IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 002625

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Claire Louise Carroll
Date of birth:	28 September 1975
Date of death:	19 May 2021
Cause of death:	1(a) Neck compression 1(b) Hanging
Place of death:	2 / 12 Hillford Street, Newcomb, Victoria, 3219
Keywords:	Complex Mental Health; Barwon Health; Suicide

INTRODUCTION

1. On 19 May 2021, Claire Louise Carroll was 45 years old when she was found deceased at home in circumstances suggestive of suicide. At the time, Ms Carroll lived in Newcomb, Victoria.

2. Ms Carroll was born in 1975 to parents Ronda and Robert Carroll. She had an older brother, Damon, who Ms Carroll was very close and shared a strong bond with. Sadly, on Good Friday in 1999 Damon took his own life. The evidence suggests the death of her brother had a profound and long-lasting effect on Ms Carroll.

3. Ms Carroll attended multiple General Practitioners (**GPs**) at the East Geelong Medical Centre since 2000. From 2009 onwards, Ms Carroll engaged with the Bellarine Community Mental Health Care team (**Bellarine CMHC**) as a voluntary patient. Her diagnoses included complex trauma[1], borderline personality disorder[2] (**BPD**) and schizoaffective disorder.[3]

4. Owing to her diagnoses, Ms Carroll experienced symptoms of auditory hallucinations, paranoid ideation, and delusions of being sexually assaulted. She also experienced dissociation at times.

5. Her regular GP, Dr Johanne Horman noted that her symptoms worsened in the years leading up to her death and that there was thought among her treating team that she may have severe complex PTSD.

6. Ms Carroll struggled more with her mental health in the evenings and throughout the night. She routinely contacted triage and emergency services, often multiple times a night, particularly when experiencing distress associated with her symptoms. Ms Carroll's mental health was also known to deteriorate around the anniversary of her brother's death.

7. Ms Carroll commenced therapy with Clinical Psychologist Ms Rikki Bee, also of the East Geelong Medical Centre, in 2016. She was referred by her GP who noted she had a history of

[1] Complex trauma is a psychological disorder that can develop in response to an extremely traumatic series of events on a context in which the individual perceives little or no chance of escape and particularly where the exposure is prolonged or repetitive.

[2] Borderline Personality Disorder is a debilitating disorder characterised by rapid and extreme mood changes including depressive, aggressive and anxious sates; intense fear of abandonment and rejection; a pattern of unstable sense of self; chronic feelings of emptiness and a tendency towards self-harming and suicidal behaviours. The behaviour of people with BPD often disrupts family and work life, long term planning and interpersonal relationships.

[3] Schizoaffective disorder is a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms such as depression or mania.

intravenous drug use. Between commencing therapy in 2016 and her death, Ms Carroll and Ms Bee had about 160 therapy consultations together.

8. Ms Bee noted that Ms Carroll experienced fluctuating suicidal ideation which would often coincide with the date of her brother's death.

9. At the time of her death, Ms Carroll was prescribed the following medications to manage her mental health:

   i. Clonazepam 6mg

   ii. Quetiapine 800mg

   iii. Paliperidone 12mg

10. Ms Carroll was linked with supports via the NDIS which included her social worker and engagement in work and art therapy. Due to COVID-19 restrictions, Ms Carroll's access to her NDIS supports was reduced around the time of her death.

THE CORONIAL INVESTIGATION

11. Ms Carroll'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.

12. 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.

13. 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.

14. Victoria Police assigned Senior Constable Brad Clark to be the Coroner's Investigator for the investigation of Ms Carroll's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

15. This finding draws on the totality of the coronial investigation into the death of Claire Louise Carroll 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]

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

Identity of the deceased

16. On 19 May 2021, Claire Louise Carroll, born 28 September 1975, was visually identified by her mother, Rhonda Carroll, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

18. Forensic Pathologist Dr Joanne Glengarry, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination of Ms Carroll's body in the mortuary on 20 May 2021 and provided a written report of her findings dated 27 May 2021.

