



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000048

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Glenda Jean Brown

Findings of:	Coroner Ingrid Giles
Delivered on:	1 October 2026
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street Southbank 3006
Hearing date:	1 October 2026
Counsel Assisting the Coroner	Mrs Natalie Newman, Acting Coroner's Solicitor
Keywords	Specialist Disability Accommodation, In Care, Reportable Death, Neurodegenerative Disease, Huntington's Disease

INTRODUCTION

1. On 3 January 2025, Glenda Jean Brown¹ was 50 years old when she died at the Eastern Health Palliative Care Unit at Wantirna Hospital.
2. Glenda was born on 14 November 1974 in Benalla, Victoria, to her parents Stuart and Phyllis Brown. Glenda had three siblings – Rhonda, David and Melissa.
3. Glenda’s father was diagnosed with Huntington’s Disease, and he passed away in 1999.
4. Glenda also lived with Huntington’s Disease, which is a rare inherited neurodegenerative disease that is currently incurable. Glenda experienced the impact of Huntington’s Disease from 2012 onwards and was formally diagnosed in 2016 through genetic testing.
5. In addition to Glenda’s primary condition of Huntington’s Disease, she also had a medical history of major depressive disorder, frontal lobe dementia, hallucinations, chronic constipation, dysphagia, impaired mobility and malnutrition with associated weight loss.
6. Glenda was on regular medications that included mirtazapine, sertraline, risperidone and valproate.
7. At the time of her death, Glenda was a National Disability Insurance Scheme (NDIS) participant and resided in Specialist Disability Accommodation (SDA) operated by Yooralla, a disability services provider. Glenda had an extensive package of supports funded under the NDIS.
8. Glenda had a limited employment history and had worked for short periods of time in nurseries, in retail and as a farmhand.
9. Glenda had had a long-term relationship with a man named Scott, and they had two children who are now teenagers. The relationship with Scott ended in 2016 but he and Glenda continued to reside in the family home following their separation in 2019, when Glenda’s care needs increased and she moved to supported accommodation.

¹ Referred to as ‘Glenda’ throughout this finding, unless more formality is required.

10. From early 2022, Glenda declined family visits, however, in the last few weeks of her life she requested visits from her sisters and other extended family members who were able to visit her on a daily basis.

THE CORONIAL INVESTIGATION

11. Glenda'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 is a mandatory report to the Coroner, even if the death appears to have been from natural causes.
12. 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.
13. 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.
14. Victoria Police assigned officer, First Constable James Anderson to be the Coronial Investigator for the investigation of Glenda's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, Glenda's accommodation provider Yooralla and health care providers, and submitted a coronial brief of evidence.
15. This finding draws on the totality of the coronial investigation into the death of Glenda Jean Brown 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.²

BACKGROUND

16. Glenda received specialist management under the care of neuropsychiatrist Dr Brian Leong (**Dr Leong**) from the State-wide Progressive Neurological Disease Service at Calvary Health Care Bethlehem (**Bethlehem**) from the time of her diagnosis in 2016.
17. From 2017, the severity of Glenda's dementia was evident and neuropsychological testing at that time revealed severe impairment of her executive function, memory and learning.
18. Glenda had two inpatient admissions at Bethlehem in 2018 and 2019. She was followed up as an outpatient and was reviewed at three-monthly intervals by Dr Leong. She had access to allied health services including occupational therapy, physiotherapy and neuropsychology.
19. In August 2019, Glenda moved into specialist disability supported accommodation in Burwood operated by Yooralla. Yooralla's facility provided specialist support and accommodation to people living with degenerative neurological conditions, such as Huntington's Disease and motor neurone disease.
20. Yooralla operated four group houses at the complex in Burwood. Glenda resided in the house called Contemporary House with eight other residents. Contemporary House provides disability support workers 24 hours per day, seven days per week. Two registered nurses are on site each day and one nurse was available overnight. These nurses provide support to all residents across the four houses within the Burwood complex.
21. Glenda's NDIS plan was managed by a registered plan manager. Her most recent plan commenced on 31 January 2024 and was due for reassessment at the end of January 2025.

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.

