IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 007430

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Grethe Larsen
Date of birth:	23 February 1955
Date of death:	25 December 2022
Cause of death:	1(a) Complications of metastatic lung cancer, in a woman with chronic obstructive pulmonary disease and multiple sclerosis
Place of death:	Sunshine Hospital Furlong Road, St Albans, Victoria, 3021
Keywords:	In care; Natural causes

INTRODUCTION

1. On 25 December 2022, Grethe Larsen was 67 years old when she died at Sunshine Hospital.

2. Grethe had a history of advanced multiple sclerosis, lung cancer, and chronic obstructive pulmonary disease (**COPD**).

3. From 27 April 2022 until her death, Grethe resided in Specialist Disability Accommodation (**SDA**) which was an apartment in Maribyrnong operated by ONCALL under a concierge model and funded by the National Disability Insurance Scheme (**NDIS**).

4. Grethe presented with contractures to her hips and knees, and significantly high tone throughout her body. She had no functional use of her lower limbs, mobilised with the use of a powered wheelchair, and transferred using a using a full body sling and ceiling hoist supported by two support staff for all transfers. She also required support workers to assist with bed mobility, including using bed mechanics to lift Grethe up the bed when she slipped down.

5. Grethe's apartment was purpose built and equipped with technology to meet her needs. She was supported by staff on site (concierge) as needed and utilised a combination of support through ONCALL and privately contracted disability support workers.

6. Grethe also accessed support coordination services from Merri Health and occupational therapy, physiotherapy and palliative care and continence nursing through community services of her choice.

7. Grethe was able to direct and manage her own supports and services.

THE CORONIAL INVESTIGATION

8. Grethe's death was reported to the Coroner as it fell within the definition of a reportable death in the Coroners Act 2008 (the Act).

9. On 12 April 2023, having commenced an investigation into the death of Grethe Larsen, I determined to discontinue my investigation under section 17 of the Act.

10. However, it has since come to my attention that Grethe's death was a death that is referred to in section 4(2)(c) of the Act. This is because Grethe was immediately before death a person

placed "in care", meaning that she was an SDA resident residing in an SDA enrolled dwelling. In those circumstances, I am required by the Act to make findings with respect to the circumstances of Grethe's death.

11. Generally, the Coroner must also hold an inquest into the death of a person "in care". However, under section 51(3A) and (3B) of the Act, the Coroner is not required to hold an inquest if the Coroner considers that the death was due to natural causes, on the basis of a report from a medical investigator which includes an opinion as such.

12. In this instance, I am satisfied on the basis of a report from Forensic Pathologist Dr Gregory Young of the Victorian Institute of Forensic Medicine (**VIFM**) dated 3 January 2023 that Grethe's death was due to natural causes and therefore that an inquest is not required. The report of Dr Young is discussed further below in relation to the medical cause of death.

13. 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.

14. 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.

15. Taking into account the circumstances of death, I determined to seek further information from the National Disability Insurance Agency (**NDIA**) and a statement from SDA Provider, ONCALL.

16. This finding draws on the totality of the coronial investigation into the death of Grethe Larsen. 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]

[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.

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

Circumstances in which the death occurred

17. In June 2022, Grethe was referred to community based palliative care services.

18. On 6 December 2022, she was discharged from palliative care at the Royal Melbourne Hospital after being admitted for right upper limb weakness secondary to brain metastases.

19. On 15 December 2022, she was reviewed by a Mercy palliative care consultant and noted to have functional decline.

20. On 19 December 2022, she was observed by ONCALL staff to be unwell and supported to contact the palliative are team. Grethe was subsequently attended by the palliative care nurse and transferred to hospital by ambulance.

21. Grethe was admitted to Sunshine Hospital with ongoing decline and not being able to self-care. In the emergency department, she was noted to be hypoxic, and a CT scan of the brain confirmed metastatic cancer, but did not show any intracranial haemorrhage.

22. She was commenced on antibiotics for possible chest infection, and was noted to have possible seizure activity on 23 December 2022.

23. After further deterioration, Grethe died on 25 December 2022.

Identity of the deceased

24. On 18 January 2023, Grethe Larsen, born 23 February 1955, was identified via circumstantial evidence and a visual comparison.

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

Medical cause of death

26. On 2 January 2023, Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (VIFM), conducted an external examination and reviewed a post mortem CT scan and relevant materials including the Vitoria Police Report of Death (Form 83) and the e-Medical Deposition. Dr Young provided a written report of his findings dated 3 January 2023.

27. A post mortem CT scan confirmed the presence of a lesion in the right lung, increased lung markings, pleural effusions, a suprapubic catheter, a calcified lesion in the right temporal lobe of the brain, and peripheral muscle wasting. There was no intracranial haemorrhage.

28. The external examination showed no unexpected signs of trauma.

29. Taking into account all available information, Dr Young provided an opinion that the death was due to natural causes and that a reasonable formulation for the medical cause of death was '1 (a) Complications of metastatic lung cancer, in a woman with chronic obstructive pulmonary disease and multiple sclerosis.'

30. I accept Dr Young's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Grethe Larsen, born 23 February 1955;

    b) the death occurred on 25 December 2022 at Sunshine Hospital Furlong Road, St Albans, Victoria, 3021, from complications of metastatic lung cancer, in a woman with chronic obstructive pulmonary disease and multiple sclerosis; and

    c) the death occurred in the circumstances described above.

32. Having considered all of the circumstances, I am satisfied that Grethe's death occurred due to natural causes and have not identified any opportunities for prevention.

I convey my sincere condolences to Grethe'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:

Erik Larsen, Senior Next of Kin

Signature:

Coroner Leveasque Peterson

Date : 13 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.