19. The post-mortem examination showed ligature injuries consistent with the stated circumstances. No other injuries were observed which could have caused or contributed to death.

20. Routine toxicological analysis of post-mortem blood detected codeine[5], clonazepam[6] and its metabolites, quetiapine[7], hydroxyrisperidone[8], doxylamine[9], and prazosin[10], while morphine[11] was detected in a post-mortem urine sample.

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[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.

[5] Codeine is an opiate available in numerous cold and flu relief preparations and products with multiple actives such as aspirin and paracetamol.

[6] Clonazepam is a nitrobenzodiazepine indicated for the treatment of seizures.

[7] Quetiapine is an atypical antipsychotic medication used for the treatment of schizophrenia.

[8] Hydroxyrisperidone (paliperidone) is a benzisoxazole derivative indicated for schizophrenia.

[9] Doxylamine is an antihistamine agent and sleep-inducing agent.

[10] Prazosin is an alpha-adrenergic blocking agent indicated for high blood pressure.

[11] Morphine is an opioid medicine prescribed for severe pain.

21. Dr Glengarry provided an opinion that the medical cause of death was *1(a) neck compression* secondary to *1(b) hanging*.

22. I accept Dr Glengarry's opinion.

Circumstances in which the death occurred

23. On 26 March 2021, Ms Carroll's Bellarine CMHC Case Manager, Mike Clarke, performed a home visit with Ms Carroll. She was irritable, did not engage and expressed that she felt threatened. Mr Clarke contacted Ms Carroll's mother, Rhonda, with concerns that her mental health was deteriorating.

24. Later that day, Ms Carroll attended her mother's house and threatened her with a knife. Police attended and transported Ms Carroll to University Hospital Geelong (**Geelong Hospital**) under section 351 of the *Mental Health Act 2014* (Vic) ('**the MHA**').[12] Ms Carroll was assessed in the Emergency Department (**ED**) and reported she attended her mother's house under the instruction of auditory hallucinations.

25. A plan was formed for Ms Carroll to be admitted to the psychiatric unit, however, she absconded from the ED prior to her admission. ED staff notified police that Ms Carroll had absconded. Ms Carroll did not return to ED and the planned psychiatric admission did not occur.

26. Ms Carroll was again transported to the ED by police on 5 April 2021 under Section 351 of the MHA after contacting emergency services and reporting she was suicidal and had a ligature around her neck. A mental health assessment was performed in the ED, and she reported poor sleep, and that she believed people were entering her home at night and sexually assaulting her. On assessment she denied suicidal thoughts and was discharged home for community follow up with Bellarine CMHC.

27. The next day, being 6 April 2021, Ms Carroll was reviewed by Bellarine CMCH psychiatrist Dr Louisa Du Toit. She presented with increased auditory hallucinations which at times commanded her to do things.

[12] Section 351 of the MHA permits a police officer to apprehend a person if they appear to have a mental illness, and because of their apparent mental illness, the person needs to be apprehended to prevent serious and imminent harm to themselves or another person. As of 1 September 2023, the MHA was replaced by the *Mental Health and Wellbeing Act 2022* (Vic) and section 351 was replaced by section 232 which is similar in operation.

28. Throughout the remainder of April 2021, Claire frequently contacted psychiatric triage, Bellarine CMHC and emergency services, often with multiple contacts a day, at times contacting all three services on the same day. The themes of these contacts were delusional thoughts about people breaking into her home, stealing her belongings, and sexually assaulting her. The evidence suggests Ms Carroll responded well to the opportunity to ventilate.

29. Between 24 - 26 April 2021, Bellarine CMHC provided medication supervision for Ms Carroll. Additional assistance was also temporarily provided between 29 April - 4 May 2021 whereby Bellarine CMHC provided proactive evening phone calls to Ms Carroll.

