IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000682

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Wendy Joy Morgan
Date of birth:	6 May 1966
Date of death:	4 February 2023
Cause of death:	1(a) Complications arising from acute on chronic haemorrhage into suprachiasmal pilocytic astrocytoma
Place of death:	23 Numbat Drive, Beveridge, Victoria, 3753
Keywords:	In care - acquired brain injury - natural causes - supported disability accommodation

INTRODUCTION

1. On 4 February 2023, Wendy Joy Morgan was 56 years old when she passed away at the residential care facility in which she resided in Beveridge. She is survived by her partner, Shaun Montgomery, and her son, Travis Bryan.

BACKGROUND

2. In 2021, Ms Morgan suffered an acquired brain injury after developing hydrocephalus[1] secondary to pilocytic astrocytoma.[2] Her medical history also included dysphasia,[3] seizures and hyponatraemia.[4]

3. After her brain injury, Ms Morgan moved into disability residential care. She required assistance for feeding and hygiene and all transfers were conducted with a sling and hoist.

THE CORONIAL INVESTIGATION

4. Ms Morgan'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. 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. Ms Morgan was a person in care at the time of her death as she was a Specialist Disability Accommodation (**SDA**) resident living in an SDA dwelling pursuant to Regulation 7(1)(d) of the *Coroners Regulations 2019*. However, an inquest was not required to be held pursuant to section 52(3A) of the Act given that Ms Morgan's death was 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.

[1] Build up of fluid in the cavities within the brain. The extra fluid puts pressure on the brain which can cause brain damage.
[2] A form of brain tumour.
[3] Swallowing dysfunction.
[4] Low blood sodium.

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 Ms Morgan's death, including information obtained from her medical records. While 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.[5]

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

Circumstances in which the death occurred

8. At around 8.50am on 4 February 2023, Ms Morgan ate some yoghurt which was provided by her carer. Ms Morgan was then assisted to have a shower. At around 9.30am, when Ms Morgan was being assisted back onto her bed, her carer noted that she became unresponsive. The carer moved Ms Morgan to the floor and contacted emergency services while another worker performed cardiopulmonary resuscitation.

9. Ambulance Victoria arrived at 9.56am but Ms Morgan could not be revived. She was pronounced deceased at 10.03am. Victoria Police attended the scene and did not identify any suspicious circumstances.

Identity of the deceased

10. On 8 February 2023, Wendy Joy Morgan, born 6 May 1966, was visually identified by her son, Travis Bryan.

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

[5] 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.

Medical cause of death

12. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine, performed an autopsy on 7 February 2023 and provided a written report of his findings dated 15 August 2023.

13. There were no injuries found which may have caused or contributed to the death. Dr Beer expressed the opinion that the death was due to natural causes.

14. Toxicological analysis of post-mortem samples identified the presence of levetiracetam[6] at a non-toxic level.

15. Dr Beer provided an opinion that the medical cause of death was 1 (a) Complications arising from acute on chronic haemorrhage into suprachiasmal pilocytic astrocytoma.

16. I accept Dr Beer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Wendy Joy Morgan, born 6 May 1966;

    b) the death occurred on 4 February 2023 at 23 Numbat Drive, Beveridge, Victoria, from Complications arising from acute on chronic haemorrhage into suprachiasmal pilocytic astrocytoma; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Ms Morgan'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:

Shaun Montgomery, Senior Next of Kin

[6] Levetiracetam is an antiepileptic used for the control of partial onset seizures.

St Vincent's Hospital, Melbourne

Constable Rowan Olsson, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 03 October 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.