IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 007157

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Margaret Ann Day
Date of birth:	13 September 1958
Date of death:	09 December 2024
Cause of death:	1a: Ischaemic brainstem stroke
Place of death:	University Hospital Geelong Ryrie Street, Geelong Victoria 3220
Keywords:	In care, SDA resident, ischaemic brainstem stroke, natural causes death

INTRODUCTION

1. On 9 December 2024, Margaret Ann Day **(Ms Day**) was 66 years old when she died at University Hospital Geelong **(UHG)**. She is survived by her siblings, Rodney, Marian and Julie.

2. Ms Day's medical history included undifferentiated hereditary ataxia syndrome and associated intellectual disability. She also suffered from dysphagia, type 2 diabetes, epilepsy and osteoarthritis, amongst other conditions.

3. At the time of her death, Ms Day was a Specialist Disability Accommodation **(SDA)** resident in an SDA enrolled dwelling at 48 Denman Street, East Geelong Victoria 3219. She received disability support from Gateways Support Services as she required assistance to undertake all aspects of her daily life. Ms Day enjoyed participating in community based social and recreational activities.

THE CORONIAL INVESTIGATION

4. Ms Day's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**)[1]. 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. In this instance, Ms Day 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 Day's death. The Coronial Investigator conducted inquiries on my behalf. As part of the

[1] Section 4(1), 4(2)(c) 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.

investigation, the Court obtained medical materials and a comprehensive statement from Barwon Health Consultant Neurologist Associate Professor Cameron Shaw **(A/P Shaw)**.

7. This finding draws on the totality of the coronial investigation into the death of Margaret Ann Day including the evidence obtained by the Court. 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

8. On 26 November 2024 at 6.30pm, Ms Day was taken to the UHG's Emergency Department by ambulance. This was on the background of the onset of focal neurological symptoms involving ataxia of her right hand and arm on the evening of the 25 November 2024 and the development of slurred speech, lethargy and drowsiness.

9. A CT brain scan completed at 10.17pm demonstrated bilateral subacute occipital posterior circulation infarcts (strokes). A CT angiogram was also completed which demonstrated basilar artery occlusion. A/P Shaw stated that Ms Day was outside the window for acute thrombolysis or clot retrieval for stroke and was at this time admitted under the Barwon Health Stroke Unit and commenced on a blood thinner to prevent further strokes and intravenous fluids.

10. On 27 November, Ms Day was dysphagic, dysarthric, drowsy and rousable to voice. She remained clinically unchanged until 29 November at which time a feeding plan was discussed with her brother Rodney. A decision was made to insert a nasogastric tube for feeding.

11. On 2 December 2024, a Medical Emergency Team call occurred in response to the observation that Ms Day had a seizure. On 3 December, she was noted to be drowsier and continued to have episodes involving upper limb movements thought to be seizures, despite intravenous loading with a further antiepileptic Levetiracetam, clonazepam therapy as required as well as her usual antiepileptics.

12. On 4 December 2024, Ms Day was observed to have clinically deteriorated further. A/P Shaw outlined that she had multiple episodes involving roving eye movements, nystagmus, bilateral

[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.

upper limb clonic movements and extensor and decerebrate posturing. She was commenced on Levetiracetam 500mg bd intravenously as a regular dose of antiepileptic to cover seizures however further imaging was organised to investigate for an extension of her stroke.

13. A repeat CT angiogram was unchanged, however a further brain MRI demonstrated further new multiple areas of infarction involving the brainstem as well as the established bilateral occipital strokes. A/P Shaw noted that the extensive extension of Ms Day's stroke was deemed an unsurvivable event. She continued to become less responsive and family discussions were held. Palliative goals of care were enacted with comfort care instituted.

14. Ms Day passed away peacefully on 9 December 2024 at 12.57am.

Identity of the deceased

15. On 9 December 2024, Margaret Ann Day, born 13 September 1958, was visually identified by her brother, Rodney Day.

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 10 December 2024 and provided a written report of her findings dated 20 January 2025.

18. The post-mortem examination revealed marked quadriceps wasting, but no other remarkable features apart from some long-standing scarring on the face and long-standing deformity of the right radial wrist. A post-mortem CT scan revealed hyperostosis frontalis interna, bilateral occipital infarcts and distal right tibia and fibula metalware. Toxicological analysis was not recommended.

19. Dr Archer provided an opinion that the medical cause of death was 1(a) Ischaemic brainstem stroke. 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 is Margaret Ann Day, born 13 September 1958;

b) her death occurred on 09 December 2024 at University Hospital Geelong, Ryrie Street Geelong Victoria 3220, from natural causes, namely, ischaemic brainstem stroke; and

c) her 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 Mrs Day died from natural causes, and I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death

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

Rodney Day, Senior Next of Kin

Lorraine Judd, Barwon Health

Leading Senior Constable Lynton Zavaglia, Coronial Investigator

Signature:

Coroner Kate Despot

Date: 30 April 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.