30. On the morning of 13 May 2021, Ms Carroll phoned her caseworker Mr Clarke. She was distressed and reported fears her home had been broken into, that she was hearing a voice of increasing intensity, and that her medications were not working. A home visit was planned for later that afternoon but when Mr Clarke arrived, Ms Carroll was not home.

31. Mr Clarke spoke with Ms Carroll on the phone the following day. She appeared settled and he identified no concerns for her welfare or safety during the call. This was the last contact between any Barwon Health staff and Ms Carroll.

32. On 18 May 2021, Ms Carroll had a home appointment with Ms Bee. She disclosed to Ms Bee that she had contacted Lifeline and Barwon Health[13] the previous evening due to hearing voices but denied any recent thoughts or plans of suicide. A follow up appointment was made, and it was planned that Ms Carroll and Ms Bee would go for a walk together during the session.

Police contact

33. In the twenty-four hours immediately preceding her passing, Claire had a number of interactions with Victoria Police including multiple telephone calls to the Geelong Police Station watchhouse and 000, as well as Victoria Police members attending her home late on 18 May 2021 to conduct a welfare check.

34. At about 5.45pm, Ms Carroll phoned the Geelong Police Station and spoke with Constable Rohit Giri who was tasked to watchhouse duties and quickly identified Ms Carroll. Throughout the call Ms Carroll's speech was slurred and she was unable to put full sentences together.

[13] There is no note in the Barwon Health medical records of such contact.

35. Constable Giri asked Ms Carroll if she required police assistance and Constable Giri reported:

> *She stated that she was fine and just needed to speak to someone. She said that she had been in touch with her psychologist regarding her mental health regularly*.[14]

36. Constable Giri again enquired whether Ms Carroll required police assistance and she refused. The telephone conversation subsequently concluded. As the call was made directly to the Geelong Police Station, and not via triple zero or the Police Assistance Line, there is no recording of the call.

37. At 9.15 pm, Ms Carroll again called the watchhouse at the Geelong Police Station. On this occasion she spoke with Constable Amelia Wanat who recognised Ms Carroll from previous interactions. Ms Carroll was extremely agitated and reported someone had taken her medication, that she was unable to calm down, felt like dying, inter alia.

38. Constable Wanat confirmed Ms Carroll had spoken to her mental health worker and asked what Ms Carroll wished for in respect of police assistance that evening with Ms Carroll replying '*I want someone to come see me*'.[15]

39. Accordingly, Constable Wanat arranged for a divisional van to attend Ms Carroll's home in Newcomb to perform a welfare check. The job description noted that Ms Carroll was a recidivist caller with mental health issues.

40. At 11.05 pm, Senior Constable Mark Arnold and Constable Steven Cole attended Ms Carroll's home. This was Senior Constable Arnold's first involvement with Ms Carroll whereas Constable Cole had multiple previous interactions with her. The police members knocked on the door and Ms Carroll responded after a few minutes. Although initially hesitant, Ms Carroll eventually opened the main wooden door and spoke with the attending members face-to-face through the screen door.

41. Ms Carroll advised the officers she was engaged with a psychologist once a week which she reported *really helped.* She advised the officers she had just taken her medication, was preparing for bed, and prior to the officers' arrival was having a cup of tea and performing deep breathing exercises.

[14] Statement of Constable Giri dated 1 June 2021.
[15] Statement of Constable Wanat dated 24 May 2021.

42. Both Senior Constable Arnold and Constable Cole stated that Ms Carroll did not disclose any suicidal ideation. Body Worn Camera footage from the interaction supports the accounts provided and indicates that Ms Carroll did not make any form of threat of self-harm during the interaction. The attending officers left Ms Carroll's home shortly afterwards.

43. Following the departure of Senior Constable Arnold and Constable Cole, in the early hours of 19 May 2021 Ms Carroll made a number of telephone calls to triple zero.

