IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2020 7044**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

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| Findings of: | Coroner John Olle |
| Deceased: | Gillian Patricia Johnston |
| Date of birth: | 9 January 1955 |
| Date of death: | 27 December 2020 |
| Cause of death: | 1(a) bowel cancer |
| Place of death: | 6-8 Montgomery Court, Wangaratta, Victoria, 3677 |
| Keywords: | Death in care, natural causes |

## INTRODUCTION

1. On 27 December 2020, Gillian Patricia Johnston (**Ms Johnson**) was 65 years old when she died at her home. At the time of her death, Gillian lived at 6 Montgomery Court, Wangaratta with five other residents. This accommodation was provided by Scope Australia, an organisation who provide support to people living with disabilities.

## THE CORONIAL INVESTIGATION

2. Ms Johnson's 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. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

3. 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.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Johnson's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, and treating clinicians – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Gillian Patricia Johnston 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

7. Ms Johnson resided in accommodation provided by disability support service, Scope Australia. Ms Johnson had an extensive medical history of various illnesses.

8. In July 2020, Ms Johnson's health plans were reviewed and amended in accordance with her deterioration of health.

9. Ms Johnston received palliative care after being diagnosed with bowel cancer up until the time of her death. Ms Johnson had regular visits from the palliative care team and her general practitioner (**GP**). Ms Johnson's care team included a speech pathologist, a podiatrist, an occupational therapist and a physiotherapist.

10. The palliative care team collaborated with Ms Johnson's sister, GP and the house staff to ensure the correct supports were being delivered to maintain Ms Johnson's independence and comfort.

11. Ms Johnson passed away peacefully in her home on 27 December 2020.

### Identity of the deceased

12. On 27 December 2020, Gillian Patricia Johnston, born 9 January 1955, was visually identified by Scope Australia manager, Joann Sturzaker.

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

### Medical cause of death

14. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 30 December 2020 and provided a written report of his

[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.

findings dated 7 January 2021. Dr Bouwer also reviewed the Victoria Police Report of Death for the Coroner (**Form 83**) and the medical records from Ovens Medical Group Wangaratta.

15. The post-mortem computed tomography (**CT**) scan showed mild cerebral atrophy with dilatation of the ventricular system. There was no acute intracranial haemorrhage. The spine showed marked kyphoscoliosis. A full bladder was noted. There was a large transverse colon tumour. Possible calcified mesenteric lymph nodes were also noted. An incidental gallstone was identified. Bilateral lung changes noted. Images were reviewed by a consultant radiologist.

16. Dr Bouwer provided an opinion that the medical cause of death was 1 (a) bowel cancer, confirming that Ms Johnson died due to natural causes.

17. I accept and adopt Dr Bouwer's opinion.

**FINDINGS AND CONCLUSION**

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

    a) the identity of the deceased was Gillian Patricia Johnston, born 09 January 1955;

    b) the death occurred on 27 December 2020 at 6-8 Montgomery Court, Wangaratta, Victoria, 3677, from bowel cancer; and

    c) the death occurred in the circumstances described above.

19. I am satisfied that Ms Johnson's death was due to natural causes, namely bowel cancer.

I convey my condolences to Ms Johnson's family.

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

Annette Davis, Senior Next of Kin

Christopher Maclsaac, Director, ICU, Royal Melbourne Hospital

Signature:


Coroner John Olle

Date : 26 September 2022

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.