IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2019 2078

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**KYLIE MAREE MATCHETT**
Date of birth:	**16 December 1969**
Date of death:	**25 April 2019**
Cause of death:	**Complications of Alzheimer's dementia in a woman with Down syndrome**
Place of death:	**43 Denman Street, East Geelong Victoria 3219**

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

1. Kylie Maree Matchett was 49-years-old at the time of her death.

2. Ms Matchett had several medical conditions including, but not limited to an intellectual disability, a heart murmur, dementia and seizure activity (suspected epilepsy).

3. Ms Matchett lived with her parents until July 2018, when increasing care requirements saw her move to an assisted living facility. She was resident at the shared supported accommodation at GenU Karingal St Laurence's Karingal House (GenU KSL) at the time of her death.

4. On 24 April 2019, night staff heard Ms Matchett moving around. She settled and went back to sleep. In the morning, staff went to check on her. Ms Matchett was found lying on the floor and was unable to be revived. Her death was unexpected. No suspicious circumstances were identified.

5. Ms Matchett's death is reportable pursuant to section 4 of the Coroners Act 2008 (Vic) (the Act) because she was a person placed in care at the time of her death. Section 3 of the Act states that a person placed in care includes a person who is under the control, care or custody of Department of Health and Human Services.

INVESTIGATIONS

Forensic pathology investigation

6. Dr Victoria Francis, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an autopsy upon the body of Ms Matchett, reviewed a post mortem computed tomography (CT) scan, medical records from Geelong University Hospital, medical records from Karingal House Geelong and referred to the Victoria Police Report of Death, Form 83.

7. Dr Francis commented that the post mortem examination showed no evidence of injury which would have contributed or led to Ms Matchett's death.

8. Dr Francis referred Ms Matchett to Dr Linda Iles, Forensic Pathologist at the VIFM, for a neuropathological examination. Dr Iles found that the neuropathology showed mild diffuse cerebral atrophy associated with abundant Alzheimer-type pathology. She further commented that late onset epilepsy in those with Down syndrome associated with Alzheimer's pathology is well recognised.

9. Toxicological analysis of post mortem samples showed lamotrigine[1], risperidone and its metabolite hydroxyrisperidone [2] and citalopram[3].

10. Dr Francis was of the opinion that Ms Matchett's death was due to natural causes and ascribed the medical cause of death to complications of Alzheimer's dementia in a woman with Down syndrome.

Coronial Investigation

11. For the purpose of my investigation, I have taken into consideration the forensic pathology investigation and the Victoria Police Report of Death. I am also aware that the Disability Services Commissioner (DSC) undertook an investigation into the delivery of disability services provided to Ms Matchett.

12. Investigations found that Ms Matchett was a sociable woman who was well liked. She enjoyed helping with domestic tasks such as folding clothes, preparing vegetables for dinner and doing the dishes. Ms Matchett also enjoyed visiting a nearby café and socialising with other patrons and staff.

13. Ms Matchett's communication skills have been described as good however, in recent times her verbal communication had deteriorated. She could understand and would speak in 'simple language'. For more than 20 years, Ms Matchett worked five days a week at GenU KSL's supported workplace. More recently, Ms Matchett participated in a GenU KSL day program provided in her home two days a week.

[1] Lamotrigine is used as an anticonvulsant.

[2] Risperidone is an antipsychotic drug.

[3] Citalopram is approved for major depression and panic disorders.

14. From July 2018, Ms Matchett lived with nine other residents at GenU KSL. She had a National Disability Insurance Scheme funded outreach worker who would support her participation in community and social activities.

15. Ms Matchett received regular in-home medical consultations from her general practitioner. In the 12 months prior to her death, Ms Matchett was also seen by a physiotherapist, occupational therapist, neurologist and geriatrician. In October of 2018, Ms Matchett began experiencing seizures and commenced epilepsy medication in early November that same year. She had five admissions to hospital relating to her seizure activity in the six months prior to her death.

16. On 25 April 2019 at approximately 8.10am, two support staff members entered Ms Matchett's room and found her to be face down on the floor, with her feet up on her low-level bed. Her arms were under her upper body. Staff rolled Ms Matchett over and noted that she was not breathing and was cold to the touch.

17. Emergency services were called and chest compressions were commenced.

18. Ambulance Victoria arrived at 8.20am and took over resuscitation efforts. Ms Matchett was unbale to be revived and was declared deceased shortly after.

19. Subsequent investigations indicate that Ms Matchett was observed awake by the night-shift staff member at 2.00am. The same staff member reported that they observed her lying in bed at 6.00am. Ms Matchett had a floor alarm mat next to her bed that would alert staff if she stepped out of her bed. The alarm was reportedly not activated, indicating that Ms Matchett had not stepped out of her bed such that the alarm would be triggered.

20. Having considered the evidence before me, I consider that there is no apparent causal connection between Ms Matchett's death and the fact that she was a person in care as defined in the Act. I am satisfied that no further investigation is required.

FINDINGS

1. I find that Kylie Maree Matchett, born 16 December 1969, died on 25 April 2019 at 43 Denman Street, East Geelong Victoria 3219.

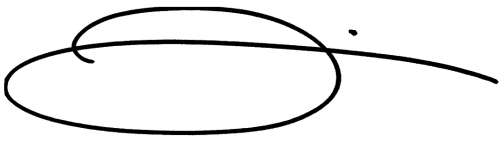
2. I accept and adopt the cause of death ascribed by Dr Victoria Francis and I find that the cause of Ms Matchett's death was complications of Alzheimer's dementia in a woman with Down syndrome

3. Section 52(3A) of the Act provides, *inter alia*, that a Coroner is not required to hold an Inquest into the death of a person who was in custody or care immediately before their death, if the Coroner considers that their death was due to natural causes. Ms Matchett's death falls under the auspices of this section of the Coronial legislation and, consequently, I have determined that it was appropriate to finalise my Investigation by way of a Form 38 *Finding into a Death with Circumstances.* Such a Finding must be published, pursuant to section 73(1B) of the Act.

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

Rodney and Jennifer Matchett
Disability Services Commissioner

Signature:



AUDREY JAMIESON
CORONER
Date**: 8 April 2020**