44. At 1.01 am, Geelong Police received a dispatch job for a burglary which Ms Carroll had phoned in for her home in Newcomb. Senior Constable Arnold and Constable Cole returned to Ms Carroll's address to patrol the area around her house. They observed that the front light was off and that no lights were visible inside Ms Carroll's unit.

45. Constable Cole contacted Ms Carroll by telephone and advised that police were outside her unit actively patrolling the area. The evidence suggests Ms Carroll was temporarily placated by the response and returned to bed.

46. At about 3.43am, another job was broadcast in respect of Ms Carroll in line with her previous calls. Police arrived at her home a short time later, and once again, Constable Cole spoke with Ms Carroll over the phone. They discussed Ms Carroll's upcoming appointment with her psychologist, and she reported that she was drinking a bourbon.

47. At no point during any of her interactions with police across 18 and 19 May 2021 did Ms Carroll make any threat of self-harm or suicide.

48. On the afternoon of 19 May 2021, Ms Carroll's mother contacted emergency services and requested a welfare check as she had been unable to contact her daughter throughout the day.

49. Police arrived at Ms Carroll's home at about 3.20pm and knocked on the door but did not receive a response. Attending members arranged for a police unit equipped with a door ram to attend. Entry to Ms Carroll's home was forced through a side door.

50. Police searched the house and discovered Ms Carroll suspended in a seated position in the bathroom with her back positioned against the door. A dressing gown string was tied around her neck and the handle of the bathroom door.

51. Attending police considered Ms Carroll was clearly deceased and did not attempt resuscitation. Ambulance Victoria paramedics attended a short time later and formally verified that Ms Carroll was deceased at the scene at 4.00pm on 19 May 2021.

CPU REVIEW

52. Having reviewed the coronial brief and in recognition of Ms Carroll's significant engagement with the mental health system, I obtained advice from the Coroners Prevention Unit (**CPU**) about the clinical management and care provided to Ms Carroll proximate to her death.

53. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided to the deceased by reviewing the medical records, and any particular concerns which have been raised.

54. Following a preliminary review of the matter, the CPU requested a statement from Dr Louise Du Toit who in turn provided a statement to the Court dated 5 July 2022.

55. As part of their review, the CPU were assisted by Dr Du Toit's statement, the coronial brief, the medical records from Barwon Health, and the court file.

56. The CPU noted Barwon Health had significant contact with Ms Carroll prior to her death, including contact with Bellarine, psychiatric triage, and in the ED. Moreover, the CPU recognised that due to her mental health diagnoses and severity of symptoms, Ms Carroll's management was complex. Contact with the triage service and/or Bellarine CMHC appeared to alleviate the distress associated with Ms Carroll's mental illness and symptoms, particularly at night.

57. Bellarine CMHC provided medication supervision to Ms Carroll between 24 - 26 April 2021. Dr Du Toit advised medication supervision was initiated after Ms Carroll reported she had lost her medication, a known issue for her. Supervision was provided until Ms Carroll was able to collect her webster pack from the pharmacy on 26 April 2021. Dr Du Toit advised ongoing supervision was not deemed necessary as Ms Carroll had managed her medications independently, facilitated by a webster pack, for many years.

58. Evening phone call support from Bellarine CMHC was provided for a short time and ceased on 4 May 2021. The support was ceased as it was deemed less necessary as Ms Carroll was engaged in some of her usual activities and she initiated contact with psychiatric triage or Bellarine CMHC when required. Further, Dr Du Toit noted that Ms Carroll's mental state fluctuated rapidly, limiting the usefulness of supportive phone calls.

59. Barwon Health created a crisis plan for Ms Carroll. The plan included family contacting Barwon Health Mental Health Drug and Alcohol Services, support from her GP, psychologist, and NDIS supports. Ms Carroll's medications were packed in a webster pack to reduce the risk of misuse and she was only provided short supply of pain medication and benzodiazepines.

