IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000476

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Louise Anne Turner
Date of birth:	5 November 1974
Date of death:	23 January 2025
Cause of death:	1a : CARDIAC HYPERTROPHY IN THE SETTING OF EPILEPSY
Place of death:	Barwon Health University Hospital Bellerine Street Geelong Victoria 3220
Keywords:	Specialist Disability Accommodation residents, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 23 January 2025, Louise Anne Turner (Louise) was 50 years old when she died at Barwon Health University Hospital Geelong. At the time of her death, she lived at 13 Molesworth Drive, Highton in Supported Disability Accommodation.

2. Louise lived with multiple health conditions including cerebral palsy, intellectual disability, schizophrenia, epilepsy, associated anxiety disorder, constipation and mild dysphagia. She required support for all aspects of daily living but could communicate verbally with the support of body language, gestures and facial expressions. Her care needs were supported through the NDIS and her most recent care plan was approved for one year commencing on 30 September 2023.

3. Louise maintained regular contact with her mother, enjoying afternoon tea on weekends, and had irregular phone contact with her father. She attended genU's Social Connections Day program three days per week where she participated in group activities, learned new skills and made meaningful connections. In the months leading up to her death, Louise experienced an increasing number of falls and declining mobility, which ultimately led to her final hospital admission.

THE CORONIAL INVESTIGATION

4. Louise's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as she was a 'person placed in custody or care' within the meaning of the Act, as a person with disability who received funded daily independent living support and resided in an SDA enrolled dwelling immediately prior to her death.[1] This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

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

[1] This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. 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.

7. This finding draws on the totality of the coronial investigation into the death of Louise Anne Turner including information from the National Disability Insurance Agency (**NDIA**). 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]

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

Circumstances in which the death occurred

8. Louise had lived at 13 Molesworth Drive, Highton since approximately 2014. Scope (AUST) Limited (Scope) provided supported independent living services to Louise at her home.

9. On 17 December 2024, Scope staff observed that Louise presented differently, getting out of bed early and being quieter than usual. Later that day at her day program, she appeared confused, searched through her bags, and declined lunch. When she returned home at approximately 3:15pm, she was walking slowly, appeared confused, had slurred speech, and bumped into walls.

10. Paramedics attended at 4:00pm but were unable to fully assess Louise due to her declining to be examined. They recommended monitoring and GP follow-up.

11. On 7 January 2025, staff observed grazes on Louise's elbows, knees and toes. She appeared unsteady and had difficulty with daily activities. She attended her GP and was subsequently taken to hospital for x-rays.

[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.

12. Louise was admitted to Barwon Health University Hospital on 9 January 2025. Imaging showed a left fibular fracture and right rib fracture. Due to agitation, she required mechanical and chemical restraint while in hospital.

13. On 21 January 2025, during her hospital admission, Louise suffered a cardiac arrest after being given midazolam for a seizure. She was transferred to the intensive care unit where resuscitation was performed.

14. Following discussions with her family about goals of care, treatment was withdrawn. Ms Turner died at 10:45pm on 23 January 2025 at Barwon Health University Hospital.

Identity of the deceased

15. On 23 January 2025, Louise Anne Turner, born 5 November 1974, was visually identified at University Hospital Geelong by her mother Maree Turner

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

Medical cause of death

17. Senior Forensic Pathologist Dr Yeliena Fay Baber from the Victorian Institute of Forensic Medicine conducted an autopsy on 29 January 2025 and provided a written report of her findings dated 11 June 2025. Dr Barber provided an opinion that the medical cause of death was 1(a) CARDIAC HYPERTROPHY IN THE SETTING OF EPILEPSY

18. In her report Dr Barber noted that the post-mortem examination revealed:

- Cardiac hypertrophy (enlarged heart weighing 460g when expected weight should be 378g)

- No evidence of urinary tract infection

- Chronic brain changes consistent with seizures

- Unremarkable toxicology findings

19. Dr Barber provided an opinion that the cause of death was due to natural causes.

20. I accept Dr Barber's opinion.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Louise Anne Turner, born 5/11/1974;

b) the death occurred on 23/01/2025 at Barwon Health University Hospital Bellerine Street Geelong Victoria 3220 from

1a : CARDIAC HYPERTROPHY IN THE SETTING OF EPILEPSY; and

c) the death occurred in the circumstances described above.

22. 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 Barwon Health University Hospital Bellerine Street Geelong Victoria 3220, that caused or contributed to Ms Turner's death.

23. Having considered all the available evidence, I find that Ms Turner's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death and to finalise the investigation of Ms Turner's death in chambers.

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.

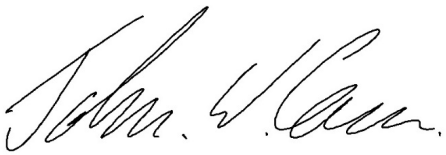
I direct that a copy of this finding be provided to the following:

Raymond Turner, Senior Next of Kin

Maree Turner, Senior Next of Kin

Senior Constable Jakob Reed, Coronial Investigator

Signature:



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Judge John Cain
State Coroner
Date:19 August 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.