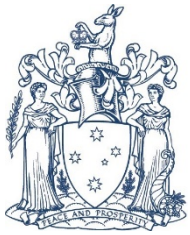

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 004607

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Deborah Leona Smith

Delivered On:	3 April 2023
Delivered At:	Melbourne
Hearing Dates:	3 April 2023
Findings of:	Coroner Simon McGregor
Counsel Assisting the Coroner	LSC Dani Lord
Keywords	National Disability Insurance Scheme, National Disability Insurance Agency, NDIS, NDIA, Eastern Access Community Health, EACH, Dissociative Identity Disorder

THE CORONIAL INVESTIGATION

1. Deborah'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.

2. Deborah's death is a reportable death as defined in the *Coroners Act 2008*. The court's jurisdiction is invoked due to the death occurring in Victoria and, subject to the second of the two-part definition, her death occurred whilst in care of the state of Victoria.[1]

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. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Deborah's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathology, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Deborah Leona Smith 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

[1] *Coroners Court Act 2008* (Vic), section 4(1), (2)(c).

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

Decision to hold an inquest

7. Under section 52, subsection 2(b) of the Coroners Act 2008, an inquest must be held into a death if the death occurred in Victoria and the deceased was, immediately before death, a person placed in custody or care.

8. Whilst Deborah lived somewhat independently, she was a recipient of significant NDIA funding and resided in state managed accommodation. Therefore, I am satisfied that Deborah was "in care" at the time of her death, and a mandatory directions hearing was held on 9 September 2022 accordingly.

9. Following the submission of this brief, I directed that this matter be dealt with as a summary mandatory inquest within the ambit of section 52(2)(b) of the *Coroners Act 2008*.

BACKGROUND CIRCUMSTANCES

10. Deborah Smith (**Deborah**) was 64 years of age at the time of her death. She originally trained as a nurse and was eventually promoted to head of an Intensive Care Unit however a traumatic experience resulted in her leaving the profession.

11. Deborah adored animals, especially her beloved cat Taffy, and was described by her family as kind, giving, funny, and loving.[3]

12. Deborah lived in a Department of Families, Fairness, and Housing unit on Mahoney's Road in Forest Hill and was a client of the National Disability Insurance Agency (then called the National Disability Insurance Scheme). Deborah was supported by carers from the Eastern Access Community Health (**EACH**) team who assisted in her activities of daily living.

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[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] Coronial brief, statement of Mandy Smith dated 24 January 2023, pages 82-83.

13. Deborah's medical history including dissociative identity disorder (**DID**), experiencing more than 20 personalities of varying ages with multiple psychiatric inpatient admissions. Her capacity and level of functioning fluctuated depending on the personality present at the time which resulted in several crisis meetings with her support coordinator, Sandy Visser (**Sandy**).[4]

14. Deborah's general practitioner, Dr Peter Lovass, noted that she also suffered from seizures and was very difficult to manage, often failing to attend appointments or referrals.[5] Due to Deborah's DID, she would often lose awareness and memory of time, activities, and cognition, severely affecting her ability to function.[6]

15. Deborah was initially reluctant to agree to support services but would often visit the EACH office in Box Hill to talk to the workers there. After several months, Deborah eventually agreed to eight hours of community support per week.[7] Dr Susan Brann (**Dr Brann**), Deborah's psychiatrist, noted that Deborah accepted the presence of her support workers but did not appear to understand why their presence was necessary.[8]

16. Sandy recalled that Deborah was often absent when support workers attended her residence however, she always returned home without requiring police intervention.[9]

17. Deborah's DID often caused significant difficulties in her life, including misplacing items and making reports that people were breaking into her unit however Sandy stated that Deborah never spoke about self-harm or suicide.[10]

18. In late 2021, Sandy observed that Deborah began to suffer from increased confusion and, whilst she initially refused increased support, her NDIA funding plan was increased with the engagement of a psychologist and an occupational therapist. It was also suggested that

[4] Coronial brief, Behaviour Support Plan, page 363.
[5] Coronial brief, statement of Dr Peter Lovass dated 5 September 2022, page 66.
[6] Coronial brief, Background assessment page 318.
[7] Coronial brief, statement of Sandy Visser dated 9 September 2022, pages 22-23.
[8] Coronial brief, statement of Dr Susan Brann dated 31 August 2022, page 70.
[9] Coronial brief, statement of Sandy Visser dated 9 September 2022, page 23.
[10] Coronial brief, statement of Sandy Visser dated 9 September 2022, page 23.