60. Early warning signs of relapse for Ms Carroll included appearing agitated and paranoid. The CPU considered it would have been beneficial to include indicators of when an admission would be required.

61. When Ms Carroll was brought to the Geelong Hospital ED under section 351 of the MHA on 26 March 2021, a plan was made to admit her to the psychiatric unit, however she left the ED before this could occur. Dr Du Toit stated her presentation was deemed "*chronic in nature, with little response to medication, but she responded well to ventilation/ cognitive challenging and grounding techniques.*[16]

62. The CPU advised that it did not appear that any additional supports were implemented by Barwon Health in relation to Ms Carroll's ongoing care after her presentation, despite the planned psychiatric admission being thwarted by her absconding.

Treatment Goals

63. Dr Du Toit advised the treatment goals for Ms Carroll were as follows:

    i. Decrease paranoia by optimising antipsychotic medication and regular reviews by a Barwon Health psychiatric registrar or psychiatrist.

    ii. Manage emotional dysregulation using non-pharmacological methods such as regular contact with her private psychologist and case manager to reinforce the strategies learnt from psychology sessions.

    iii. Reduce medication intake as Ms Carroll was taking large amounts of benzodiazepines and was on high doses of two antipsychotic medications. Dr Du Toit advised her medications were gradually being reduced and were provided in webster packs.

[16] Statement of Dr Du Toit dated 5 July 2022.

iv. Reduce substance abuse, primarily cannabis through motivational interviewing and engagement in meaningful activities through NDIS support.

v. Increase physical activity through applying for a gym membership and attending yoga and pilates with the support of her NDIS worker.

vi. Reduce reliance on her mother as a carer by utilising NDIS supports.

vii. Reduce reliance on mental health services and police. Dr Du Toit recognised Ms Carroll remained highly reliant on external support services and that a plan was made to request additional NDIS funding to enable a carer to stay with her overnight.

CPU Conclusion

64. In the months preceding Ms Carroll's death, it appears that she experienced a deterioration in her mental health and a reduction in her supports with the cessation of NDIS supports due to COVID-19. No significant additional supports were put in place during this time, nor after her presentation to the ED on 26 March 2021.

65. The CPU considered the decision to cease short term medication supervision was appropriate as she demonstrated the ability to manage her medications independently. Toxicological analysis of post-mortem samples indicates Ms Carroll was compliant with her medications at the time of her death.

66. The CPU considered it would have been reasonable for evening phone support to continue to provide a structured mechanism to attempt manage Ms Carroll's distress which worsened at night. The CPU advised this represented a missed opportunity, particularly while waiting for the implementation of nightly NDIS supports, although could not conclude that daily support calls would have prevented her death.

67. The CPU considered Ms Carroll's crisis plan did not adequately address her complex presentation, known mental state fluctuations, and frequent contacts with after-hours services (psychiatric triage and emergency services). Her supports appeared uncoordinated and unstructured with frequent contact between Bellarine, psychiatric triage, and emergency services, often multiple times across multiple services within the one day.

68. The CPU considered that providing a forum for all services and supports involved with Ms Carroll would have allowed an opportunity to refine the crisis plan and ensure all were aware of the details of the crisis plan with clearly delineated roles and responsibilities. This could

have been achieved through presentation at the Emergency Services Liaison Meeting (or equivalent), where representatives from police and ambulance could also attend, and may have provided an opportunity for greater coordination of supports, handover of salient information such as mental state and risk, and clarification of roles and responsibilities. Additionally, this could have also been achieved through a case conference involving Bellarine CMHC, Emergency Mental Health (including psychiatric triage), and police.

69. The lack of cohesion in Ms Carroll's collaborative care planning was identified in the Barwon Health Clinical Incident Review following her death. The review identified the need for a new Service Delivery Framework designed to increase the frequency of patient contact and psychiatric reviews, as well as improved internal communication between different Barwon Health mental health services. The CPU considered this appeared reasonable.

