IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 002877

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Margaret Anne Brown
Date of birth:	1 October 1952
Date of death:	3 June 2021
Cause of death:	1(a) Cardiomyopathy 2 Atrial fibrillation, pulmonary hypertension, alcohol intoxication
Place of death:	3 / 32 Napier Street, Mornington, Victoria, 3931

INTRODUCTION

1. On 3 June 2021, Margaret Anne Brown was 68 years old when she died at home. At the time of her death, Margaret lived at unit 3, 32 Napier Street, Mornington.

2. Margaret's medical history included alcohol abuse, a permanent pacemaker, haemochromatosis, atrial fibrillation, left ventricular hypertrophy, Crohn's disease, osteoporosis, depression, mastectomy, seizures, and strokes.

3. At the time of her death, Margaret was prescribed amiodarone, rivaroxaban, cholecalciferol, metoprolol, esomeprazole, paroxetine, ranitidine, salbutamol, atorvastatin, and ramipril.[1] Temazepam, doxylamine succine (Restavit) and alprazolam were also located by investigators in Margaret's residence.[2]

4. Margaret, a former nurse, lived at the Napier Street address but was assisted by her friend and carer, Marilyn Parkin, who had been caring for her on a part-time basis since approximately 2015. Marilyn would attend Margaret's residence several times a day and would carry out cleaning and shopping tasks for her.[3] Marilyn stated that Margaret initially paid Marilyn $200 per week for her assistance however she later began to pay Marilyn in $2000 instalments on an intermittent basis.[4]

5. Margaret struggled with a history of alcohol abuse; Marilyn stated that Margaret would drink every day and she would ask Marilyn to purchase large amounts of alcohol for her throughout the week.[5] When Marilyn and Margaret returned from shopping, they would often have a drink together.[6]

6. Marilyn stated that there had been multiple occasions prior to Margaret's death when she had located Margaret unconscious in her house and had called an ambulance for her, however she stated that she had never known Margaret to express any thoughts of self-harm or suicidality.[7]

[1] Medical Examiner's Report dated 16 September 2021, page 2.
[2] Coronial brief, scene photos, pages 50, 56, 62.
[3] Coronial brief, statement of Marilyn Parkin dated 2 September 2021, pages 24-27.
[4] Coronial brief, statement of Marilyn Parkin dated 2 September 2021, page 27.
[5] Coronial brief, statement of Marilyn Parkin dated 2 September 2021, page 25.
[6] Coronial brief, statement of Marilyn Parkin dated 2 September 2021, page 26.
[7] Coronial brief, statement of Marilyn Parkin dated 2 September 2021, page 25; statement of Marilyn Parkin dated 3 June 2021, page 21.

THE CORONIAL INVESTIGATION

7. Margaret'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.

8. 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.

9. 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.

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

11. This finding draws on the totality of the coronial investigation into the death of Margaret Anne 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.[8]

12. In considering the issues associated with this finding, I have been mindful of Margaret's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006* (Vic), in particular sections 8, 9 and 10.

[8] 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.

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

Circumstances in which the death occurred

13. On 3 June 2021 at approximately 11.00am, Margaret visited Marilyn at her house and told her that she intended to cook food for her dog that day.[9] Marilyn stated that Margaret gave Marilyn her bank card and told her that, when they went shopping the following day, Marilyn was to withdraw $2000. Marilyn then drove Margaret home and shared a drink with her.[10]

14. Following their drink, Margaret then requested Marilyn to assist her to put on her pyjamas as she wanted to go to bed.[11] Marilyn assisted Margaret to bed with a glass of bourbon which was found on the bedside table.[12] Marilyn then left at 12.30pm.[13] Marilyn noted that Margaret would often go to bed in the afternoon and get up for dinner.[14]

15. On 3 June 2021 at approximately 2.00pm, Margaret's neighbour, Adam Virgona, heard her dog barking and looked over the fence, observing a large flame coming from a pot in the kitchen. Adam forced open Margaret's door and called out for her. Unable to elicit a response, Adam grabbed the pot, switched off the stove, and threw the pot on the front porch.[15]