22. Glenda was under the care of a general practitioner, Dr Ingrid van Tinteren from Honeycomb Health in Burwood. A comprehensive review of Honeycomb's clinical records reveals that her GP was attentive to her needs and often attended in person to assess Glenda's reported complaints and to support Yooralla staff in their care.

Glenda's deterioration in 2024

23. During 2024, Glenda experienced a progressive decline in her physical, cognitive and psychiatric health status. She required assistance to move from one position to another and a four wheeled walking frame to mobilise. She also required assistance with activities of daily living due to limb weakness, impaired balance and limited dexterity.
24. As a result of this decline, Glenda experienced fourteen unwitnessed falls at Yooralla despite a robust falls management plan and the provision of assistive equipment. She was assessed by nursing staff following each occasion and care was escalated to her GP for further review on two occasions. No obvious injuries were identified or reported as a result of these falls and Glenda's physical status did not change as a result of any fall.
25. In October and November 2024, Glenda was admitted to Box Hill Hospital for hallucinations, refusing oral intake, weight loss, increasing refusal of care, lethargy, weakness and multiple falls. Glenda also experienced several unwitnessed falls whilst in hospital but did not sustain any obvious injuries or change in physical function.
26. On 12 November 2024, Glenda was again admitted to Box Hill Hospital and stayed in hospital for a month due to the progressive decline in physical, cognitive, neuropsychiatric and functional status. During her admission, Glenda was assessed by multiple teams including psychiatry and palliative care. The consensus decision was that Glenda was on maximal medical therapy and there was no role for invasive treatments, given these interventions would be contrary to Glenda's wishes.
27. At this time, Glenda's treating team formed the view that she was most vulnerable to a sudden deterioration in medical status and her specific risks included the risk of aspiration and chest infections, further falls and of re-feeding syndrome given her poor oral intake.

28. The hospital team informed Glenda's GP that she had entered the end stage of Huntington's disease, and whilst she was not actively dying at that time, she had entered the palliative phase. She was prescribed medications in alignment with a comfort care approach to her ongoing management.
29. On 13 December 2024, Glenda was discharged from Box Hill Hospital and returned to Yooralla. Her medications had been rationalised and predominantly focused on pain relief and symptoms control. She was prescribed morphine at four-hourly intervals from this time onwards.

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

Circumstances in which the death occurred

30. On 23 December 2024, Glenda was transported to Box Hill Hospital for generalised pain that was unable to be controlled with regular morphine. The emergency department team noted her rapid decline over the 10 days since she had been discharged.
31. She was assessed by the palliative care team who formed the view that Glenda had progressed to the final stage of her life, given her frailty and advanced disease. Accordingly, the goals of care were to prioritise her comfort and minimise distress.
32. On 24 December 2024, at 3:30pm, Glenda was transferred to Eastern Health Palliative Care Unit in Wantirna for end-of-life care. Glenda continued to refuse oral intake and declined medications. Her care team deemed her to be competent to make the decision to refuse oral medications as the goals of care were clearly defined as supportive management only.
33. Throughout her admission in the palliative care unit, Glenda remained frail and was bed-bound, requiring all care to be provided to her.
34. Given her high risk of aspiration, a speech pathologist recommended pureed food and thickened fluids. Glenda's oral intake remained poor, and she could only tolerate minimal sips of thickened fluids. The nurses were not able to administer oral medications, and her pain was managed with a buprenorphine patch and subcutaneous morphine.

35. On 2 January 2025, Glenda was observed to have experienced a brief episode of coughing and spluttering, likely due to an aspiration event in the context of dysarthria and dysphagia. Such an event is not unexpected and is a recognised complication of Huntington's Disease, and was a known risk.
36. On 3 January 2025, Glenda was no longer responsive, and she passed away at 11.45am, in the presence of her sister and members of her extended family.

Identity of the deceased

37. On 3 January 2025, Glenda Jean Brown, born 14 November 1974, was visually identified by her sister, Melissa Brown.
38. Identity is not in dispute and requires no further investigation.

