IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002003

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Dorothy Lynette Vasiliou
Date of birth:	8 February 1952
Date of death:	8 April 2024
Cause of death:	1(a) Metastatic melanoma in a woman with multiple sclerosis
Place of death:	8/23 Hanke Road, Doncaster, Victoria, 3108
Keywords:	Death in care; disability; natural causes

INTRODUCTION

1. On 8 April 2024, Dorothy Vasiliou was 72 years old when she died in her home. At the time of her death, Dorothy lived in Specialist Disability Accommodation ('**SDA**') in Doncaster.

2. Dorothy was married in 1974 to Nicholas Vasiliou, and they had three daughters together, Kellie Vasiliou, Lynette Vasiliou and Amanda McAnuff.

3. In 1992, Dorothy was diagnosed with multiple sclerosis ('**MS**') and lived at home with the support of her husband. Between 2019 and 2020, Dorothy's MS progressed to the secondary progressive stage and her fulltime care became difficult. Dorothy's family decided to trial a residential aged care facility named Greenview in Donvale.

4. In December 2020, Dorothy was diagnosed with pulmonary embolism and made a full recovery. Shortly after her release from hospital, she moved into her SDA dwelling and received 24-hour disability support.

5. According to Dorothy's General Practitioner ('**GP**'), Dorothy was admitted to Eastern Health in April 2023 for shortness of breath. A chest x-ray revealed a large left pleural effusion, and Dorothy was diagnosed with stage 4 metastatic melanoma. In consultation with her treating Oncologist, she began Tyrosine Kinase Inhibitor ('**TKI**') therapy and successfully entered remission.

6. In mid-February 2024, Dorothy began to struggle with her breathing again. A computed tomography ('**CT**') scan revealed her cancer had returned. Dorothy ceased her TKI therapy and discussed palliative care options with the request for no further intervention. From this point on, Dorothy was treated in her home by disability support workers and nursing staff.

7. Dorothy loved caring for her family and attending family gatherings. She enjoyed reading crime novels and poetry, listening to music and armchair gardening.

THE CORONIAL INVESTIGATION

8. Dorothy's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Specifically, Dorothy was immediately before her death 'a person placed in custody or care', as she was an SDA resident residing in an SDA enrolled

dwelling.[1] 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.

9. Section 52(2) of the Act prescribes when a coroner must hold an Inquest into a death. This includes where the deceased was, immediately before death, a person placed in custody or care. However, as Dorothy's death was due to natural causes, I am not required to hold an Inquest.[2]

10. 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.

11. 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.

12. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Dorothy'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.

13. This finding draws on the totality of the coronial investigation into the death of Dorothy Lynette Vasiliou 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]

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1 Regulation 7(d) of the *Coroners Regulations 2019.*
2 Section 52(3A) of the *Coroners Act 2008.*
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.

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

Circumstances in which the death occurred

14. On 4 April 2024, Dorothy's health rapidly declined with periods of non-responsiveness. She required oxygen and found it difficult to swallow medication.

15. Over the following days, Dorothy's health continued to deteriorate. With the support of her GP, Dorothy was administered end of life medication by the community palliative care team.

16. Dorothy died at about 11.30pm on 8 April 2024 in the presence of her three daughters.

Identity of the deceased

17. On 11 April 2024, Dorothy Lynette Vasiliou, born 8 February 1952, was visually identified by her daughter, Amanda McAnuff, who completed a Statement of Identification.

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

Medical cause of death

19. Forensic Pathologist Dr Joanne Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Dorothy Lynette Vasiliou on 15 April 2024. Dr Glengarry considered the Victoria Police Report of Death (Form 83), post mortem CT scan and medical records provided by Eastern Health and provided a written report of her findings dated 17 April 2024.

20. The findings of the post mortem CT scan included a left kidney stone, calcification of the coronary arteries and aorta, right pleural effusion involving the whole right pleural cavity with mediastinal shift and a left pleural drain in situ. There was a left pulmonary consolidation.

21. The findings at external examination were consistent with the reported circumstances.

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

23. Dr Glengarry provided an opinion that the medical cause of death was 1(a) METASTATIC MELANOMA IN A WOMAN WITH MULTIPLE SCLEROSIS.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Dorothy Lynette Vasiliou, born 8 February 1952;

    b) the death occurred on 8 April 2024 at 8/23 Hanke Road, Doncaster, Victoria, 3108;

2. I accept and adopt the medical cause of death ascribed by Dr Glengarry and I find that Dorothy Lynette Vasiliou, a woman with multiple sclerosis, died from metastatic melanoma.

3. AND, I have determined that the application of section 52(3A) of the Act is appropriate in the circumstances as I accept that Dorothy Lynette Vasiliou's death was due to natural causes, and I find there is no relationship or causal connection between her death and her status as a person placed in custody or care immediately before his death.

I convey my sincere condolences to Dorothy'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

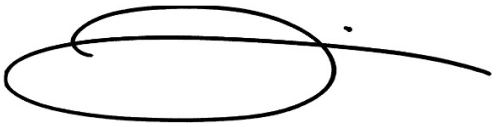
I direct that a copy of this finding be provided to the following:

Nicholas Vasiliou, Senior Next of Kin

Yvette Kozielski, Eastern Health

First Constable Lenise Walker, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 23 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.