IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2015 4232**

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**SUZANNE LAURA McILLREE**
Date of birth:	**2 JANUARY 1956**
Date of death:	**14 AUGUST 2015**
Cause of death:	**COMPLICATIONS OF SEPSIS DUE TO CELLULITIS IN A WOMAN WITH MULTIPLE COMORBIDITIES**
Place of death:	**NORTH EAST HEALTH, 35-47 GREEN STREET, WANGARATTA VICTORIA 3677**

HIS HONOUR:

BACKGROUND

1. Suzanne Laura McIllree was born on 2 January 1956. She was 59 years old at the time of her death. Suzanne had a moderate to severe intellectual disability and primary lymphedema. She resided in a care facility at 83 Williams Road Wangaratta. She was described by her friends, family and carers as a happy person, who everybody loved.

2. According to General Practitioner Dr Patrick O'Connor, Suzanne suffered from asthma, epilepsy, eczema and hyperthyroidism. He describes Suzanne has having very significant illnesses and impairments and she was wheelchair bound. She required constant attention for basic feeding as she was prone to silent reflux and was at a high risk of aspiration pneumonia.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Suzanne's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as immediately before death she was a person placed under the care of the secretary to the Department of Health and Human Services ('DHHS').[1] Ordinarily, a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and the deceased person was immediately before death a person placed in custody or care.[2] However, a coroner is not required to hold an inquest if the coroner considers that the death was due to natural causes.[3]

4. The jurisdiction of the Coroners Court of Victoria is inquisitorial[4]. The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

5. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

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[1] Section 4, definition of 'Reportable death', *Coroners Act 2008;* Section 4, definition of 'Person placed in custody or care', *Coroners Act 2008.*
[2] Section 52(2)(b) *Coroners Act 2008.*
[3] Section 52(3A), *Coroners Act 2008.*
[4] Section 89(4) *Coroners Act 2008.*
[5] *Keown v Khan* (1999) 1 VR 69.

6. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

7. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

8. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

9. Coroners are also empowered:

   (a) to report to the Attorney-General on a death;

   (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

   (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

10. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[6] 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 that they caused or contributed to the death.

[6] (1938) 60 CLR 336.

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

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

11. Suzanne was visually identified by her friend Mary Norman on 25 August 2015. Identity was not in issue and required no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

12. On 26 August 2015, Dr Victoria Francis, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an inspection on the body of Suzanne McIllree and provided written report dated 2 September 2015, concluding a reasonable cause of death to be "I(a) complications of sepsis due to cellulitis in a woman with multiple medical comorbidities". I accept her opinion in relation to the cause of death.

13. Dr Francis noted that the left leg showed erythema and swelling consistent with the diagnosis of cellulitis. The post mortem Computed Temography (CT) scan showed no evidence of intracranial haemorrhage. There was peripheral oedema of the limbs and bilateral pleural effusions and lung changes consistent with aspiration pneumonia.

14. Dr Francis opined that the death was due to natural causes.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

15. On 6 August 2015, Suzanne's carers at her care facility noted that she was unwell, lethargic, warm to the touch, she had a high temperature and a rapid pulse. An ambulance was called and she was transported to North East Health, where she was admitted to the Emergency Department. Suzanne's condition deteriorated over the next few days and by 12 August 2015 she was palliated. At 10.00pm on 14 August 2015, Suzanne passed away.

COMMENTS

16. Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death:

    1. Suzanne's death was reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) ('the Act') because she was immediately before death a person placed in care, as defined by section 3 of the Act. Section 52 of the Act mandates the holding of an Inquest, except in circumstances where the person is deemed to have died from natural causes, pursuant to section 52(3A). In these circumstances, I have exercised my discretion pursuant to section 52(3A) not to hold an inquest into Suzanne's death.

FINDINGS

16. Having investigated the death of Suzanne Laura McIllree and having considered all of the available evidence, I am satisfied that no further investigation is required.

17. I find that the care provided to Suzanne by the Department of Health and Human Services was reasonable and appropriate.

18. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Suzanne Laura McIllree, born 2 January 1956;

    (b) that Suzanne Laura McIllree died on 14 August 2015, at North East Health from complications of sepsis due to cellulitis; and

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

19. I convey my sincerest sympathy to Suzanne's family and friends.

20. Pursuant to section 73(1B) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

(a) Suzanne's family, senior next of kin;

(b) Investigating Member, Victoria Police; and

(c) Interested Parties.

Signature:

MR JOHN OLLE

CORONER

Date: 19 April 2017