IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 007234

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Katherine Lorenz
Deceased:	Catherine Mary Lyons
Date of birth:	25 November 1963
Date of death:	16 December 2022
Cause of death:	1(a) Complications of Trisomy 21
Place of death:	Monash Medical Centre, 246 Clayton Road, Clayton, Victoria, 3168
Key Words:	In care, natural causes death, trisomy 21

INTRODUCTION

1. On 16 December 2022, Catherine Mary Lyons **(Ms Lyons)** was 59 years old when she died at the Monash Medical Centre **(MMC)**. At the time of her death, Ms Lyons resided in a supported residential service in Ashwood, managed by OC Connections.

2. Ms Lyons was supported by her family throughout her life and is survived by her mother, Maureen Lyons, and siblings, Greg, Kerrie, Anne, and Michael Lyons.

3. Ms Lyons' medical history included trisomy 21, moderate intellectual disability, aspiration pneumonia, Alzheimer's dementia, Raynaud's disease, Tourette's syndrome, type II diabetes and hypothyroidism, amongst other conditions. She had limited communication skills and required the support of a wheelchair. Her family noted the exemplary care that she received from staff at OC Connections.

4. Throughout her life, Ms Lyons had multiple hospital admissions for issues including fever, lethargy, unwitnessed falls, chest infection and other respiratory issues. Her last admission at the MMC was on 25 January 2022, where she presented with decreased interaction, intermittent desaturation, apnoea, and hypoxia. The impression was that she had aspiration pneumonia with Type 2 respiratory failure, acute kidney injury, sinus bradycardia and fluctuating conscious state. She was treated with intravenous medications and oxygen and rapidly improved. She was discharged on 27 January 2022.

THE CORONIAL INVESTIGATION

5. Ms Lyons' 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. However, if a person satisfies the definition of a person placed in care immediately before the death, the death is reportable even if it appears to have been from natural causes.[1]

6. Since 2019, funding for disability services in Victoria has shifted from the Department of Families, Fairness and Housing to the National Disability Insurance Scheme. This shift meant that the definition of '*person placed in custody or care'* in section 3(1) of the Act to include '*a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health'* was no longer sufficient to

[1] See the definition of *'reportable death'* in section 4 of the *Coroners Act 2008* (Vic), especially s4(2)(c) and the definition of a *'person placed in custody or care'* in section 3(1) of the *Coroners Act 2008* (Vic).

capture the group of vulnerable people in receipt of disability services that the legislature had intended. The Coroners Regulations 2019 were amended on 11 October 2022 to create a new category of person considered to be 'in care' under Regulation 7 of the Coroners Regulations 2019, being a *'person in Victoria who is an SDA resident residing in an SDA enrolled dwelling'*. The amendments also introduce an associated reporting obligation under Regulation 8 for a person who: (ii) is funded to provide an SDA resident with daily independent living support; and (ii) has reasonable grounds to believe that the resident's death has not been reported to a coroner or the Institute.

7. As Ms Lyons was an SDA resident residing in an SDA-enrolled dwelling at the time of her passing, her death is considered to be an 'in care' death. This requires that additional steps to be taken in the coronial process, including that an inquest (public hearing) be held unless the Coroner considers the death was due to natural causes, and that the present Findings be published on the Internet.

8. 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.

9. 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.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Lyons' death. The Coroner's Investigator, Senior Constable Richard Fitzgerald, 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.

11. This finding draws on the totality of the coronial investigation into the death of Ms Lyons 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.[2]

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

Circumstances in which the death occurred

12. On 8 December 2022, Ms Lyons was seen by Dr Michelle Tan at the Monash Medical Group with symptoms suggestive of a respiratory tract infection. On examination, she did not appear unwell and did not have a fever. Her throat examination revealed mild inflammation. Dr Tan prescribed the antibiotic, Augmentin Duo Forte.

13. On 12 December 2022, Ms Lyons was reviewed by Dr Tan. Her carer reported that her cough had improved, but she was noted to have drowsiness during the day. Her chest was clear, and she was afebrile. Dr Tan noted that Ms Lyons did not look unwell and advised the carers that she be monitored closely regarding her drowsiness and cough. Dr Tan was aware that a locum doctor had reviewed Ms Lyons and suggested that her drowsiness may be due to her medications (e.g.: Serenace, Oxazepam, Mirtazapine). As Ms Lyons' cough had improved and she was not short of breath, Dr Tan reduced the dose of Mirtazapine from 45mg to 30mg. Ms Lyons was due to be reviewed by her regular general practitioner in two weeks.

14. At 8.50am on 15 December 2022, a nurse located Ms Lyons in an unresponsive state in her residence. She was breathing but her lips were blue. Emergency services were contacted. Upon the arrival of paramedics, Ms Lyons' oxygen saturation levels were found to be low at 76%. She was provided with high flow oxygen and became responsive, but drowsy.

15. Ms Lyons was transported to the MMC and admitted to the ward. On clinical examination she was afebrile, and her oxygen saturation was 93%. An initial review of her chest x-ray was interpreted as pulmonary oedema. A formal chest x-ray report was that the interstitial change was more consistent with infection, but her blood test revealed normal white cell count and minimally elevated CRP, inconsistent with active infection. Ms Lyons had a mild acute kidney injury, elevated potassium, elevated troponin, and BNP, consistent with type 2 myocardial infarction and heart failure.

[2] 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.

16. Ms Lyons' condition deteriorated overnight with worsening type 2 respiratory failure. It was determined that she was unsafe for non-invasive ventilation. Following consultation with her family, Ms Lyons' active treatment was ceased. She was palliated and subsequently died on 16 December 2022 at 8.20pm.

Identity of the deceased

17. On 20 December 2022, Catherine Mary Lyons, born 25 November 1963, was visually identified by her sister, Kerrie Lyons.

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

Medical cause of death

19. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine conducted an external examination on 21 December 2022 and provided a written report of his findings dated 5 January 2023.

20. Post-mortem CT scan showed increased lung markings, pleural effusions, and focal coronary artery calcification in the chest. The brain showed ventriculomegaly and basal ganglia calcification, and no intracranial haemorrhage. No unexpected signs of trauma were identified.

21. Dr Young noted that complications of trisomy 21 include aspiration pneumonia and early onset Alzheimer's dementia. Death may commonly occur from respiratory complications.

22. Toxicological analysis of post-mortem samples identified the presence of mirtazapine, haloperidol, periciazine and traces of paracetamol.

23. Dr Young provided an opinion that the medical cause of death was due to natural causes, namely, *1 (a) Complications of Trisomy 21*.

24. I accept Dr Young's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Catherine Mary Lyons, born 25 November 1963;

    b) the death occurred on 16 December 2022 at Monash Medical Centre, 246 Clayton Road, Clayton, Victoria, 3168, from natural causes, namely, complications of trisomy 21; and

c) the death occurred in the circumstances described above.

I convey my sincere condolences to Ms Lyons' 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:

Kerrie Lyons, Senior Next of Kin

Senior Constable Richard Fitzgerald, Coroner's Investigator

Department of Families, Fairness and Housing

Signature:

Coroner Katherine Lorenz

Date : 11 September 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.