IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003684

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Katherine Lorenz
Deceased:	Edwina Kate Moulin
Date of birth:	20 March 1971
Date of death:	9 July 2023
Cause of death:	1(a) spontaneous intracranial haemorrhage 1(b) ruptured berry aneurysm
Place of death:	Austin Hospital 145 Studley Road, Heidelberg, Victoria, 3084
Keywords:	Specialist Disability Accommodation, SDA, death in care, brain aneurysm

INTRODUCTION

1. On 9 July 2023, Edwina Kate Moulin was 52 years old when she died in hospital from a ruptured berry aneurysm. At the time of her death, Edwina was a National Disability Insurance Scheme (**NDIS**) participant receiving funding for Supported Independent Living (**SIL**) from La Vita Care in a Specialist Disability Accommodation (**SDA**) enrolled dwelling. Edwina was receiving these supports following an Acquired Brain Injury (**ABI**) and other complications from a stroke in 2019.

2. Berry aneurysms are the most common type of brain aneurysm and appear as a berry-like ballooning of the arteries in the brain caused by weakness in the artery wall. They are often undetected as they often do not cause any signs or symptoms until they rupture. While there are risk factors that can contribute to development and rupture of an aneurysm, there is often no clear cause for either.

THE CORONIAL INVESTIGATION

3. Edwina'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 of a person 'in care', which includes Edwina as a person living in an SDA enrolled dwelling.

4. The Act recognises that people in care are vulnerable and affords them protection by requiring that the circumstances of their death are investigated by a coroner, irrespective of the medical cause of death, and by mandating that as part of that investigation there should be an inquest or formal hearing unless it is a death 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.

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 the death of Edwina Kate Moulin. 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]

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

Circumstances in which the death occurred

8. On 6 July 2023, Edwina attended an in-person physiotherapy appointment before returning to her home at about 3pm. She attended choir later in the evening and had spent time with her mother earlier in the day. At approximately 9.30pm, Edwina vomited but did not otherwise indicate that she felt unwell. Instead, this was attributed to a side effect of her medication.

9. Edwina's mother had called La Vita Care earlier in the evening to raise concerns about a recurring urinary tract infection associated with Edwina's permanent indwelling suprapubic catheter. Edwina's mother urged that her GP appointment should be brought forward from 10 to 7 July 2023 if Edwina was still unwell.

10. At various times overnight, staff continued to check on Edwina given her nausea and vomiting. Edwina reportedly asked staff to play music on her iPad and that she wasn't feeling unusually unwell.

11. At 4.20am, on 7 July 2023, staff noted that Edwina's breathing was loud and that she wasn't responding to her name. Staff called Triple Zero and reported that Edwina had a pulse but was otherwise unresponsive. Paramedics from Ambulance Victoria attended soon after and conveyed Edwina to the Austin Hospital.

12. On arrival at hospital, a CT scan of the brain showed extensive bleeding from a previously unknown aneurysm in the brain. Consultation with the neurosurgical unit suggested that this was a non-survivable event, and Edwina was transferred to the ICU for end-of-life care. Edwina died later that day.

[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.

Identity of the deceased

13. On 7 July 2023, Edwina Kate Moulin, born 20 March 1971, was visually identified by her mother, Sandra Davies, who completed a statement of identification.

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

Medical cause of death

15. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 10 July 2023 and provided a written report of the findings.

16. The examination findings were consistent with the clinical history.

17. Dr Baber provided an opinion that the medical cause of death was:

    1(a) spontaneous intracranial haemorrhage

    1(b) ruptured berry aneurysm

18. Dr Baber also provided an opinion that the death was from natural causes.

19. I accept Dr Baber's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Edwina Kate Moulin, born 20 March 1971;

    b) the death occurred on 9 July 2023 at Austin Hospital, 145 Studley Road, Heidelberg, Victoria, 3084, from; and

    c) the death occurred in the circumstances described above.

21. Having considered all the available evidence, I find that Edwina's death was from natural causes and was unrelated to the care she received as a person 'in care'. As such, the circumstances around the general care provided to Edwina are not sufficiently proximate nor causative of the death to allow me to investigate any concerns relating to them.

I convey my sincere condolences to Edwina'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:

Sandra Davies, Senior Next of Kin

First Constable Joseph Lual, Coroner's Investigator

La Vita Care

Alfred Health

Signature:

Coroner Katherine Lorenz

Date : 29 February 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.