IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 2909

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*
*Section 67 of the **Coroners Act 2008***

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| Findings of: | Coroner Jacqui Hawkins |
| Deceased: | Penelope Thelma Jane Hill |
| Date of birth: | 5 May 1965 |
| Date of death: | 15 June 2018 |
| Cause of death: | I(a) Pneumonia<br>Contributing Factors: Renal failure and Downs syndrome |
| Place of death: | Wodonga Hospital, Vermont Street, Wodonga, Victoria, 3690 |

## BACKGROUND

1. Penelope Thelma Jane Hill was 53 years old at the time of her death. Ms Hill had Downs syndrome and moderate intellectual disability and lived in supported accommodation managed by the Department of Health and Human Services in Wodonga.

2. Ms Hill's medical history included chronic renal disease, large atrial septal defect, and hypothyroidism.

3. Ms Hill's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008*.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, 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.[1]

5. In writing this Finding, I do not purport to summarise all the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

## MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

### Identity of the deceased

6. Penelope Hill was visually identified by her brother, Ian Hill, on 18 June 2018. Identity was not in issue and required no further investigation.

### Medical cause of death

7. On 20 June 2018, Dr Malcolm Dodd, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination of the body of Ms Hill and reviewed the Form 83 Victoria Police Report of Death, Medical Deposition, and the post mortem computed tomography (CT) scan.

[1] 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.

8. The post mortem CT scan showed bilateral lung changes consistent with pneumonia and an enlarged heart.

9. Toxicological analysis of post mortem blood detected the presence of midazolam.

10. Dr Dodd provided an opinion that the medical cause of death was 1(a) *Pneumoni*a, with contributing factors *renal failure* and *Downs syndrome* and was due to natural causes.

**Circumstances in which the death occurred**

11. On 9 June 2018, Ms Hill collapsed whilst out shopping and was transported to Wodonga Hospital.

12. At hospital, she was found to have an elevated temperature and hypertension. Clinical investigations suggested she had septic shock secondary to pneumonia, in the setting of her existing chronic kidney disease and Downs syndrome.

13. Ms Hill was appropriately managed with intravenous antibiotics and fluids. However, her health continued to deteriorate, and her goals of care were discussed with her family. Ms Hill developed anuric renal failure on 13 June 2018, and passed away at 6.55am on 15 June 2018.

14. Having considered the evidence I am satisfied that no further investigation is required.

**FINDINGS**

15. Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

    (a) the identity of the deceased was Penelope Thelma Jane Hill born 5 May 1965; and

    (b) Ms Hill died on 18 June 2018 from 1(a) *Pneumonia* with contributing factors *renal failure and downs syndrome*;

    (c) in the circumstances described above.

16. I wish to express my sincere condolences to Ms Hill's family. I acknowledge the grief and devastation that you have endured as a result of your loss.

17. I order pursuant to section 73(1B) of the *Coroners Act 2008*, that this finding be published on the Coroners Court of Victoria Website.

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

The family of Ms Hill;

Information recipients; and

Coroner's Investigator, Victoria Police

Signature:


JACQUI HAWKINS
Coroner
Date: 11 May 2020