IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 000071

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Maxine Lorraine Sanderson
Date of birth:	10 November 1962
Date of death:	04 January 2024
Cause of death:	1a: Ischaemic heart disease 1b: Coronary artery atherosclerosis
Place of death:	11 McCracken Street Shepparton Victoria 3630
Keywords:	In care, SDA resident, natural causes death

INTRODUCTION

1. On 4 January 2024, Ms Maxine Lorraine Sanderson (**Ms Sanderson**) was 61 years old when she passed away at her supported living facility in Shepparton.

2. Ms Sanderson's medical history included an intellectual disability and depression amongst other conditions. She was a Specialist Disability Accommodation Resident **(SDA)** in an SDA enrolled dwelling at 11 McCracken Street Shepparton, Victoria.

3. Her assisted living services were provided by Connect GV, a registered National Disability Insurance Scheme **(NDIS)** provider.

THE CORONIAL INVESTIGATION

4. Ms Sanderson'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 that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody[1] is a mandatory report to the coroner, even if the death appears to have been from natural causes. Ms Sanderson 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."*[2]

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 Sanderson's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Maxine Lorraine Sanderson including evidence contained in the coronial brief. Whilst I have reviewed

[1] See the definition of 'reportable death' in section 4 of Act, especially section 4(2)(c) and the definition of 'person placed in custody or care' in section 3(1) 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.

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

8. On 4 January 2024 at 9.30am, Ms Sanderson attended High Street in Shepparton with three of her co-residents and their support workers, Ms Puninder Kaur and Ms Amandeep Kaur. The group had coffee together and browsed several stores.

9. The group returned to the residence at approximately 11.45am. Ms Sanderson indicated to her support workers that she was going to have a nap in her room.

10. At approximately 12.45pm, Ms Puninder Kaur knocked on Ms Sanderson's door as she was due to take her lunchtime medications. When there was no response, Ms Puninder Kaur entered the room and located Ms Sanderson lying face down on the ground between the bed frame and window. She was unresponsive. Cardiopulmonary resuscitation was commenced, and emergency services were contacted.

11. Upon the arrival of paramedics, Ms Sanderson was declared deceased at 1.14pm. Police arrived shortly thereafter. No suspicions circumstances were identified.

Identity of the deceased

12. On 4 January 2024, Maxine Lorraine Sanderson, born 10 November 1962, was visually identified by Personal Carer, Stacey Ferrito.

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

Medical cause of death

14. Forensic Pathologist Dr Hans De Boer from the Victorian Institute of Forensic Medicine conducted an autopsy on 9 January 2024 and provided a written report of his findings dated 12 February 2024.

[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.

15. The post-mortem examination revealed severe atherosclerosis of the left anterior descending artery with non-occlusive thrombus, mild to moderate atherosclerosis of the circumferent artery and right coronary artery, previous infraction of the anterior and posterior wall of the left ventricle and focal bronchitis in the lower lobe of the left lung.

16. Dr De Boer noted that critical stenosis is defined as narrowing of greater than 75% of the vessel lumen and is associated with sudden cardiac death. The mechanism of death in such cases is an arrhythmia triggered by acute myocardial ischemia. Sudden unexpected death in an (apparently) healthy individual is consistent with cardiac arrythmia. The heart did not show histological signs of acute infarction, but the earliest histological changes of myocardial infarction can only be seen after 12-24 hours of survival. Histology did reveal signs of more remote infarction. Such foci of old infarction can alter the conductive properties of the heart muscle, which may also cause fatal cardiac arrythmias.

17. Toxicological analysis of post-mortem samples identified the presence of venlafaxine[4] (and its metabolite Desmethylvenlafaxine), doxylamine[5] and traces of paracetamol. These were within therapeutic levels and were not contributory to the death.

18. Dr De Boer provided an opinion that the medical cause of death was *1(a) Ischaemic Heart Disease, 1(b) Coronary artery atherosclerosis*. Dr De Boer considered that the death was due to natural causes.

19. I accept Dr De Boer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased is Maxine Lorraine Sanderson, born 10 November 1962;

    b) her death occurred on 04 January 2024 at 11 McCracken Street Shepparton Victoria 3630, from natural causes, namely, ischaemic heart disease in the setting of coronary artery atherosclerosis, and;

    c) her death occurred in the circumstances described above.

[4] Used in the treatment of depression.
[5] An antihistamine agent and sleep-inducing agent.

21. 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 Sanderson 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 Sanderson's 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:

Clifton Sanderson, Senior Next of Kin

Liliana Pacey, NDIS Quality and Safeguards Commission

First Constable David Cline, Coroner's Investigator

Signature:

Coroner Kate Despot

Date: 20 May 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.