Deborah move into supported accommodation however she refused, preferring to remain on her own with her cat, Taffy.[11]

19. Throughout 2022, support workers continued to assist Deborah however she told Sandy that she did not want carers attending every day, preferring to have some days without support staff.[12] Dr Brann noted that Deborah's condition appeared to have deteriorated and that her degree of impairment had escalated noticeably, including to the point where she was unaware of what she was doing or why she was doing it.[13]

20. In June 2022, Sandy applied to the Victorian Civil and Administrative Tribunal for a guardianship order to facilitate the creation of a behavioural support plan and the use of lock boxes to manage Deborah's medication and any subsequent risks of overdose due to her DID. The application was later refused.[14]

CIRCUMSTANCES OF DEATH

21. In July 2022, Sandy gave Deborah a lift home after observing her walking on Mahoneys Road. Deborah told Sandy that she had misplaced her keys and, after arriving at her residence, climbed over her fence to check if the backdoor was open. After finding it was closed, Deborah climbed the fence again and eventually located her keys in her handbag.[15]

22. Several weeks prior to her death, Deborah began complaining of a sore knee resulting in a limp. She attended an appointment with her support worker and was given a referral for an X-ray, however she misplaced this and was scheduled to attend a further appointment on 10 August 2022.[16]

23. On 8 August 2022, a support worker attended Deborah's residence and noticed that she had very little food in the house. She refused to visit the shops however, preferring to go back

[11] Coronial brief, statement of Sandy Visser dated 9 September 2022, page 24.
[12] Coronial brief, statement of Sandy Visser dated 9 September 2022, pages 25-26.
[13] Coronial brief, statement of Dr Susan Brann dated 6 June 2022, pages 71-73.
[14] Coronial brief, statement of Sandy Visser dated 9 September 2022, pages 26-27.
[15] Coronial brief, statement of Sandy Visser dated 9 September 2022, page 28.
[16] Coronial brief, statement of Sandy Visser dated 9 September 2022, page 28.

to bed. The carer advised her that he would return on 10 August to take her to see Dr Lovass and left her to rest.[17]

24. Deborah asked her support worker to buy her groceries as she was not feeling well. Sandy contacted Deborah who told her that she was going to spend the day resting.[18]

25. On 9 August 2022, one of Deborah's non-support days, Sandy rang Deborah several times but was unable to elicit an answer. This was not unusual as Deborah would often go to the local shops by herself several times a day, however Sandy requested that the support worker update her on Deborah's condition when they attended the following day.[19]

26. At approximately 10.15am, Deborah visited the local bank where she spoke to one of the staff, Jacqueline Lewis (**Jacqueline**). Jacqueline, who had assisted Deborah on previous visits, stated that Deborah appeared her usual self.[20]

27. On 10 August 2022, Sandy was notified that Deborah was not home. A welfare check by Victoria Police members was organised however Deborah was unable to be located at home or at the local shops. At 4.05pm, when Deborah still had not returned home, Sandy contacted police and reported her as missing.[21]

28. Over the following days, extensive searches were conducted by Victoria Police members, including regular checks at her residence, contact with hospital emergency departments, checks with local business owners, media releases, and regular patrols of the local and surrounding areas, however these did not provide any clues as to Deborah's whereabouts.[22]

29. On 14 August 2022 at 9.25am Victoria Police members reattended Deborah's residence but were unable to locate her.[23]

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[17] Coronial brief, Candella case notes dated 8 August 2022, page 80.
[18] Coronial brief, statement of Sandy Visser dated 9 September 2022, page 28.
[19] Coronial brief, statement of Sandy Visser dated 9 September 2022, page 28.
[20] Coronial brief, statement of Sandy Visser dated 9 September 2022, pages 35-36.
[21] Coronial brief, statement of Sandy Visser dated 9 September 2022, page 29.
[22] Coronial brief, statement of Senior Constable Dean Russell dated 11 October 2022; search history pages 118-127.
[23] Coronial brief, statement of Leading Senior Constable Sloane Willing dated 16 September 2022, page 40.