Medical cause of death

39. Forensic Pathologist Dr Chong Zhou (**Dr Zhou**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of Glenda's body on 6 January 2025 and provided a written report of her findings dated 7 January 2025.
40. The post-mortem examination revealed:
 - a) faint pink bruise to the outside of the left upper arm
 - b) a purple bruise to the outside of the left ankle
 - c) faint yellow/green bruise to the front of right lower leg
41. The post-mortem CT showed an old pelvic fracture, brain atrophy, a minor coronary artery calcification and loss of height in a lumbar vertebra.
42. The pelvic fracture evident on the CT scan was reviewed by Forensic Radiologist, Dr Chris O'Donnell, who estimated the fracture to have been weeks, if not months old.
43. Dr Zhou provided an opinion that the medical cause of death was *1(a) Complications of Huntington's Disease, 2 Pelvic fracture*.

44. Dr Zhou noted that that the predominant cause of death was the sequelae of Glenda's Huntington's Disease. However, the pelvic fracture or a complication of the fracture (for example, a pulmonary embolism) as a potential contributing factor towards Glenda's death was not able to be conclusively determined by Dr Zhou.
45. I accept the opinion of Dr Zhou.

FINDINGS AND CONCLUSION

46. I, Coroner Ingrid Giles, having investigated the death of Glenda Jean Brown, and having held an inquest in relation to this death on 1 October 2026 at the Coroners Court of Victoria; find that:
- a) the identity of the deceased was Glenda Jean Brown, born 14 November 1974;
 - b) Glenda's death occurred on 3 January 2025 at Eastern Health Wantirna, 251 Mountain Highway, Wantirna Victoria 3152, from 1(a) Complications of Huntington's Disease, 2 Pelvic Fracture; and
 - c) her death occurred in the circumstances described above.
47. I find that while Glenda experienced multiple falls over the course of the last three months of her life, the specific event that caused the pelvic fracture has not been able to be ascertained. I have not found this to reflect any want of care on the part of Glenda's carers or clinicians, noting the diligent documentation and falls management strategies implemented by Yooralla and the nursing and medical assessments of hospital staff that were conducted in relation to the falls that Glenda experienced whilst in hospital.
48. Indeed, according to medical records and Yooralla's incident reporting documentation, Glenda did not report pain or significant injury after any fall. I also that Glenda's physical function did not appear to be compromised following any particular fall. In the context of the number of unwitnessed falls, it is possible that Glenda had sustained a fall, or falls, that staff were not aware of and therefore, this would explain why the pelvic fracture was undiagnosed and not documented in her medical record.

49. Further, and relevantly, the predominant cause of Glenda's death as outlined by the forensic pathologist is the (sadly inevitable) progression of her Huntington's Disease.
50. Accordingly, in the circumstances, and while noting that family had some concerns about, amongst other things, the staffing of the Yooralla facility over the years, I consider that there are no issues regarding the care provided to Glenda which require further investigation in the coronial jurisdiction. Glenda's death was not unexpected and is attributable to her significant burden of natural disease. I find that the available evidence does not support a finding that there was any want of clinical management or care on the part of the disability service provider, or clinical staff at Eastern Health, that caused or contributed to Glenda's death.

ACKNOWLEDGMENTS

I thank Mrs Natalie Newman and Registry staff for their excellent assistance at inquest, and I also thank coronial investigator First Constable James Anderson for his assistance throughout my investigation.

Finally, I offer my sincere condolences to all who loved and cared for Glenda, and I thank her family for their heartfelt impact statement. I note in particular that, in addition to referencing the impacts of the COVID-19 lockdowns on Glenda, Glenda's family reflected on the importance from their perspective of having the cause of death including specific reference to 'Huntington's Disease', including for the purposes of ensuring visibility of the disease and acknowledgment of its impacts. I have determined this to be a crucial factor to record in my finding and I acknowledge the importance of Glenda's family's perspective, insight and lived experience.

ORDERS AND 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:

Melissa Brown, Senior Next of Kin

First Constable James Anderson

Yooralla

Eastern Health

Dr Ingrid van Tinteren, Honeycomb Health

Signature:



**INGRID GILES
CORONER**



Date: 1 October 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 inquest. 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.
