IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005778

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Linda Snadden
Date of birth:	12 December 1960
Date of death:	15 October 2023
Cause of death:	1a: ASPIRATION PNEUMONIA IN THE SETTING OF REFRACTORY FOCAL STATUS EPILEPTICUS
Place of death:	Northern Hospital 185 Cooper Street Epping Victoria 3076
Keywords:	In care, specialist disability accommodation, SDA, disability, natural causes

INTRODUCTION

1. On 15 October 2023, Linda Snadden[1] was 62 years old when she died at hospital. At the time of her death, Linda lived in Mooroolbark, Victoria.

2. During her adulthood, Linda worked as a teacher. As her health declined, during the 2000s, she left the education profession. She enjoyed going to the library, crocheting, shopping, watching television and speaking with her friend, Jenny.

3. Linda experienced progressive cognitive decline on the background of a previous brain surgery due to a frontal cystic meningioma, a brain tumour. She also had a childhood acquired brain injury. Linda's medical history included obesity, Type 2 diabetes mellitus, atrial fibrillation, severe obstructive sleep apnoea, hypoventilation syndrome, severe pulmonary hypertension, recurrent cellulitis and gastro-oesophageal reflux disease (**GORD**).

4. Due to Linda's limited cognition, she required around-the-clock assistance for all daily tasks. Since February 2023, Linda received funding from the National Disability Insurance Scheme (**NDIS**) to live in a Specialist Disability Accommodation (**SDA**) enrolled dwelling operated by SDA Options, with CareChoice providing Supported Independent Living supports.

5. Linda had several admissions to hospital including on two periods between July and October 2023, prior to her final admission. On these occasions, Linda presented with slurred speed and single-sided abnormal facial movements – such as twitching or drooping. She was managed using anti-seizure medication and discharged to follow up with an epilepsy clinic.

THE CORONIAL INVESTIGATION

6. Linda's death fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as she was a *'person placed in custody or care'* within the meaning of the Act, as a person in Victoria who was an *'SDA resident residing in an SDA enrolled dwelling'* immediately prior to her death. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort, and is reflected in the definition of a *'person placed in custody or care'* in section 3(1) of the Act, read in conjunction with Regulation 7 of the *Coroners Regulations 2019*.

7. 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

[1] Referred to throughout this finding as 'Linda', unless more formality is required.

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.

8. 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.

9. There is a requirement under section 52(2)(b) of the Act to hold an Inquest into the death of a person who was in custody or care immediately prior to passing, though pursuant to section 52(3A) of the Act, the coroner is not required to hold an Inquest if the coroner considers the death was due to natural causes. I exercise my discretion under this provision not to hold an Inquest in the present case on the basis that Linda's passing was due to natural causes and there are no further issues I have identified that require the hearing of *viva voce* evidence.

10. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Linda's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of Linda Snadden 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.[2]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

12. On 22 September 2023, during dinner at approximately 6:30pm, Linda began coughing. The feeds delivered via her naso-gastric tube were coming from her mouth, indicating a vomiting episode.

13. Staff contacted emergency services. While waiting for paramedics, staff observed Linda to be having a seizure. At approximately 7:30pm, Ambulance Victoria paramedics arrived and

[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.

transported Linda to the Northern Hospital. While hospitalised, Linda experienced further seizures and was administered various anti-epileptic medications.

14. On 10 October 2023, a computed tomography (**CT**) scan of Linda's brain demonstrated a large right parietal mass with surrounding oedema and midline shift of adjacent brain structures. Linda was too fragile for neurosurgical intervention.

15. Over the ensuing days, Linda's condition deteriorated, and she experienced a reduced level of consciousness. On 14 October 2023, she became hypoxaemic and tachypnoeic. Treatment was initially commenced for possible aspiration pneumonia, with antibiotics and supplemental oxygen. However, given Linda's ongoing deterioration, the decision was made to transition her to an end-of-life pathway.

16. On 15 October 2023, at 4:20pm, clinicians declared Linda deceased.

IDENTITY OF THE DECEASED

17. On 14 November 2023, Linda Snadden, born 12 December 1960, was visually identified by her brother, John Snadden, who completed a formal Statement of Identification.

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

MEDICAL CAUSE OF DEATH

19. Forensic Pathologist Dr Matthew Lynch (**Dr Lynch**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on the body of Linda Snadden on 23 October 2023. Dr Lynch considered materials including the Victoria Police Report of Death for the Coroner (**Form 83**), medical records provided by Northern Health and post-mortem CT scan and provided a written report of his findings dated 13 November 2023.

20. The post-mortem CT scan demonstrated a ventriculoatrial shunt, cardiomegaly,[3] and increased lung markings.

21. Dr Lynch provided an opinion that the death was due to natural causes, and that the medical cause of death was 1(a) *aspiration pneumonia in the setting of refractory focal status epilepticus*. I accept Dr Lynch's opinion.

[3] Enlargement of the heart.

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 Linda Snadden, born 12 December 1960;

    b) the death occurred on 15 October 2023 at Northern Hospital 185 Cooper Street, Epping Victoria 3076, from 1(a) *aspiration pneumonia in the setting of refractory focal status epilepticus*; and

    c) the death occurred in the circumstances described above.

23. Having considered all of the circumstances, I am satisfied that Linda Snadden's death occurred due to natural causes, in the setting of multiple health conditions.

24. I find that the treatment provided by staff at Northern Hospital and CareChoice was reasonable and appropriate in the circumstances.

25. The factual matrix of Linda Snadden's death does not support a conclusion that her being *'in care'* at the time of her death – according to the Act – had a causal relationship with the death.

I convey my sincere condolences to Linda's family for their profound loss.

ORDERS AND DIRECTIONS

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:

John Snadden, Senior Next of Kin

Northern Health

CareChoice

Sergeant Emma-Lee Maynard, Coronial Investigator

Signature:

Ingrid Giles

Coroner

Date: 15 July 2025

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.