IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000692

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Dianne Christine Hobbs
Date of birth:	26 January 1954
Date of death:	4 February 2023
Cause of death:	1(a) Metastatic ovarian adenocarcinoma
Place of death:	56 Sladen Street, Hamlyn Heights, Victoria, 3215
Keywords:	Supported Disability Accommodation (SDA), In care, Natural causes

INTRODUCTION

1. On 4 February 2023, Dianne Christine Hobbs was 69 years old when she died at her home. At the time of her death, Ms Hobbs lived in Supported Disability Accommodation (**SDA**) in Hamlyn Heights that was managed by Scope Australia, from whom she received National Disability Insurance Scheme (**NDIS**) funded and regulated support.

2. Ms Hobbs' medical history included hypoxic ischaemic encephalopathy from birth, intellectual disability, epilepsy, myocarditis arising from a Covid-19 infection, breast cancer, osteoporosis, gastro-oesophageal reflux disease, and breast cancer. She underwent an oophorectomy in 2006 for an ovarian cyst and a left breast mastectomy in 2009. In 2013, Ms Hobbs underwent a right total hip replacement.

3. In November 2022, Ms Hobbs underwent computed tomography (**CT**) scan of her chest, abdomen and pelvis which revealed a large left cystic lesion and further lesions which had spread to the peritoneum, liver, spleen, and T9 vertebral body. On 25 November 2022, a paracentesis was performed that confirmed a diagnosis of advanced stage ovarian cancer.

4. On 19 December 2022, Ms Hobbs was referred to Barwon Health palliative care. On 3 January 2023, she formally commenced in-home palliative care and her carers began receiving nursing support for her end-of-life care.

THE CORONIAL INVESTIGATION

5. Ms Hobbs' death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Ms Hobbs' death was reportable as she was she a person placed *"in care"* under s4(2)(c) of the Act.[1] This category of deaths are reportable to ensure independent scrutiny of the circumstances given the vulnerability of the deceased and the level of level of power and control exercised by those who care for them. If such deaths occur as a result of natural causes, a coronial investigation must take place, but the holding of an inquest is not mandatory.

6. 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

[1] She was an SDA resident residing in an SDA enrolled dwelling before the time of her death; Reg 7(1)(d), *Coroners Regulations 2019*.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. 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.

8. This finding draws on the totality of the coronial investigation into the death of Ms Hobbs including evidence contained in her medical records, information from the NDIS and a medical deposition completed by Barwon Health. 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.[2]

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

Circumstances in which the death occurred

9. On 17 January 2023, Ms Hobbs suffered a fall from bed and sustained bruising to her left shoulder and left hip. She was transferred to the Emergency Department (**ED**) of Geelong Hospital, however scans of her chest, pelvis and left shoulder did not reveal any bony injuries.

10. On 19 January 2023, Ms Hobbs was readmitted to the ED as she was unable to weight bear and complained of left hip pain. She underwent further imaging but no injuries were revealed, and she received pain relief as needed.

11. Ms Hobbs' condition continued to deteriorate and by 2 February 2023, she was unable to take oral medications and was commenced on a syringe driver for pain relief and sedation. She subsequently passed away on 4 February 2023 at 3.00pm.

Identity of the deceased

12. On 4 February 2023, Dianne Christine Hobbs, born 26 January 1954, was visually identified by her carer, Donna Montgomery.

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[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.

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

Medical cause of death

14. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine conducted an examination on 6 February 2023 and provided a written report of her findings dated 3 March 2023.

15. Dr Francis reviewed a post-mortem computed tomography (**CT**) scan, which revealed bilateral pleural effusions, increased lung markings, ascites, and severe emaciation with a right hip prosthesis. There was no evidence of external trauma.

16. Dr Francis provided an opinion that the medical cause of death was 1(a) Metastatic ovarian adenocarcinoma. She considered that Ms Hobbs' death was due to natural causes.

17. I accept Dr Francis' opinion.

CONCLUSION

18. Having carefully considered the available evidence, I am satisfied that the care Ms Hobbs received in the period proximate to her death was reasonable and appropriate.

19. As noted above, Ms Hobbs' death was reportable by virtue of section 4(2)(c) of the Act because, immediately before her death, she was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Ms Hobbs died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an Inquest into her death.

FINDINGS

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

    a) the identity of the deceased was Dianne Christine Hobbs, born 26 January 1954;

    b) the death occurred on 04 February 2023 at 56 Sladen Street, Hamlyn Heights, Victoria, 3215, from metastatic ovarian adenocarcinoma; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Ms Hobbs' 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:

Barry Hobbs, Senior Next of Kin

Barwon Health

National Disability Insurance Scheme Quality and Safeguards Commission

Constable Dylan Furness, Coroner's Investigator

Signature:

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Coroner David Ryan

Date : 29 August 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.