except in those circumstances where the death is considered to be due to natural causes.[7]

8. In accordance with section 52(3B) of the Act, a death may be considered to be due to natural causes if the coroner has received a report from a medical investigator, in accordance with the *Coroners Court Rules* 2009, that includes an opinion that the death was due to natural causes. I have received such a report in this case. Therefore, I limit my findings with respect to the circumstances in which the death occurred and exercise my discretion not to hold an inquest.

MATTERS IN RELATION TO WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

9. On 20 October 2016, DHHS House Supervisor Ms Sarah Canvert identified the body of the deceased to be Ms Judith Faye Myors, born 18 June 1955.

10. Identity was not in issue and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

11. On 21 October 2016, Dr Victoria Francis, Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon Ms Myors' body and provided a written report, dated 17 November 2016. In that report, Dr Francis concluded that a reasonable cause of death was intracerebral haemorrhage.

12. Dr Francis reported that the post-mortem Computed Tomography (CT) scan showed marked large bowel distension and a large right intracranial haemorrhage centred around the basal

[4] See Preamble and s 67, *Coroners Act 2008*.
[5] Section 3 and 4 *Coroners Act 2008.*
[6] Section 52(2)(b) of the *Coroners Act 2008*.
[7] Section 52(3A) of the *Coroners Act 2008.*

ganglia with bilateral intraventricular haemorrhage in the lateral ventricles. Dr Francis noted the features were suggestive of hypertensive haemorrhage.

13. On the basis of the information available at the time of completing her report, Dr Francis provided an opinion that Ms Myors' death was due to natural causes.[8]

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

14. At approximately 1.30am on 20 October 2016, DHHS case worker Ms Jenny Yap conducted her usual checks on the residents of the residential service where Ms Myors resided. Ms Yap found Ms Myors sleeping soundly, and did not report any signs of distress.

15. At approximately 3.30am, Ms Yap commenced the next round of usual checks on residents. Ms Yap found Ms Myors in bed unresponsive with her mouth open. Ms Yap could not find a pulse. She called 000 and commenced cardiopulmonary resuscitation (**CPR**).

16. Ambulance Victoria paramedics arrived a short time later, but Ms Myors was unable to be revived. The attending paramedics declared Ms Myors deceased at 4.00am

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

17. Following a thorough review of the coronial brief of evidence and Ms Myors' DHHS resident record, I am satisfied that Ms Myors' medical care and management was reasonable and appropriate, and that there are no prevention issues arising from the circumstances of Ms Myors' death.

18. In her statement to the Court, Ms Myors' cousin, Ms Pamela Knight, commends the DHHS staff for their care of Ms Myors, stating:

> "*I highly commend the staff …., together with Mark, for the high quality of care that they provided to Judy. As a close family member, I could not have wished for better care and compassion that was given to Judy by all the staff that supported her*."[9]

[8] Medical Examiner's Report, page 4.

[9] Coronial brief, statement of Pamela Knight, dated 8 May 2017, 2.

FINDINGS AND CONCLUSION

19. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) the identity of the deceased was Judith Faye Myors, born 18 June 1955;

    (b) the death occurred on 20 October 2016 at a DHHS managed residential service in Kew, Victoria, from intracerebral haemorrhage; and

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

20. I convey my sincerest sympathy to Ms Myors' family.

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

    (a) Mrs Thelma Myors, Senior Next of Kin;

    (b) Senior Constable Nico Wethey, Coroner's Investigator; and

    (c) Mr Shane Beaumont, Department of Health and Human Services.

22. Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet in accordance with the *Coroners Court Rules* 2009.

Signature:

JUDGE SARA HINCHEY
STATE CORONER
Date: 21 November 2017