IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002141

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Miranda Louise Lynch
Date of birth:	13 December 1976
Date of death:	24 April 2023
Cause of death:	1(a) Sepsis of unknown origin
Place of death:	Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria, 3128
Keywords:	In care death, natural causes, sepsis

INTRODUCTION

1. On 24 April 2023, Miranda Louise Lynch was 46 years old when she passed away at Box Hill Hospital. At the time of her death, Ms Lynch lived at 45 Lemon Grove, Nunawading, Victoria, 3131 in specialist disability care accommodation.

2. Ms Lynch resided with her parents at their home in Warrandyte, until the age of 35. From that time, she moved to the specialist disability care facility in Nunawading, run by Life Without Barriers.

3. Ms Lynch had a complex medical history which included severe cerebral palsy, spasmatic quadriplegia, epilepsy, hip dysplasia, chronic pain syndrome, dextroscoliosis, and aspiration pneumonia. She was wheelchair bound and received food via a percutaneous endoscopic gastrostomy (**PEG**) tube. Ms Lynch was non-verbal; however, she was able to communicate with others using her picture book. She regularly attended the First Base Yooralla Ferntree Gully day placement for many years, where she enjoyed the company of her friends.

THE CORONIAL INVESTIGATION

4. Ms Lynch's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).[1] Ms Lynch was a "*person placed in custody or care*" pursuant to the definition in s 4 of the Act, as she was "*a prescribed person or a person belonging to a prescribed class of person*" due to her status as an "*SDA resident residing in an SDA enrolled dwelling*".[2]

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The 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

[1] Section 4(1), (2)(c) of the Act.

[2] Pursuant to Reg 7(1)(d) of the *Coroners Regulations 2019*, a "*prescribed person or a prescribed class of person*" includes a person in Victoria who is an "*SDA resident residing in an SDA enrolled dwelling*", as defined in Reg 5. I have received information that Ms Lynch resided at an address where the residents meet these criteria.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Lynch's death. The Coroner's Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Miranda Louise Lynch 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.[3]

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

Circumstances in which the death occurred

9. On 28 March 2023, Ms Lynch was admitted to St Vincent's Hospital, Melbourne, to have her baclofen pump replaced. During the admission, she was diagnosed with aspiration pneumonia and was managed for tachypnoea and tachypnoea. She was discharged home on 5 April 2023.

10. On 20 April 2023, Ms Lynch experienced two episodes of altered consciousness. The first episode occurred at about 10.30am that morning whilst she was at her day placement, although it appeared to spontaneously resolve. Her carers called an ambulance and paramedics attended and cleared Ms Lynch to return home. She left the day placement early that day and returned to her home in Nunawading.

11. At about 2.00pm that day, Ms Lynch experienced a second episode of altered consciousness, however on this occasion, she was unable be roused. Her carers called 000 and requested an ambulance, which transported Ms Lynch to Box Hill Hospital. Upon admission to hospital, Ms Lynch was noted to be bradycardic, hypotensive, and hypothermic. She was treated with intravenous fluids, hydrocortisone, and antibiotics.

12. Clinicians formed a preliminary diagnosis of cold sepsis and ran several tests to investigate the cause of the sepsis. Her recently replaced baclofen pump was inspected to confirm it was

[3] 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.

not the cause of the sepsis. She experienced episodes of vomiting and required frequent suctioning of her airways by nursing staff. Despite numerous investigations, the source of Ms Lynch's sepsis was unable to be determined and she required increased suctioning of her airways over the course of the admission.

13. At about 5.30am on 24 April 2023, staff observed that Ms Lynch was not breathing. Ms Lynch had an advanced care directive in place which directed that she was not to receive any invasive resuscitation measures, and she was declared deceased at 6.01am.

Identity of the deceased

14. On 24 April 2023, Miranda Louise Lynch, born 13 December 1976, was visually identified by her mother, Anita Lynch.

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

Medical cause of death

16. Forensic Pathologist, Adjunct Associate Professor (**A/Prof**) Sarah Parsons, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external post-mortem examination on 26 April 2023 and provided a written report of her findings dated 8 May 2023.

17. Examination of the post-mortem CT scan showed a PEG tube and bilateral pleural effusions.

18. Adjunct A/Prof Parsons had recommended that an autopsy be performed to determine the source or the location of the sepsis and to determine if there was meningitis. I initially directed an autopsy be performed as it was communicated to me that that the family of Ms Lynch did not object. However, the family of Ms Lynch subsequently objected to the procedure. As Adjunct A/Prof Parsons was able to provide an opinion on a reasonable cause of death without an autopsy, I directed that the autopsy not occur.

19. Toxicological analysis of post-mortem samples was not indicated and was therefore not performed.

20. Adjunct A/Prof Parsons provided an opinion that the medical cause of death was "*1 (a) Sepsis of unknown origin*" and that the death was due to natural causes.

21. I accept Adjunct A/Prof Parsons' opinion.[4]

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Miranda Louise Lynch, born 13 December 1976;

    b) the death occurred on 24 April 2023 at Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria, 3128, from sepsis of unknown origin; and

    c) the death occurred in the circumstances described above.

I convey my condolences to Ms Lynch'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:

Francis and Anita Lynch, Senior Next of Kin

Eastern Health

Constable Carly Notting, Victoria Police, Coroner's Investigator

Signature:

Coroner Catherine Fitzgerald

Date : 04 February 2024

[4] Pursuant to s 52(3A) of the Act, a coroner is not required to hold an inquest where the deceased was, immediately before death, a person placed in custody or care, if the coroner considers that the death was due to natural causes.

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.