IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 007042

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	MHJ[1]
Date of birth:	1969
Date of death:	19 December 2023
Cause of death:	1a: UNASCERTAINED
Place of death:	13 Jaques Grove Forest Hill Victoria 3131
Keywords:	In care, SDA resident, unascertained, natural causes death

[1] This finding has been deidentified.

INTRODUCTION

1. On 19 December 2023, MHJ was 54 years old when she died at her supported living facility in Forest Hill. MHJ is survived by her sister, Ms RG.

2. MHJ's medical history included, epilepsy, intellectual disability, schizophrenia, dementia, urosepsis, sleep apnoea and previous bowel resection. The frequency and severity of the seizures was unknown. She was on various prescribed medications to assist her conditions.

3. At the time of her death, MHJ was a Specialist Disability Accommodation **(SDA)** resident in an SDA enrolled dwelling at 13 Jaques Grove Forest Hill Victoria 3131. She received support from Life Without Barriers.

THE CORONIAL INVESTIGATION

4. MHJ's death was reported to the coroner as it fell within the definition of a reportable death in the Coroners Act 2008 (**the Act**).[2] 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, MHJ 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."*[3]

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. 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.

[2] Section 4(1), 4(2)(c) of the Act.
[3] 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.

7. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of MHJ's death. The Coronial Investigator conducted inquiries on my behalf. This finding draws on the totality of the coronial investigation into the death of MHJ including 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.[4]

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

Circumstances in which the death occurred

8. On 19 December 2023 at approximately 9.30pm, MHJ was observed to be asleep and snoring in her bedroom by care staff.

9. At 9.45pm, care staff checked on MHJ but noticed that she had stopped snoring and was cold to the touch. Upon turning on the light, the carer observed that MHJ had black coloured saliva from her mouth and was unresponsive. Emergency services were contacted, and cardiopulmonary resuscitation was commenced.

10. Emergency services arrived and continued resuscitative efforts. Unfortunately, MHJ was declared deceased at the scene.

Identity of the deceased

11. On 20 December 2023, MHJ, born 1969, was visually identified by her carer, Peter McFarlane.

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

Medical cause of death

13. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 22 December 2023 and provided a written report of her findings dated 24 May 2024.

[4] 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.

14. Dr Fronczek noted that at autopsy, there was no post-mortem evidence of any injuries which may have caused or contributed to the death. MHJ was known to have epilepsy; however, the frequency and severity of the seizures was unknown. It is well recognised that epilepsy predisposes an individual to a higher risk of sudden death, and it is thought that this is mediated through neuro-cardiac and / or neurorespiratory pathways. Various classifications have been proposed for sudden death in persons with epilepsy. Under the unified classification proposed by Nashef et al. (2012, Epilepsia 53(2):227-233), this death would fall under the category of "Definite SUDEP" because the criteria for SUDEP are satisfied, and there is no competing cause of death.

15. On 27 December 2023, Associate Professor Dr Linda Iles **(A/P Iles)** of the VIFM completed a neuropathological examination and provided a written report of her findings on 21 May 2024. The examination identified:

    a) Microcephaly

    b) Bilateral thalamic gliosis

    c) Diffuse cerebellar gliosis and folial atrophy with olivocerebellar tract atrophy

16. A/P Iles commented that there were no acute neuropathological changes identified. There were remote changes which could be related to seizure activity or the effects of antiepileptic drugs.

17. Toxicological analysis detected citalopram (antidepressant) and risperidone (antipsychotic) and metabolite in non-toxic concentrations. Vitreous humour biochemistry was non-contributory. The inflammatory marker CRP was not elevated, and no microorganisms were cultured in the urine. The isolated bacteria in the blood are considered contamination/post-mortem colonisation.

18. Dr Fronczek provided an opinion that the medical cause of death was *1(a) Unascertained.* Based on the available information, she was of the view that the death was due to natural causes.

19. I accept Dr Fronczek's opinion.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was MHJ, born 1969;

b) the death occurred on 19 December 2023 at 13 Jaques Grove Forest Hill Victoria 3131, from unascertained causes; and

c) the death occurred in the circumstances described above.

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

I convey my sincere condolences to the family of MHJ 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:

RG, Senior Next of Kin

Constable Alexander Nishanian, Coronial Investigator

Signature:

Coroner Kate Despot

Date: 09 May 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.