30. At about 11.50am, Deborah was located lying face down on a path at the Quest apartments on Burwood Highway, Burwood East, by local workmen.[24] Victoria Police members attended the scene and however, on examination, Deborah was obviously deceased.[25]

31. The scene where Deborah was located was on a garden path between the Quest Apartments and the edge of the property which is bordered by a tall wooden fence approximately 2.5 metres high. There was a metal gate blocking access to the road.

32. It appears that Deborah had walked down the path, encountered the metal gate, and attempted to climb the wooden fence but had fallen, resulting in the injuries that claimed her life.[26]

33. The investigation into the circumstances of Deborah's death did not reveal any suspicious circumstances.[27]

MEDICAL CAUSE OF DEATH

34. After her death, Deborah was conveyed to the Victorian Institute of Forensic Medicine (**VIFM**) and, on 26 August 2022, Dr Melanie Archer, a specialist forensic pathologist, performed an autopsy.

35. Dr Linda Iles, a specialist forensic pathologist, performed a neurological examination on 29 August 2022, the findings of which were incorporated into Dr Archer's final report.

36. The post-mortem examination revealed:

    a) Possible marginal brain swelling;

    b) Remote lacuna infarction of the right anterior thalamus;

    c) Widespread cortical plaques; and

[24] Coronial brief, statement of Jayden Hayes dated 8 November 2022, page 37.
[25] Coronial brief, statement of Leading Senior Constable Sloane Willing dated 16 September 2022, page 40.
[26] Coronial brief, photographs pages 177-179.
[27] Coronial brief, statement of Detective Sergeant Gerald Muileman dated 2 December 2022, page 52.

d) No features of an acute traumatic brain injury.

37. Fractures of the left neck of femur with retroperitoneal and intramuscular haemorrhage were also noted, as was a fracture of the left mandibular ramus. Hepatic fibrosis, port hepatis surgical clips, and evidence of remote bowel surgery were noted.

38. Finally, lung adhesions predominantly on the right side and a sacral pressure ulcer were observed.

39. Toxicological analysis of post-mortem samples identified the presence of the clonazepam metabolite, 7-aminoclonazepam which was consistent with therapeutic use. Ethanol (alcohol) was not detected.

40. The location where Deborah was located suggested that her injuries resulted from a fall from height with no evidence of an assault.

41. Dr Archer formulated that the cause of Deborah's death was from complications following a fractured femur and mandible. It is possible that environmental factors also contributed to her death.

42. I agree with Dr Archer's formulation.

FINDINGS AND CONCLUSION

43. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[28] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a

[28] Briginshaw v Briginshaw (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

44. Having considered the evidence, I am satisfied that, on 9 August 2022, Deborah travelled by foot or by bus to the Quest Apartments in Burwood East, approximately 1.2 kilometres from her home address.

45. The reasons for Deborah doing this is unknown, however I note Deborah's history of DID and carrying out actions which she had limited comprehension or recall of doing. Therefore, it is possible that Deborah may not have been aware of why she was travelling there in the first place.

46. At an unknown time following her arrival at the Quest Apartments, Deborah gained access to the rear of the property and walked to a point where there was a fence and gate preventing access to the Burwood Highway.

47. Due to the presence of the gate blocking her path, Deborah likely attempted to climb the fence but fell, resulting in the injuries that ultimately claimed her life. It is likely that her DID was a significant contributing factor in her fall and death.

48. I am further satisfied that there were no suspicious circumstances that were causative of or contributed toward Deborah's death.

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

    a) the identity of the deceased was Deborah Leona Smith, born 1 February 1958;

    b) the death occurred on or about 14 August 2022 at 315 Burwood Highway, East Burwood, from *complications following a fractured neck of femur and mandible*; and

    c) the death occurred in the circumstances described above.

50. Having considered the circumstances, I am satisfied that the care that Deborah received from her support services prior to her death was reasonable and appropriate, noting her reluctance to more fully engage with her carers and other services.

51. I am further satisfied that the actions of Victoria Police were reasonable and appropriate following the filing of Deborah's missing person's report, given the circumstances.

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

Pursuant to section 73(1A) 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:

Mandy Smith, Senior Next of Kin

Darren Bain, National Disability Insurance Scheme Quality and Safeguards Commission

Detective Senior Constable Trevor Reitman, Victoria Police, Coroner's Investigator

Signature:

Coroner Simon McGregor
Date: 3 April 2023

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.