IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 005383

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Louise Elizabeth Hayes
Date of birth:	9 September 1971
Date of death:	29 September 2020
Cause of death:	1(a) Aspiration pneumonia in the setting of cerebral palsy and epilepsy
Place of death:	The Kilmore & District Hospital, Anderson Road, Kilmore, Victoria, 3764
Keywords:	'in care'

INTRODUCTION

1. On 29 September 2020, Louise Elizabeth Hayes was 49 years old when she passed away at The Kilmore and District Hospital.

2. At the time of her death, Ms Hayes resided at a group home located in Fawkner. The home was formerly operated by the Department of Health and Human Services (now the Department of Families, Fairness and Housing) prior to its transfer to disability services provider Aruma in 2019.

3. Ms Hayes had a medical history of cerebral palsy, left hemiparesis, epilepsy and dysphagia. She was non-ambulant and non-verbal and required assistance with all aspects of daily living and mobilised with the assistance of a wheelchair.

THE CORONIAL INVESTIGATION

4. Ms Hayes' death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. The death of a person in care is a mandatory report to the Coroner, even if the death appears to have been from natural causes. For the purposes of my coronial investigation, Ms Hayes "was a person placed in custody or care" immediately before her death within the definition of the *Coroners Act 2008* **(the Act)**.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. This finding draws on the totality of the coronial investigation into the death of Louise Elizabeth Hayes including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary

for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Circumstances in which the death occurred

8. Around early 2020, Ms Hayes' health began to significantly deteriorate, and she started to experience increased seizures and recurrent episodes of aspiration pneumonia requiring frequent hospitalisation.

9. On 14 September 2020, Ms Hayes was admitted to the Northern Hospital due to a further episode of aspiration pneumonia. She was non-responsive to antibiotics and was refusing food.

10. In consultation with medical practitioners and Ms Hayes' family, the decision was made to commence end of life care.

11. On 24 September 2020, Ms Hayes was transferred to the Kilmore and District Hospital where she continued to receive palliative care. Ms Hayes passed away on 29 September 2020.

Identity of the deceased

12. On 1 October 2020, Louise Elizabeth Hayes, born 09 September 1971, was identified via circumstantial evidence.

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

Medical cause of death

14. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 11 November 2020 and provided a written report of her findings dated the same.

[1] 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.

15. The post-mortem CT scan showed lung consolidation with multiple opacities. Ms Hayes brain had dilated ventricles, with no evidence of acute obstructive hydrocephalus. The CT also showed evidence of scoliosis , a full bladder and rectal faecal loading.

16. The external examination revealed wasting of the left upper and lower limbs in comparison to the right.

17. Dr Archer provided an opinion that the medical cause of death was 1 (a) Aspiration pneumonia in the setting of cerebral palsy and epilepsy.

18. I accept Dr Archer's opinion.

FURTHER INVESTIGATIONS

19. The Disability Services Commissioner commenced an investigation under section 128I of the *Disability Act 2006* in relation to the disability services provided to Ms Hayes. At the conclusion of the Commissioner's investigation the Court was advised that no adverse findings were made against Aruma in relation to the disability services provided to Ms Hayes.

FINDINGS AND CONCLUSION

20. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Louise Elizabeth Hayes, born 09 September 1971;

    b) the death occurred on 29 September 2020 at The Kilmore & District Hospital, Anderson Road, Kilmore, Victoria, 3764, from aspiration pneumonia in the setting of cerebral palsy and epilepsy; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Ms Hayes' family and loved ones for their loss.

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.

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

Michelle Hayes, Senior Next of Kin

The Disability Services Commissioner

Victorian Disability Worker Commission

Constable S. Cronin, Victoria Police

Signature:

Coroner Kate Despot

Date : 25 February 2026

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 investigation. 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.