IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 005885

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Deceased:	Marilyn[1]
Delivered on:	20 August 2021
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	20 August 2021
Findings of:	Coroner Paresa Antoniadis Spanos
Counsel Assisting the Coroner:	Natalie Savva, Senior Coroner's Solicitor

[1] In deference to her family's wishes, Marilyn will only be referred to by her first name in this finding.

INTRODUCTION

1. Marilyn was 62 years old when she died at Caufield Hospital on 27 October 2019. At the time, Marilyn lived in supported accommodation in Malvern East.[2] She is survived by her brothers Ian and Stuart.

2. She had a medical history that included schizophrenia, Barrett's oesophagus, abdominal hysterectomy, postural hypotension and intellectual disability.

INVESTIGATION AND SOURCES OF EVIDENCE

3. This finding draws on the totality of the coronial investigation into the death of Marilyn including evidence contained in the coronial file comprising her medical records; the e-medical deposition from The Alfred Hospital and the inspection report and toxicology report from the Victorian Institute of Forensic Medicine (**VIFM**).

4. All of this material, together with the inquest transcript, will remain on the coronial file.[3] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

5. The purpose of a coronial investigation of a *reportable death*[4] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[5] Marilyn's death clearly falls within the definition of reportable death,

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[2] Her accommodation offered 24/7 on-site care to ten residents with intellectual disability.

[3] From the commencement of the ***Coroners Act 2008*** (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

[4] The term is exhaustively defined in section 4 of the ***Coroners Act 2008*** [the Act]. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

[5] Section 67(1).

specifically section 4(2)(d) of the Act which includes (relevantly) a death of a person who immediately before death was a patient within the meaning of the *Mental Health Act 2014*.

6. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[6]

7. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[7]

8. Coroners are empowered to report to the Attorney-General in relation to a death; 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 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.[8] These are effectively the vehicles by which the coroner's prevention role can be advanced.[9]

9. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[10]

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[6] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[7] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[8] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[9] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[10] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

IDENTIFICATION

10. Marilyn, born 5 September 1957, was visually identified by Dr Maria Tsanglis who had been treating her for 16 years and signed a formal Statement of Identification to this effect on 27 October 2019.

11. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

Objection to autopsy

12. When an autopsy is recommended but does not proceed due to strong objection, the ability to ascertain a clear cause of death is limited, as is, for example, the ability to critically appraise the clinical care and management of a patient proximate to death.

13. The family of Marilyn strongly objected to an autopsy being performed on religious grounds. Section 8 of the Act requires me to have regard, as far as possible in the circumstances, to the fact that different cultures have different beliefs and practices surrounding death that should, where appropriate, be respected; and that there is a need to balance the public interest in protecting a living or deceased person's personal or health information with the public interest in the legitimate use of that information.

14. Implicit is the need to balance the wishes of the Senior Next of Kin, the privacy of the deceased and integrity of their body and respect for their wishes if known, with the desirability of investigating the cause and circumstances of reportable deaths, and where possible, contributing to a reduction in the number of preventable deaths.

15. In deference to the family's wishes, I determined that it was appropriate for the coronial investigation into Marilyn's death to proceed without an autopsy.

Medical cause of death

16. Forensic Pathologist Dr Paul Bedford from the VIFM conducted an external examination on 28 October 2019 and provided a written report of his findings dated 1 November 2019.

17. A computed tomography scan of the body showed coronary artery calcifications, but no clear cause of death was identified.

18. Toxicological analysis of post-mortem samples detected therapeutic levels of the antidepressant fluoxetine and its metabolite, the antipsychotic drugs aripiprazole and olanzapine but no alcohol or other commonly encountered drugs or poisons.

19. Dr Bedford provided an opinion that the medical cause of death was 1 (a) Unascertained.

20. I accept Dr Bedford's opinion.

CIRCUMTANCES IN WHICH DEATH OCCURRED

21. Marilyn's mental state began to deteriorate between 2 and 4 August 2019. She had poor oral intake, her sleep was disturbed, and she tried to escape from her accommodation.

22. Marilyn was admitted to The Alfred Hospital Emergency Department on 11 August 2019 and placed on an assessment order pursuant to section 314 of the *Mental Health Act 2014* that day. A consultant psychiatrist upheld the order the following day and the Mental Health Tribunal made a 12-week in-patient treatment order on 4 September 2019. Marilyn was placed in the Baringa Acute Aged Psychiatry Unit at Caufield Hospital.

23. A sinus tachycardia was noted throughout her admission, which was discussed with the Cardiology Department. Repeat electrocardiograms (**ECG**), an echo and serial ECGs were performed with no significant findings.

24. Marilyn experienced ongoing psychosis during her admission with command hallucinations. Her oral intake remained poor. Unilateral electroconvulsive treatment began on 25 October 2019 without incident.

25. Nursing records described Marilyn as well on 26 October 2019. Overnight, Marilyn was agitated and was wandering around the ward. She was given 2.5mg of olanzapine at 1:00am on 27 October 2019 to help her to settle.

26. During routine overnight checks at 5:00am and 6:15am, Marilyn was noted to be breathing. Just after 7:30am, a nurse found Marilyn facing the wall. She was pale, not breathing and showed no signs of life. A Code Blue was called at 7:39am and nursing staff commenced cardiopulmonary resuscitation (**CPR**).

27. CPR continued for 14 minutes with assistance from Mobile Intensive Care Ambulance paramedics, but Marilyn remained in asystole and was declared deceased at 8:00am on 27 October 2019.

FINDINGS AND CONCLUSION

28. The applicable standard of proof for coronial findings is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications. [11]

29. Adverse findings or comments against individuals or institutions are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and in so doing caused or contributed to the death under investigation.

30. Having applied the applicable standard of proof to the available evidence, I find that:

    a. the identity of the deceased was Marilyn, born 5 September 1957;

    b. the death occurred on 27 October 2019 at Caulfield Hospital, 260 Kooyong Road, Caulfield, Victoria, 3162;

    c. the medical cause of Marilyn's death remains unascertained; and

[11] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 especially at 362-363. "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…"*

d. the death occurred in the circumstances described above.

PUBLICATION OF FINDING

31. Pursuant to section 73(1) of the Act, unless otherwise ordered by the coroner, the findings made following an inquest must be published on the internet in accordance with the rules. I make no such order.

DISTRIBUTION OF THE FINDING

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

Marilyn's brothers as Senior Next of Kin

Alfred Health

Signature:

Paresa Antoniadis Spanos
Coroner
Date: 20 August 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.