IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2020 5942**

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**PHILLIP BYRNE, CORONER**
Deceased:	**SHARON BROWN**
Date of birth:	**12 JUNE 1966**
Date of death:	**31 OCTOBER 2020**
Cause of death:	**I (a) COMPLICATIONS OF DEMENTIA**
Place of death:	**MCCULLOCH HOUSE, 246 CLAYTON ROAD, CLAYTON, VIC 3168**

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Section 67 of the ***Coroners Act 2008***

I, PHILLIP BYRNE, Coroner having investigated the death of SHARON BROWN
without holding an inquest:
find that the identity of the deceased was SHARON BROWN
born on 12 June 1966
and the death occurred on 31 October 2020
at McCulloch House, 246 Clayton Road, Clayton, Victoria 3168

from:

I (a) COMPLICATIONS OF DEMENTIA

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

BACKGROUND

1. Sharon Brown, 54 years of age at the time of her death, resided at 3/65 Albenca Street, Mentone, a facility administered by the Department of Health and Human Services, having been a ward of the state since birth. Ms Brown had no known next of kin. Ms Brown had a history of dementia, intellectual disability, epilepsy, biliary stricture, thrombocytopenia, hypothyroidism, renal impairment, vitamin D deficiency, depression, hypercholesterolaemia, insomnia, cholecystectomy and cataract surgery.

BROAD CIRCUMSTANCES SURROUNDING DEATH

2. Ms Brown was referred to Monash Hospital Medical Centre by her general practitioner on 22 September 2020 with symptoms consistent with dehydration and hyponatraemia considered to be due to poor oral intake. Upon assessment it was considered Ms Brown had left lower lung pneumonia which was appropriately treated with antibiotics. During admission Ms Brown had ongoing nausea, vomiting and drowsiness. Ms Brown's condition

continued to deteriorate and on 9 October 2020 she was transferred to McCulloch House for palliative care where on 31 October 2020 she passed away.

REPORT TO THE CORONER

3. Being "in care" within the meaning of the *Coroner Act 2008* Ms Brown's death was appropriately reported to the coroner.

4. Having considered the circumstances, having conferred with a forensic pathologist, and there being no next of kin to consult, I directed an autopsy and, at the discretion of the forensic pathologist performing the directed autopsy, ancillary tests.

5. The directed autopsy was performed at the Victorian Institute of Forensic Medicine by Forensic Pathologist Dr Gregory Young who in a subsequent Autopsy Report advised Ms Brown's death was due to:

   I(a) COMPLICATIONS OF DEMENTIA

   He commented:

   > *"The autopsy confirmed the presence of bronchopneumonia in the lower lobe of the left lung. The liver showed centrilobular congestion and microvesicular steatosis. The biliary stent was patent, and the surrounding common bile duct showed atypical cells suspicious for, but not diagnostic of, malignancy."*

   And, importantly, added people with dementia risk aspiration of food or vomitus which can result in bronchopneumonia. He further opined people with dementia risk dehydration and biochemical derangements such as hyponatraemia due to decreased oral intake. Dr Young concluded Ms Brown's death was due to natural causes.

6. In light of the advice provided by Dr Young, and having examined the Form 83 Police Report of Death and the comprehensive e-Medical Deposition submitted by Monash Medical Centre, together with the fact no next of kin had been identified, I concluded no further investigation was warranted as Ms Brown had died of natural causes.

FINDING

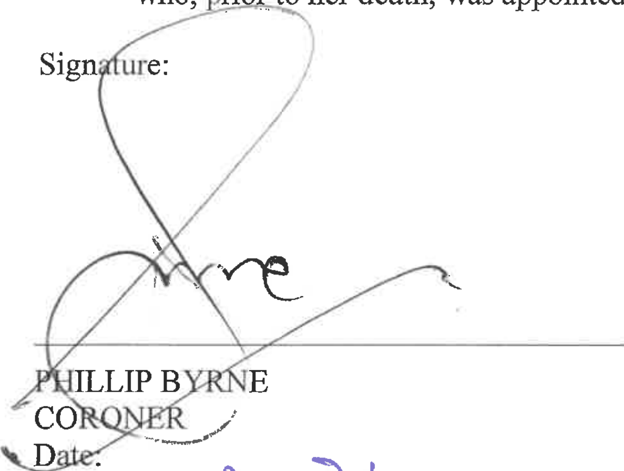
7. I formally find Sharon Brown died at McCulloch House, Clayton, on 31 October 2020 due to complications of dementia.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

DISTRIBUTION OF FINDING

8. As no family members have been identified I ask that, as a matter of courtesy, my registrar provide a copy of this finding to Mr David Wilson of the Office of the Public Advocate who, prior to her death, was appointed Ms Brown's guardian.

Signature:



PHILLIP BYRNE
CORONER
Date: 10.2.21