IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 006025

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Janene Louise Weston
Date of birth:	17 November 1973
Date of death:	14 October 2024
Cause of death:	INTRACRANIAL HAEMORRHAGE
Place of death:	13 Rhubarb Place Mickleham Victoria 3064
Keywords:	In care, Specialist Disability Accommodation, SDA, natural causes

INTRODUCTION

1. On 14 October 2024, Janene Louise Weston was 50 years old when she was found deceased at her specialist disability accommodation (**SDA**). At the time of her death, Ms Weston resided in Mickleham at an SDA operated by CareChoice.

THE CORONIAL INVESTIGATION

2. Ms Weston's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**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 is a mandatory report to the Coroner, even if the death appears to have been from natural causes. Ms Weston was 'a person placed in custody or care' within the meaning of section 4 of the Act, as she was 'a prescribed class of person'[1] due to her status as an 'SDA resident residing in an SDA enrolled dwelling'.

3. 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.

4. 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.

5. Senior Constable (SC) Nikolas Kadiric acted as the Coroner's Investigator for the investigation of Ms Weston's death. SC Kadiric conducted inquiries on my behalf and compiled a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Janene Louise Weston 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

[1] *Coroners Act 2008* (Vic) s 4(2)(j)(i).

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

BACKGROUND

7. As an adult, Ms Weston suffered from non-necrotising autoimmune encephalitis resulting in an acquired brain injury. She also suffered multiple strokes which compounded her other physical health problems.

8. In October 2022, Ms Weston moved into specialist disability accommodation as she required a high level of care consequent upon her acquired brain injury. Ms Weston was wheelchair bound and required two carers to assist for most activities. She had single-sided weakness, and limited verbal communication. Staff were required to assist with eating and drinking. Ms Weston also exhibited a strong aversion to personal care (including showering and bathing), and other challenging behaviours.

9. In the year preceding her death, CareChoice staff noticed a gradual decline in Ms Weston's overall health. This deterioration included decreased appetite and weight loss, an increase in behaviours of concern, and an increase in episodes of constipation and urinary tract infections.

10. In 2024, Ms Weston underwent several admissions to the Northern Hospital. Some of which were due to left leg swelling and associated pain. Although clinicians held concerns that Ms Weston may have been suffering deep vein thrombosis (**DVT**), she was uncooperative and could not be scanned to exclude DVT. Subsequently, Ms Weston was commenced on apixaban[3] as clinicians concluded that the benefits of avoiding propagation of thrombosis and pulmonary embolism, outweighed the risk of bleeding.

11. In August 2024, Ms Weston presented again to the Northern Hospital with a left infected obstructed kidney, in the setting of significant comorbidities. She was managed operatively and made a good recovery. She was ultimately discharged back to her SDA.

---

[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.

[3] Apixaban is a novel oral anticoagulant used to treat or prevent deep venous thrombosis.

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

Circumstances in which the death occurred

12. On 13 October 2024, Ms Weston was seen to be in a calm mood and participated in her regular evening routine. She ate and drank normally and had no complaints of pain or discomfort. She took her prescribed medications without issue, and no signs of distress were observed overnight.

13. At 7.00am on 14 October 2024, a carer checked on Ms Weston. She appeared to be asleep. The carer then prepared breakfast for her and returned to her room at 7.30am, where she found Ms Weston non-responsive, and pale in colour. The carer immediately contacted emergency services.

14. Victoria Police Officers and Ambulance Victoria Paramedics arrived on scene a short time later. Paramedics declared Ms Weston deceased at the scene.

15. Police found no evidence of any suspicious circumstances.

Identity of the deceased

16. On 14 October 2024, Janene Louise Weston, born 17 November 1973, was visually identified by her carer, Carli Mathiesen.

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

Medical cause of death

18. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine conducted an examination on 15 October 2024 and provided a written report of her findings dated 7 November 2024.

19. The post-mortem examination and CT scan revealed a left frontoparietal intraparenchymal haemorrhage[4] with surrounding oedema[5] and midline shift,[6] and a pontine Duret haemorrhage.[7]

[4] An intraparenchymal haemorrhage occurs within the brain parenchyma (functional tissue in the brain).
[5] Swelling caused by excess fluid trapped in the tissue.
[6] A shift of the brain across the centre line.
[7] Duret haemorrhages are small haemorrhages that occur in the middle section of the brain.

20. Toxicological analysis of post-mortem samples identified the presence of oxycodone,[8] duloxetine,[9] and propranolol,[10] but no other common drugs or poisons.

21. Dr Fronczek provided an opinion that the medical cause of death was *"1(a) Intracranial haemorrhage"*.

22. Dr Fronczek stated that death was due to natural causes.

23. I accept Dr Fronczek's opinion.

FAMILY CONCERNS

24. On 15 October 2024, Ms Weston's son, Bailey Weston-Stoneham, contacted the Court with concerns regarding Ms Weston's medication regime and the potential for changes to her medication to have had an adverse impact.

CORONERS PREVENTION UNIT REVIEW

25. In light of Mr Weston-Stoneham's concerns and as part of my investigation, I sought assistance from the Coroners Prevention Unit (**CPU**),[11] to review Ms Weston's medical care and determine the appropriateness of her medications from 2024.

26. The CPU advised that the changing of medications did not cause the intracranial haemorrhage, but rather the presumed DVT necessitated treatment with a blood thinner to prevent a pulmonary embolus. Being on a blood thinner increases the risk of bleeding, but that risk is subordinate to the risk of leaving an untreated DVT.

27. In the circumstances, the CPU had no concerns with respect to the medical treatment provided to Ms Weston.

28. I accept the opinion of the CPU.

---

[8] Oxycodone is a semi-synthetic opiate narcotic analgesic related to morphine used clinically to treat moderate to severe pain.

[9] Duloxetine is a serotonin and noradrenaline reuptake inhibitor.

[10] Propranolol is a beta-adrenergic blocking agent commonly used for the treatment of high blood pressure and cardiac arrhythmias.

[11] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Janene Louise Weston, born 17 November 1973;

    b) the death occurred on 14 October 2024 at 13 Rhubarb Place, Mickleham, Victoria 3064, from an intracranial haemorrhage; and

    c) the death occurred in the circumstances described above.

30. Having considered all of the circumstances, I am satisfied that the care provided to Ms Weston at her SDA and at the Northern Hospital was appropriate.

ACKNOWLEDGEMENTS

I convey my sincere condolences to Ms Weston's family for their loss.

I thank the Coroner's Investigator and those assisting for their work in this investigation.

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:

Bailey Weston-Stoneham, Senior Next of Kin

Dr Usman Muhammad

Senior Constable Nikolas Kadiric, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 12 August 2026

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.