16. Fire Rescue Victoria (**FRV**) services attended the scene and located Margaret on her bed with both of her feet on the ground in an unresponsive state.[16] She was carried outside where cardiopulmonary resuscitation was commenced by FRV members.[17]

17. Ambulance Victoria paramedics attended the scene and continued resuscitation efforts however these were ultimately unsuccessful and at 2.50pm, paramedics verified that Margaret had passed away.[18]

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[9] Coronial brief, statement of Marilyn Parkin dated 3 June 2021, page 21.
[10] Coronial brief, statement of Marilyn Parkin dated 3 June 2021, page 28.
[11] Coronial brief, statement of Marilyn Parkin dated 2 September 2021, page 28.
[12] Coronial brief, statement of Rachel Noble, dated 9 June 2021, page 35.
[13] Coronial brief, statement of Marilyn Parkin dated 2 September 2021, page 28.
[14] Coronial brief, statement of Marilyn Parkin dated 2 September 2021, page 25.
[15] Coronial brief, statement of Adam Virgona dated 3 June 2021, pages 14-15; statement of Rachel Noble, dated 9 June 2021, page 36.
[16] Coronial brief, statement of Marilyn Parkin dated 2 September 2021, page 29; statement of Rachel Noble, dated 9 June 2021, page 36.
[17] Coronial brief, statement of Rachel Noble, dated 9 June 2021, page 36.
[18] Ambulance Victoria Verification of Death form dated 3 June 2021; statement of Rachel Noble, dated 9 June 2021, page 36.

Fire investigation

Scene examination

18. Following Margaret's death, Victoria Police Forensic Officer (**FO**) Rachel Nobel attended the incident location and conducted a forensic examination of the scene with FRV Fire Investigators Station Officers (**SO**) Adrian Devenish and Paul Villani.[19]

19. FO Nobel noted that Margaret's residence was a three-bedroom unit with a double garage constructed of sandstone brick with plasterboard internal walls and ceiling It was kept in a relatively tidy manner and had a smoke detector located in the ceiling in the hallway between bedrooms which contained a battery but was non-operable when tested by investigators.[20]

20. Investigators noted that FRV crews responding to the fire at Margaret's residence did not hear an alarm on arrival or during subsequent searches of the property. The alarm unit was surrounded by sooted spider webs, indicating that smoke activity had occurred within range of the detector. On manual testing, the alarm failed to operate, indicating a probable fault with the detector.[21]

21. Investigators observed that the fire had occurred in Margaret's kitchen which was furnished with a gas stove where the fire had been contained to, with heavy sooting on the stove's back-splash area and on the underside of the stainless steel rangehood. Light sooting was observed throughout the rest of the unit, but no other obvious areas of fire damage were found, suggesting that smoke and hot gases from the fire had likely spread throughout the house.[22]

22. FO Nobel noted that the pattern of damage around the stove indicated a single point of origin on the right side of the stove, and that the evidence supported the account given by Mr Virgona in his statement to investigating officers. FO Nobel concluded that whilst the source of ignition was not conclusively determined, it was reasonable to conclude that the fire started due to a lit element igniting the pot which had boiled over.[23]

[19] Coronial brief, statement of Rachel Noble, dated 9 June 2021, page 33.
[20] Coronial brief, statement of Rachel Noble, dated 9 June 2021, page 35; Fire Rescue Victoria Fatal Fire Investigation Report (undated), page 79.
[21] Coronial brief, Fire Rescue Victoria Fatal Fire Investigation Report (undated), page 80.
[22] Coronial brief, statement of Rachel Noble, dated 9 June 2021, pages 35-36.
[23] Coronial brief, statement of Rachel Noble, dated 9 June 2021, page 36.