70. In reviewing Ms Carroll's treatment plan as described by Dr Du Toit, the CPU noted significant reliance was placed on external supports to assist Ms Carroll achieve her treatment goals, particularly her psychologist and NDIS support workers.

71. There was an emphasis on utilising NDIS supports for engagement in meaningful activity, accessing the community, and a plan for a support worker to stay overnight with Ms Carroll. However, this was during the COVID-19 pandemic with consequent reductions in the provision of NDIS services. The CPU recognised this was acknowledged by Bellarine, however no additional supports were put in place.

72. The CPU also noted that documentation within the clinical file included limited descriptions of Ms Carroll's mental state or risk. Plans and outcomes following clinical team discussions were not described in detail, which may have affected the continuity of care provided. This was also identified in the Barwon Health Clinical Incident Review and is to be address by the Continuing Care Service Manager which the CPU considered an appropriate response.

73. I accept the CPU's advice.

FINDINGS AND CONCLUSION

74. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the Briginshaw gloss or explications.[17]

[17] Briginshaw v Briginshaw (1938) 60 C.L.R. 336 especially at 362-363. *"The seriousness of an allegation made, the*

75. Moreover, the effect of the authorities is that Coroners should not make adverse comments or findings against individuals or institutions, unless the evidence provides a comfortable level of satisfaction that they departed materially from the standards of their profession and in so doing, caused or contributed to the death.

76. It is axiomatic that the material departure from applicable standards be assessed without the benefit of hindsight, on the basis of what was known or should reasonably have been known at the time, and not from the privileged position of hindsight. Patterns or trajectories that may be appreciated at a later time or may even obvious once the tragic outcome has come to pass are to be eschewed in favour of a fair assessment made.

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

i. The identity of the deceased was Claire Louise Carroll, born 28 September 1975;

ii. Ms Carroll died on 19 May 2021 at 2 / 12 Hillford Street, Newcomb, Victoria, 3219;

iii. The cause of Ms Carroll's death was neck compression secondary to hanging; and

iv. The death occurred in the circumstances described above.

v. The available evidence, including the lethality of the means chosen and Ms Carroll's well documented history of mental ill health, supports a finding that she intentionally took her own life.

vi. I am satisfied that the responses provided by each Victoria Police member who had contact with Ms Carroll between 18-19 May 2021, whether in person or via the phone, was reasonable and appropriate.

vii. Having identified that Ms Carroll was highly agitated, Constable Wanat appropriately coordinated a response from a divisional van to perform a welfare check.

viii. Ms Carroll did not present as being at risk of suicide or imminent self-harm during any of the three separate contacts with Senior Constable Arnold and Constable Cole.

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…".

ix. Ms Carroll's interactions with police did not satisfy the legislative requirements for apprehension under section 351 of the MHA. I am satisfied that the conduct of all Police members was appropriate, competent and professional.

x. Barwon Health's management of Ms Carroll was complicated by her significant mental health diagnoses and complex symptomology.

xi. Ms Carroll's crisis plan and the decision to discontinue evening phone calls were suboptimal and represented a missed opportunity for Barwon Health to better provide support to Ms Carroll.

xii. Barwon Health's management of Ms Carroll was over reliant on external supports, such as the NDIS, her GP and private psychologist, particularly in the context of reduced NDIS supports due to COVID-19.

xiii. Ms Carroll's mental health deteriorated significantly in the months leading up to her death and due to her complex mental health issues, the evidence does not support a finding that a causal relationship exists between the sub-optimal aspects of Barwon Health's management of Ms Carroll and her subsequent death.

I convey my sincere condolences to Ms Carroll's family 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:

Rhonda Carroll, senior next of kin

Robert Carroll, senior next of kin

Barwon Health

East Geelong Medical Centre

Senior Constable Brad Clark, Victoria Police, Coroner's Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date : 07 March 2024

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.