IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002559

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Jennifer Mary Clayden
Date of birth:	7 February 1963
Date of death:	9 May 2024
Cause of death:	1(a) Complications of Down's syndrome, epilepsy and advanced dementia
Place of death:	6-8 Stradbroke Street, Norlane, Victoria, 3214
Keywords:	Specialist Disability Accommodation; SDA; death in care; Down's syndrome; epilepsy; advanced dementia

INTRODUCTION

1. On 9 May 2024, Jennifer Clayden was 61 years old when she died in her home. At the time of death, Jennifer lived in Specialist Disability Accommodation ('**SDA**') in Norlane.

2. Jennifer was born with Down's syndrome and lived with epilepsy and Alzheimer's disease. Her other conditions included dysphagia, Perthes' disease, neutropenia autoimmune disease, Raynaud's syndrome, hepatitis B, osteoarthritis and reflux.

3. Jennifer had four siblings and lived with her mother Joan Clayden, who was her primary carer for most of her life.

4. In August 2019, Jennifer moved into her SDA dwelling and received Supported Independent Living ('**SIL**') from Scope Australia ('**Scope**'). Jennifer had limited verbal communication however had good receptive skills. She was relatively independent and was able to walk, shower, feed herself and would participate in house outings.

5. In March 2022, Jennifer's health declined resulting her being unable to stand independently. She required support for all daily living activities including meal preparation, personal care, medication administration and required a ceiling hoist for transfer to a comfort chair.

6. During a hospital admission in May 2023, Jennifer's family and hospital staff developed a Resuscitation and Goals of Management Plan to transition Jennifer's care to a comfort-based approach. The plan included not to provide life-prolonging treatment or resuscitation moving forward. Jennifer was referred to Barwon Health Community Palliative Care ('**CPC**') for post discharge care in her SDA with the support of her General Practitioner ('**GP**') via telehealth appointments. After review by a CPC nurse, Jennifer was discharged from CPC on 23 June 2023.

7. Between June 2023 and May 2024, Jennifer remained in the care of her SDA with the assistance of her family, GP, Scope staff and allied health professionals. During settled periods, Jennifer enjoyed watching musicals on television and singing or chatting with Scope staff.

THE CORONIAL INVESTIGATION

8. Jennifer'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, Jennifer 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 Jennifer's death was due to natural causes, I am not required to hold an Inquest.[2]

10. 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.

11. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Jennifer'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.

12. This finding draws on the totality of the coronial investigation into the death of Jennifer Mary Clayden 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]

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

Circumstances in which the death occurred

13. On 4 May 20204, Scope staff noticed that Jennifer had a cough and appeared unwell. Staff requested a locum service to attend to further assess Jennifer, however no doctors were available, and they were advised to call the following day if they remained concerned. Over the next few days, Jennifer appeared to improve and was eating with no further issues.

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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.

14. On 7 May 2024, Jennifer was reviewed by a locum doctor who attended and provided an updated script for buprenorphine patches and Systane eye drops.

15. On 9 May 2024, Jennifer was enjoying her morning tea until about 10.20am, when Scope staff noticed her face turn pale and then purple or blue. Scope staff contacted Triple Zero and commenced cardiopulmonary resuscitation (**CPR'**).

16. Paramedics arrived shortly after and made attempts to resuscitate Jennifer. During this period, Jennifer's family were contacted and instructed paramedics to cease CPR. Jennifer died on 9 May 2024 at 10.54am.

Identity of the deceased

17. On 9 May 2024, Jennifer Mary Clayden, born 7 February 1963, was visually identified by her brother, Anthony Clayden, 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 Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted a partial examination of the body of Jennifer Clayden on 13 May 2024. Dr Beer considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, VIFM contact log, and VIFM Preliminary Examination Form and provided a written report of his findings dated 27 June 2024.

20. The autopsy showed features of Down's syndrome, with no clear cardiac cause of death. There was extensive aspirated material in the upper airways extending into the lung bronchi. Dr Beer noted it is not possible to accurately determine the nature of the terminal event, as while aspirated material was seen in the upper airways, CPR had been performed which provides a more than reasonable explanation that it was an artifactual finding. This is more likely given there was no history of choking or coughing in the events prior to death.

21. Dr Beer did not identify any injuries at autopsy that may have caused or contributed to the death.

22. Toxicological analysis of post mortem samples identified the presence of:

    a) Amitriptyline ~0.08mg/L

b) Nortriptyline ~0.05mg/L

c) Citalopram ~0.3mg/L

d) Risperidone ~12ng/mL

e) Hydroxyrisperidone ~7ng/L

f) Levetiracetam ~13mg/L

23. Dr Beer provided an opinion that the medical cause of death was 1(a) COMPLICATIONS OF DOWN'S SYNDROME EPILEPSY AND ADVANCED DEMENTIA.

FINDINGS AND CONCLUSION

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

g) the identity of the deceased was Jennifer Mary Clayden, born 7 February 1963;

h) the death occurred on 9 May 2024 at 6-8 Stradbroke Street, Norlane, Victoria, 3214;

i) I accept and adopt the medical cause of death ascribed by Dr Brian Beer and I find that Jennifer Mary Clayden died from complications of Down's syndrome, epilepsy and advanced dementia.

2. AND, I have determined that the application of section 52(3A) of the Act is appropriate in the circumstances as I find that Jennifer's death was due to natural causes, and 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 Jennifer'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.

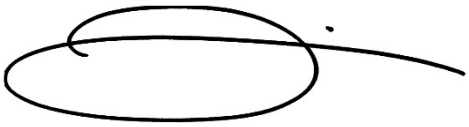
I direct that a copy of this finding be provided to the following:

Joan Clayden, Senior Next of Kin

Naomi Baquing, Scope Australia

Leading Senior Constable Warwick Vale, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 14 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.