Fire safety issues

23. Several fire safety issues were identified during the course of the investigation, including:

    a) Behavioural risks:

        i. Unsafe smoke practices (possible smoking in bed, around home oxygen);

        ii. The presence and consumption of alcohol; and

        iii. Possible unsafe cooking practices.

    b) Environmental risks:

        i. Non-operable smoke alarm; and

        ii. The presence of home oxygen therapy in the bedroom.

    c) Personal risks:

        i. Person aged over 65 years;

        ii. Decreased ability to perform activities of daily living;

        iii. Use of multiple medications, including sedatives;

        iv. Multiple chronic physical health conditions; and

        v. Decreased mobility.[24]

24. FRV Acting Manager Geoff Kaandorp, At Risk Groups, noted that the multiple risks identified above significantly increased the risk of fire at Margaret's residence.[25]

Identity of the deceased

25. On 3 June 2021, Margaret Anne Brown, born 1 October 1952, was visually identified by her carer, Marilyn Parkin.

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

[24] Report of Geoff Kaandorp, At Risk Groups, Fire Rescue Victoria, dated 27 August 2021.
[25] Report of Geoff Kaandorp, At Risk Groups, Fire Rescue Victoria, dated 27 August 2021.

Medical cause of death

27. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 4 June 2021 and provided a written report of her findings dated 16 September 2021.

28. The post-mortem examination revealed an occipital scalp bruise and patchy purpuric bruising mainly over the dorsum of the forearms and hands bilaterally (with some skin tears, consistent with the ageing process and use of rivaroxaban), and pulmonary emphysematous changes.

29. The autopsy also revealed a permanent pacemaker[26] and a left atrial appendage filter with thrombus in situ. There was evidence of a right parietooccipital remote infarction, uterine fibroids, and hepatic siderosis in the setting of a history of haemochromatosis.

30. Toxicological analysis of post-mortem samples identified the presence of ethanol (alcohol) at a level equivalent to a Blood Alcohol Concentration (**BAC**) of 0.16 per cent.[27] Levetiracetam, metoprolol, and paroxetine were also detected.[28]

31. Dr Archer noted that there was a fire in Margaret's house at the time she was discovered unresponsive however there was no evidence of smoke inhalation or burns. There was no evidence of any major trauma that was likely to have caused or contributed to her death.

32. Dr Archer further noted that Margaret had significant natural disease in the form of a cardiomyopathy. Previous hospital admissions had resulted in a diagnosis of Takotsubo cardiomyopathy (likely to be a transient condition, however). Dr Archer opined that Margaret's cardiomyopathy was multifactorial, and contributing factors are most likely to be atrial fibrillation, and pulmonary hypertension. Concurrent alcohol use may also contribute.

33. Dr Archer provided an opinion that the medical cause of death was due to 1 (a) cardiomyopathy, with atrial fibrillation, pulmonary hypertension, and alcohol intoxication as contributing factors.

[26] Margaret's pacemaker was examined by a cardiologist, Associate Professor Neil Strathmore, who found it to be working normally. Assoc. Prof. Strathmore noted that the pacemaker did not capture a cardiac arrhythmia that led to her death and did not allow for a determination of her exact time of death. The information that can be gained from a pacemaker may depend on the type and settings of the device, however.

[27] This level has the potential to result in intoxication, depending on individual tolerance, although it is not a toxic amount. Alcohol can be associated with cardiac arrhythmia and may have contributed to the deceased's death in the setting of underlying heart disease.

[28] These drugs did not cause or contribute to death and are most in keeping with therapeutic use.

34. I accept Dr Archer's opinion.

CONCERNS

35. I note the concerns raised by Woodhams O'Keeffe who act on behalf of Margaret's Estate that a cash withdrawal of $2000 from Margaret's bank account occurred on 3 June 2021, verified by records from Margaret's bank account at the National Australia Bank which were included in the coronial brief.[29]

36. According to Marilyn's statement, she withdrew the $2000 in the belief that it constituted a payment for her services, consistent with Margaret's instructions given to her that morning. Marilyn then gave the bank card to Margaret's relative, Annie Brown.[30]

37. As advised by the Coronial Investigator, Victoria Police, Detective Sergeant Matthew McCormack, there were no criminal offences identified as pertaining to the withdrawal of the $2000 by Marilyn following Margaret's death, and that any disputes over the claim of right to that withdrawal can be pursued in the civil jurisdiction.

