IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 000027

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Isobel Francis
Date of birth:	23 April 1958
Date of death:	30 December 2023
Cause of death:	1a: Status epilepticus complicating cerebral palsy
Place of death:	Austin Hospital 145 Studley Road Heidelberg Victoria 3084
Keywords:	In care, natural causes, cerebral palsy, SDA resident

INTRODUCTION

1. On 30 December 2023, Isobel Francis **(Ms Francis)** was 65 years old she died at the Austin Hospital. Ms Francis is survived by her sister, Ms Bronwen Francis.

2. Ms Francis suffered from measles encephalitis at a young age, and this caused intellectual impairment and cerebral palsy. She was non-verbal in her communication and lived in a Specialist Disability Accommodation **(SDA)** residence in Preston. Ms Francis received supported independent living support services from Scope.[1]

THE CORONIAL INVESTIGATION

3. Ms Francis' death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**)[2]. 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.

4. In this instance, Ms Francis was a *"person placed in custody or care"* pursuant to the definition in section 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."*[3]

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

7. This finding draws on the totality of the coronial investigation into the death of Isobel Francis including evidence contained in the coronial brief. Whilst I have reviewed all the material, I

[1] A not-for-profit disability service provider.
[2] Section 4(1), 4(2)(c) of the Act.
[3] 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.

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.[4]

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

Circumstances in which the death occurred

8. On 30 September 2023, Ms Francis was admitted to the Austin Hospital with pancreatitis and pneumonia. She was stabilised and eventually discharged on 16 October 2023.

9. Ms Francis subsequently developed a chest infection and was prescribed antibiotics. On 23 November 2023, she was again admitted to the Austin Hospital with aspiration pneumonia. She was discharged with oral antibiotics on 28 November.

10. Between 5 December 2023 to 20 December, Ms Francis was re-admitted to hospital due to aspiration pneumonia, hyponatraemia and functional decline.

11. On 26 December 2023 at 7.30am, Ms Francis' disability support workers observed that she appeared tired and lethargic with worsening functional decline. An ambulance was called, and Ms Francis was admitted to the Austin Hospital. She underwent a brain CT scan which did not identify any acute intracranial pathology. A chest X-ray identified new opacities in the left lower zone, and Ms Francis was treated empirically for aspiration pneumonia.

12. Ms Francis suffered multiple seizures on 27 December. She was noted to have reduced conscious state and low blood pressure and was reviewed in a medical emergency call that evening. The impression was that her reduced Glasgow Coma Score could be multifactorial including ongoing status epilepticus, being post-ictal, a hypoactive delirium and sedative effects of the antiepileptics. The intensive care unit registrar discussed with Ms Bronwyn Francis that it was unclear how long this reduced conscious state would last and that it could potentially be a terminal event.

13. A statement from Dr Ethan Tan from Austin Health outlined that on 28 December 2023, both the epilepsy team and general medicine team reviewed Ms Francis and did not see any improvements in her conscious state with ongoing seizures despite antiepileptics in the afternoon of 27 December and the morning of 28 December. Dr Tan noted that *'the epilepsy*

[4] 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.

team did not believe starting a third antiepileptic would be beneficial in Isobel's case since it may worsen her reduced conscious state.' Due to her poor recovery and deterioration, clinicians held discussions with Ms Bronwyn Francis. Ms Francis was transferred to palliative care for end-of-life measures.

14. Ms Francis passed away on the morning of 30 December 2023 at 9.10am.

Identity of the deceased

15. On 3 January 2024, Isobel Francis, born 23 April 1958, was visually identified by Scope Australia Operations Manager Maggie Gruner.

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

Medical cause of death

17. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine conducted an external examination on 5 January 2024 and provided a written report of her findings dated 23 January 2024.

18. Examination of the postmortem CT scan showed bilateral external ear calcifications, swollen brain, bilateral pleural effusions, and patchy increased lung markings. The external examination showed no remarkable features. There was no evidence of any injuries that could have caused or contributed to death.

19. Dr Archer provided an opinion that the medical cause of death was *1(a) Status epilepticus complicating cerebral palsy.* Dr Archer considered that the death was due to natural causes.

20. I accept Dr Archer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Isobel Francis, born 23 April 1958;

    b) the death occurred on 30 December 2023 at Austin Hospital, 145 Studley Road, Heidelberg, Victoria 3084 from status epilepticus complicating cerebral palsy and

    c) the death occurred in the circumstances described above.

22. I note that section 52 of the Act requires that an inquest be held, except in circumstances where the death was due to natural causes. I am satisfied that Ms Francis died from natural causes, and I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death.

I convey my sincere condolences to Ms Francis' family, carers and loved ones 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:

Bronwen Francis, Senior Next of Kin

Ms Noemi Baquing, Austin Health

Senior Constable Christopher Rainey, Coronial Investigator

Signature:

Coroner Kate Despot

Date: 24 March 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.