IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 4535

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	Caroline Harris Meallin
Date of birth:	1 February 1972
Date of death:	17 August 2023
Cause of death:	I (a) SIGMOID VOLVULUS IN THE SETTING OF COVID-19 INFECTION
Place of death:	Austin Hospital – 145 Studley Road, Heidelberg. VIC
Keywords:	In Care; Natural Causes

INTRODUCTION

1. Caroline Meallin was aged 51 years at the time of her death.
2. At the time of her death, Caroline received support through the National Disability Insurance Scheme (**NDIS**). Caroline lived with intellectual disability and secondary disability was cerebral palsy with significant physical and cognitive decline leaving Caroline wheelchair bound and with a peg tube in situ. She required full support for all activities for daily living and exhibited decline cognitive ability in the period proximate to her death.
3. In the period prior to her death Caroline lived at the Ventilator Accommodation Support Service (**VASS)** at 335 Clarendon Street, Thornbury, Victoria - a specialist accommodation facility for individuals who require support with complex respiratory conditions or mechanical ventilation. Clients receives 24/7 support from disability support workers (DSW) and registered nurses, many with post-graduate qualifications in respiratory nursing or critical care.

THE CORONIAL INVESTIGATION

4. Caroline's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008 (Act).*
5. This is because, immediately before death, Caroline was a person 'In Care', meaning that she was an SDA resident residing in an SDA enrolled dwelling. The death of a person 'In Care' is a mandatory report to the Coroner even if the death appears to have been from natural causes.
6. Generally, the Coroner must hold an inquest into the death of a person 'In Care'. However, under section 51(3A) and (3B) of the Act, the Coroner is not required to hold an inquest if the Coroner considers that the death was due to natural causes, on the basis of a report from a medical investigator which includes an opinion as such.
7. In this instance, I am satisfied on the basis of a report dated 23 August 2023 of Dr Yeliena Fay Baber, forensic pathologist at the Victorian Institute of Forensic Medicine (**VIFM**). I am satisfied, that Caroline's death was due to natural causes and therefore an inquest is not required. The report of Dr. Baber is discussed further below in relation to the medical cause of death.
8. The role of a Coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause 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 promotion 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. This finding draws on the totality of the coronial investigation, including information contained in the police report of death PRD (Form 83), the medical deposition, the manager of VASS Yooralla and Caroline's NDIS participation plan.
11. Whilst I have reviewed all the material, I will only refer that which is directly relevant to my findings or necessary for narrative clarity. In a coronial jurisdiction, facts must be established on the balance of probabilities.

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

Circumstances in which the death occurred

12. On the 12th of August 2023, Caroline was admitted to the Austin Hospital from a high-level care disability accommodation where she resided due to cerebral palsy; she was transported by ambulance due to a reduced conscious state. On admission she was found to be febrile and hypoxic with a confirmed diagnosis of COVID-19. She was also found to have sigmoid volvulus on the abdominal x-ray. This was considered a terminal admission in the setting of progressive decline from cerebral palsy, and the decision had been made by family for no intervention and comfort care. She passed away on 7 August 2023.

Identity

13. On the 19th August 2023, Caroline Harris Meallin, born 1 February 1972, was officially identified by her mother, Jan Meallin.
14. Identity is not in dispute and requires no further investigation.

Medical Cause of Death

15. On the 21st August 2023, Dr Yeliena Baber, forensic pathologist at the Victorian Institute of Forensice Medicine (**VIFM**) conducted an external examination and reviewed the medical deposition and post-mortem CT Scan.
16. Dr Baber provided a written report of her findings dated 23 August 2023.

17. Dr Baber formed the opinion that Caroline died of natural causes and a reasonable formulation for medical cause of death was 'I(a) SIGMOID VOLVULUS IN THE SETTING OF COVID-19 INFECTION'.
18. I accept Dr. Baber's opinion.

FINDINGS IN CONCLUSION

19. Pursuant to Section 67 (1) *Coroners Act* I make the following findings;
    (a) The identify of the deceased was Caroline Harris Meallin born 1 February 1972
    (b) Death occurred on 17 August 2023 at the Austin Hospital, Heidelberg from sigmoid Volulus in the setting of COVID 19 infection; and
    (c) the death occurred in the circumstances described above.
20. Having considered all the circumstances I am satisfied Caroline died of natural causes. I have not identified any concerns in relation to the quality of care provided in the period proximate to her death. Indeed the evidence reveals that Caroline received excellent professional care throughout her life.
21. I convey my sincere condolences to Caroline's family for their loss and to the support workers who offered her a lifetime of dedicated professional care and attention.
22. Pursuant to section 73 (1B) Act I order that this finding to be published on the Coroners Court Victoria website in accordance with the rules.
23. I direct that a copy of this finding be provided to the following;
    Jan Meallin, Senior Next of Kin
    National Pacific Insurance Agency
    Yooralla, VASS

Signature:

Coroner John Olle
Date: 27 March 2024

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.