FINDINGS

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

    a) the identity of the deceased was Margaret Anne Brown, born 1 October 1952;

    b) the death occurred on 3 June 2021 at 3 / 32 Napier Street, Mornington, Victoria, 3931, from *cardiomyopathy* with *atrial fibrillation*, *pulmonary hypertension*, and *alcohol intoxication* as contributing factors; and

    c) the death occurred in the circumstances described above.

[29] Coronial brief, NAB bank records, page 120.
[30] Coronial brief, statement of Marilyn Parkin dated 2 September 2021, page 28, 30.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

39. I note the conclusions of the investigation into the fire at Margaret's residence on 3 June 2021, in which investigators posited that a working smoke alarm may have alerted her to the fire occurring. Whilst it reasonable to conclude on the basis of the available evidence that the fire did not cause or contribute to her death, the importance of functioning smoke alarms in residential properties cannot be understated.

40. Under the *Building Regulations 2018* (Vic), the installation of functioning smoke alarms is compulsory and must be located in a position designed to wake sleeping occupants in order to give them time and safe passage to evacuate the building. Furthermore, under the *Residential Tenancies Act 1997* (Vic), it is the responsibility of the Landlord to ensure that functioning smoke alarms are installed and are maintained throughout the life of the property.

41. The importance of functioning smoke alarms is emphasised in the context of at-risk groups, including elderly individuals or those with disabilities. Whilst Margaret was not the recipient of any professional in-home support services (and therefore not subject to any formal risk assessments or safety planning), for those receiving professional care, it is vital that organisations responsible for caring and providing services for individuals with needs carry out proper risk assessments that consider fire safety issues, and that these assessments are reviewed on a regular basis to evaluate whether any improvements or alterations may be made.

42. It is useful, however, to highlight those individuals providing informal or ad-hoc services (such as in Margaret's case) should be mindful of the individual needs of those that they assist, and should be especially cognisant of safety risks, including those associated with fire, and discuss safety issues with the individual where appropriate.

43. I note the comments and subsequent recommendations made by the then-Deputy State Coroner Iain West in the matter of the death of *Pearl Recht*[31] in which His Honour noted the number of preventable residential fire fatalities involving At Risk Groups who receive in-home support services, and the importance of the use of the 'Basic Home Fire Safety Training Materials' by community aged care providers in Victoria.

[31] COR 2011 3161.

44. This should include the incorporation of basic home fire safety into policy and practice guidelines for the assessment of those receiving in-home services, including the installation of additional smoke alarms in residences where the client is considered to be at a greater risk due to health, disability, or lifestyle factors.[32]

45. On 1 February 2013, the Acting Secretary for the Minister of Health and Ageing (now administered by the Minister for Disability, Ageing, and Carers) responded to His Honour's recommendations noting that they were consistent with the Community Care Common Standards as set out in the *Aged Care Act 1997* (Cth), and that community aged care providers are required to ensure that their staff are adequately trained to deliver services to their clients. Furthermore, and more specifically to fire safety risks, the Department issued an alert to Commonwealth community care services providers to make them aware of His Honour's recommendations and associated responsibilities.[33]

[32] COR 2011 3161, page 3.
[33] Rosemary Huxtable, Acting Secretary, Response to Recommendations dated 1 February 2013.

I convey my sincere condolences to Margaret'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:

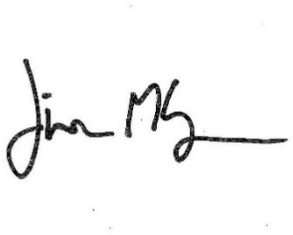
Pauline Barton, Senior Next of Kin

Woodhams O'Keeffe

Paul Villani, Fire Rescue Victoria

Detective Sergeant Matthew McCormack, Victoria Police, Coroner's Investigator

Signature:



CORONER SIMON McGREGOR

CORONER

Date: 25 May 2022

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.