IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 004369

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Jacqui Hawkins, Deputy State Coroner
Deceased:	Gillian Burgess
Date of birth:	9 November 1958
Date of death:	4 August 2022
Cause of death:	1(a) undetermined (natural causes)
Place of death:	15 Hill Street, Stawell, Victoria, 3380
Keywords:	Death in care, Natural Causes, Specialist Disability Accommodation, National Disability Insurance Scheme

INTRODUCTION

1. On 4 August 2022, Gillian Burgess (**Ms Burgess**) was 63 years old when she was found deceased in her bedroom. At the time of her death, Ms Burgess was a National Disability Insurance Scheme (**NDIS**) participant living in a Specialist Disability Accommodation (**SDA**) enrolled dwelling.

2. Ms Burgess was autistic, had an intellectual disability, and was non-verbal. She also had a range of medical conditions including chronic kidney disease and heart disease. Ms Burgess had been living in the care facility for the last eight years.

3. On 1 August 2022, Ms Burgess was diagnosed with COVID-19. On 3 August 2022 she was prescribed and administered molnupiravir, an anti-viral therapy for mild to moderate COVID-19 infection.

THE CORONIAL INVESTIGATION

4. Ms Burgess' 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.

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. This finding draws on the totality of the coronial investigation into the death of Ms Burgess 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]

IDENTITY OF THE DECEASED

8. On 4 August 2022, Gillian Burgess, born 9 November 1958, was visually identified by her carer, Leanne Margaret McDonald.

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

MEDICAL CAUSE OF DEATH

10. Forensic Pathologist Dr Matthew Lynch (**Dr Lynch**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 8 August 2022 and provided a written report the findings.

11. The post-mortem examination showed findings consistent with the clinical history. Post-mortem biochemistry showed an elevated CRP of 59.6mg/L which is suggestive of tissue damage and/or inflammation.

12. Dr Lynch noted that while there was no evidence of obvious pneumonic changes on post-mortem CT imaging, the possibility that the recent COVID-19 infection had contributed to the death should not be excluded, especially in the context of an elevated CRP level.

13. Toxicological analysis of post-mortem samples identified the presence of fluoxetine, norfluoxetine, valproic acid, and paracetamol. Dr Lynch commented that the levels of each of these drugs were consistent with therapeutic use.

14. Dr Lynch provided an opinion that the medical cause of death was *1 (a) undetermined (natural causes)*.

15. I accept Dr Lynch's opinion.

[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.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

16. On 4 August 2022, care workers observed Ms Burgess walking around the inside of the facility overnight. At some time between 4.30am and 7.30am she returned to bed.

17. At approximately 7.30am, Ms Burgess' carer attempted to wake her but realised that she had become unresponsive. Care workers removed Ms Burgess from the bed, commenced CPR, and called for an ambulance.

18. Shortly afterwards, paramedics from Ambulance Victoria attended and took over resuscitation efforts but unfortunately Ms Burgess could not be revived.

19. Officers from Victoria Police also attended. They spoke to Ms Burgess' doctor and documented that Ms Burgess was in relatively good health and that her doctor thought her recent COVID-19 diagnosis had likely contributed to her death.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Gillian Burgess, born 9 November 1958;

    b) the death occurred on 4 August 2022 at 15 Hill Street, Stawell, Victoria, 3380, from undetermined (natural causes); and

    c) the death occurred in the circumstances described above.

21. Ms Burgess' death was reportable by virtue of section 4(2)(c) of the Act because, immediately before her death, she was a person in care. Section 52 of the Act requires an inquest to be held, except in circumstances where the death was due to natural causes. I am satisfied that Ms Burgess died from natural causes and that no further investigation is required. Accordingly, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death and to finalise the investigation of her death on the papers.

22. While the exact cause of death is undetermined, in the absence of evidence to the contrary I find that the recent COVID-19 infection contributed to the death.

I convey my sincere condolences to Gillian'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:

Jennifer Dufty, Senior Next of Kin

Danielle Kelley, National Disability Insurance Scheme

Senior Constable Jake Fiddes, Coroner's Investigator

Signature:

Jacqui Hawkins, Deputy State Coroner

Date : 25 May 2023

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.