IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 002142

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Ms W[1]
Date of birth:	21 July 1946
Date of death:	20 April 2020
Cause of death:	*Complications of Dementia in a Woman with a Intellectual Disability and Epilepsy*
Place of death:	Chelsea, Victoria

[1] This finding has been de-identified by order of Coroner Sarah Gebert to replace the names of the deceased, her family members and select individuals with pseudonyms to protect their identity and redact identifying information.

INTRODUCTION

1. Ms W was 73 years of age at the time of her death. She was referred to as 'Ms W' by her family. Her senior next of kin is her brother Mr K.

2. Ms W lived in a supported accommodation home in Chelsea which was managed by Scope. She had done so for 14 years. There were three other residents. State Trustees administered her finances.

3. On 20 April 2020, Ms W was found unresponsive in her room by one of her carers. She was due to move into an aged care facility the following day.

THE CORONIAL INVESTIGATION

4. Ms W's death was reported to the coroner as she was considered to be *a person placed in custody or care* under section 3(1) of the *Coroners Act 2008* **(the Act)** and so fell within the definition of a reportable death under the Act.

5. 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.

6. 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.

7. Victoria Police assigned First Constable Megan Lewis to be the Coroner's Investigator for the investigation of Ms W's death and she prepared a statement regarding her investigation. The Court also obtained Ms W's records from the Aspendale Clinic as well as Homescope.

8. As advice was received from investigating pathologist that Ms W's death was due to *natural causes*[2], a mandatory inquest was not required.[3]

[2] Paragraph 19.
[3] S52(3A) of the Act.

9. This finding draws on the totality of the coronial investigation into the death of Ms W 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.[4]

Background

10. Mr K said that his sister was in state care from a very young age due to the nature of her disabilities. She previously resided in Kew Residential Services from when she was 12 years old. He said that over her lifetime their family (including another brother and a sister) had quite regular contact with Ms W which included outings until a few years before her death when her reduced mobility made it difficult to take her out, and the family were restricted to house visits only.

11. Mr K said he saw his sister on a fairly regular basis and had last seen her a few days before her passing as she was about to be moved to an aged care facility. He explained that the move was necessary as her current carers were finding it difficult to provide the level of care required as her condition declined. He said that his sister's age was also a factor in her being moved to aged care.

12. According to her general practitioner (**GP**), Ms W had a long-term intellectual disability and was non-verbal. She had an additional history of dementia, asthma and epilepsy. It was noted in March 2020, that her mental state and level of function had gradually deteriorated over the last few years and staff had reported her becoming increasingly intolerant of normal daily care. Her ability to feed herself had deteriorated markedly, as had her ability to weight bear and self-ambulate. He commented that, *The care staff are great with her and are used to calming her, but her behaviours are really becoming too much for them.*

[4] 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.

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

Circumstances in which the death occurred

13. At approximately 8.40 am on 20 April 2020, carer Mandeep noted that Ms W appeared to be unconscious in her wheelchair. She was found to be unresponsive and staff immediately rang emergency services.

14. Cardiopulmonary resuscitation (**CPR**) was commenced under the instruction of the call taker until paramedics arrived at 8.52am. Unfortunately Ms W was unable to be assisted and she was pronounced deceased shortly after their arrival.

Identity of the deceased

15. On 20 April 2020, Ms W, born in 1946, was visually identified by House Supervisor Tania Judd who had known her for nine years.

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

Medical cause of death

17. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 22 April 2020 and provided a written report of her findings dated 9 September 2020.

18. Toxicological analysis of post-mortem blood samples detected Hydroxypiperidine (~8 ng/mL), Mirtazapine (~0.2 mg/L), Levetiracetam (~13 mg/L) and Oxazepam (~0.1 mg/L). These results suggested no toxicological contribution to death.

19. Dr Archer provided an opinion that the medical cause of death was *Complications of Dementia in a Woman with an Intellectual Disability and Epilepsy* and that on the basis of the material available to her, Ms W's death was due to *natural causes.*

20. I accept Dr Archer's opinion.

FINDINGS AND CONCLUSION

21. Pursuant to section 67(1) of the Act I make the following findings:

    a) the identity of the Deceased was Ms W, born 1946;

b) the death occurred on 20 April 2020 at Chelsea, Victoria from *Complications of Dementia in a Woman with an Intellectual Disability and Epilepsy*; and

c) the death occurred in the circumstances described above.

22. I convey my sincere condolences to Ms W's family for their loss.

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

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

a) Mr K, Senior Next of Kin

b) First Constable Megan Lewis, Coroner's Investigator

Signature:

Sarah Gebert

Coroner

Date: 20 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.