IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 001095

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Ms L
Date of birth:	
Date of death:	01 March 2021
Cause of death:	*Cerebrovascular accident*
Place of death:	Northern Hospital, 185 Cooper Street, Epping, Victoria

INTRODUCTION

1. Ms L,[1] born on [redacted], was 45 years of age at the time of her death. She is survived by her parents Mr and Mrs L and her two brothers.

2. Ms L lived in a supported accommodation home in South Morang which was managed by Scope.

3. On 28 February 2021, Ms L was hospitalised following a stroke. Sadly, she deteriorated quickly and on 1 March 2021 she passed away at the Northern Hospital.

THE CORONIAL INVESTIGATION

4. Ms L'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 Constable Tamara Allmann to be the Coroner's Investigator for the investigation of Ms L's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from and compiling a coronial brief of evidence. The brief contains statements from Ms L's mother, her carer, medical practitioners who treated her at the Northern Hospital, the forensic pathologist who examined her, paramedics and Constable Allmann, as well as other relevant materials.

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[1] Referred to in this finding as "Ms L", unless more formality is required.

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

9. This finding draws on the totality of the coronial investigation into the death of Ms L 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. Ms Lwas born at the Western General Hospital in Melbourne, Victoria.

11. At birth, Ms L was diagnosed with Down syndrome. Mrs L recalls that she had a fairly independent childhood where she played with other neighbouring children and rode her bike. However, at 7 years old, she developed difficulties walking and was subsequently diagnosed with chronic juvenile rheumatoid arthritis for which she took medication from 2011 prescribed by a rheumatologist and paediatrician.

12. Ms L initially attended Heidelberg Primary but when she was 12 or 13 years old transferred to Concord until she was 18. Ms L later attended St John of God in Greensborough, a special needs school.

13. Throughout her life, Ms L had a number of health complications. From an early age, Ms L had *oesophagus dilations*, which made swallowing food difficult. Later, she was hospitalised for pneumonia. In 2018, Ms L was diagnosed with cancer in her left eye which resulted in surgery to remove her eye. Throughout the course of her life, Ms L had around *30 to 60 surgeries* to treat her conditions.

14. Ms L resided with her parents until she was 28 years old, following which she moved to an assisted living facility in Reservoir. In May 2016, Ms L gained access to the National Disability Insurance Scheme (**NDIS**) and in 2020, she moved into the care facility in South Morang (**Scope**), where she was provided with 24/7 care. Her primary carer was Naomi Shiels.

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[2] Paragraph 28.

[3] S52(3A) of the Act.

[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.

15. Ms Shiels recalled that after breakfast and a bath, *everyday [they] would go out somewhere,* for example, Melbourne Zoo, the Aquarium, Time Zone or watching the football with Ms Shiels' husband at their home.

16. Ms L was described by her mother as a *mad football fan* [who] *barracked for the bulldogs* and that when at St John of God, she would make artwork and sell it. Mrs L described her relationship with her daughter as *close* and that Ms L would ring her three times a day to tell her little things.

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

Circumstances in which the death occurred

17. Between 4.00 and 5.00pm on 28 February 2021, Ms L, Ms Shiels and Ms Shiels' parents attended the Pancake Parlour at Doncaster Shopping Centre for dinner. Ms Shiels recalled that Ms L seemed *fine and happy,* however over the course of dinner, she observed Ms L to *become tired and withdrawn*. When driving back to Scope, Ms Shiels noticed Ms L *seemed more and more off, as in tired and not responding quickly.*

18. When they arrived at Scope, Ms Shiels recalled that she asked Ms L to move her arms and legs but Ms Shiels noticed they were not moving despite Ms L's efforts. Ms Shiels immediately called an ambulance followed by Mrs L. Paramedics received the call at approximately 7.06pm.

19. At approximately 7.10pm, paramedics attended the scene and determined that Ms L was *displaying stroke like symptoms, left arm weakness, slurred speech and facial droop*. Paramedics provided basic first aid and at approximately 7.23pm she was transported to the Northern Hospital Emergency Department where a brain scan revealed a *right basal ganglia bleed*. Discussions were conducted between doctors and Ms L's parents about options moving forward and *making her comfortable*.

20. On 1 March 2021, Ms L was moved to the Northern Hospital Stroke Ward. At approximately 6.00am, her parents and Ms Shiels were contacted by the hospital who advised that Ms L was deteriorating rapidly. Sadly, she was unable to be assisted and was pronounced deceased at 7.37pm. Ms Shiels was present at her passing before Mr and Mrs L arrived shortly after.

21. Due to COVID-19, police did not attend the hospital. At around 3.30pm, Coroner's Investigator Constable Allmann was sent a notice by coronial admissions of Ms L's passing. She subsequently prepared a brief of evidence and found no suspicious circumstance surrounding the death.

Identity of the deceased

22. On 1 March 2021, Ms L, born [redacted], was visually identified by her father Mr L.

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

Medical cause of death

24. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 2 March 2021 and provided a written report of his findings dated 5 March 2021.

25. The post-mortem examination showed *findings in keeping with the clinical history.*

26. The post-mortem CT scan revealed a *large right cerebral haemorrhage centred around basal ganglia, extension into ventricles, right to left shift.*

27. Toxicological analysis of post-mortem blood samples detected Hydroxychloroquine[5] (~3.0mg/L) and Paracetamol[6] (~10mg/L).

28. Dr Beer provided an opinion that the medical cause of death was *Cerebrovascular accident* and that on the basis of the material available to him, Ms L's death was *due to natural causes.*

29. I accept Dr Beer's opinion.

FINDINGS AND CONCLUSION

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

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[5] Hydroxychloroquine is an aminoquinoline derivative used for the treatment of malaria and other infectious diseases, lupus erythematosus, and rheumatoid arthritis (Baselt, 2017).

[6] Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs such as codeine and propoxyphene. Plasma concentrations giving optimal therapeutic benefit are considered to range from 20-40 mg/L.

a) the identity of the Deceased was Ms L, born [redacted];

b) the death occurred on 1 March 2021 at the Northern Hospital, 185 Cooper Street, Epping, Victoria from *Cerebrovascular accident*; and

c) the death occurred in the circumstances described above.

31. I convey my sincere condolences to Ms L's family for their loss.

32. 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.

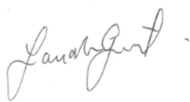
33. I direct that a copy of this finding be provided to the following:

a) Mr and Mrs L, Senior Next of Kin

b) Constable Tamara Allmann, Coroner's Investigator

c) Richard Laufer, Northern Health

Signature:



Coroner Sarah Gebert

Date: 31 March 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.