

IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: **COR 2018 3034**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*

*Section 67 of the Coroners Act 2008*

Findings of:	<b>PHILLIP BYRNE, CORONER</b>
Deceased:	<b>VICKI JANE BENNETT</b>
Date of birth:	<b>22 SEPTEMBER 1961</b>
Date of death:	<b>25 JUNE 2018</b>
Cause of death:	<b>I (a) PNEUMONIA</b>
Place of death:	<b>13 COCKATOO DRIVE, CARRUM DOWNS, VICTORIA, 3201</b>

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## **FINDING INTO DEATH WITHOUT INQUEST**

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*Section 67 of the Coroners Act 2008*

I, PHILLIP BYRNE, Coroner, having investigated the death of VICKI JANE BENNETT  
without holding an inquest:

find that the identity of the deceased was VICKI JANE BENNETT

born on 22 September 1961

and the death occurred on 25 June 2018

at 13 Cockatoo Drive, Carrum Downs, Victoria, 3201

**from:**

1 (a) PNEUMONIA

Pursuant to section 67(1) of the **Coroners Act 2008** I make findings with respect to **the following circumstances:**

### **BACKGROUND**

1. Vicki Jane Bennett, 56 years of age at the time of her death, was a resident in a Department of Health and Human Services (**DHHS**) group home at 13 Cockatoo Drive, Carrum Downs. Ms Bennett had a significant intellectual disability.

### **CIRCUMSTANCES SURROUNDING DEATH**

2. On 23 June 2018, Ms Bennett experienced vomiting and diarrhoea. A doctor was called who, after assessment, suggested she be admitted to hospital for further assessment. Ms Bennett refused to go to hospital making it clear she wished to remain at home. In the early afternoon of 25 June, Ms Bennett collapsed and became unresponsive. Cardiopulmonary resuscitation (**CPR**) was not successful and Ms Bennett could not be revived. She was formally declared deceased by an attending ambulance paramedic.

## REPORT TO THE CORONER

3. Ms Bennett's death was reported to the coroner due to her being "in care" within the meaning of the *Coroners Act 2008 (the Act)* at the time of her death.
4. I directed an autopsy and ancillary tests. An autopsy was performed at the Victorian Institute of Forensic Medicine by Dr Pradeep Bandara who subsequently advised Ms Bennett's death was due to:

*I (a) pneumonia.*

5. Toxicological analysis of a post mortem blood specimen was unremarkable.
6. Although I am satisfied Ms Bennett's death was due to natural causes, the Act requires me to make a formal finding.

## CONCLUSION

7. On the material available, I believe one could not reasonably conclude that the care/treatment of Ms Bennett was other than reasonable and appropriate.

## COMMENT

8. Pursuant to section 67 (3) of the *Coroners Act 2008*, I make the following comments connected with the death.
9. I note in the first contact with Coronial Admissions and Enquiries, Ms Bennett's mother, Mrs Margaret Bennett, advised she had no concerns with the care provided to her daughter at the assisted living facility.
10. In earlier correspondence, I advised Mrs Bennett I would leave my investigation in abeyance awaiting the outcome of a review by the office of the Disability Services Commissioner (DSC) in relation to the provision of services to Ms Bennett. However, I now propose to proceed to finalisation of my coronial investigation.

## FINDING

11. I formally find Vicki Jane Bennett died at her residence at 13 Cockatoo Drive, Carrum Downs, on 25 June 2018 due to pneumonia.
12. Pursuant to section 73 (1) (B) of the *Coroners Act 2008*, I order that this finding be published on the Coroners Court of Victoria website.

## DISTRIBUTION OF FINDING

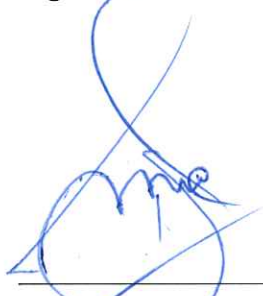
13. I direct that a copy of this finding be provided to the following:

Mrs Margaret Bennett, Senior Next of Kin;

Ms Jacinda De Witts, Acting General Counsel and Chief Legal Officer, Legal Services, DHHS; and

Senior Constable Evan Humber, Reporting Officer, Victoria Police

Signature:



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PHILLIP BYRNE  
CORONER

Date: 28 March 2019

