IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2023 006774**

# FINDING INTO DEATH WITHOUT INQUEST

*Form 38 Rule 63(2)*

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

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| Findings of: | Coroner Catherine Fitzgerald |
| Deceased: | Sandra Susan Black |
| Date of birth: | 30 May 1969 |
| Date of death: | 6 December 2023 |
| Cause of death: | 1a: Aspiration pneumonia<br>1b: Alzheimer's dementia complicating down's syndrome |
| Place of death: | Austin Hospital, 145 Studley Road, Heidelberg, Victoria 3084 |
| Keywords: | Death in care, aspiration pneumonia, Alzheimer's dementia, natural causes |

## INTRODUCTION

1. On 6 December 2023, Sandra Susan Black was 54 years old when she died at the Austin Hospital. At the time of her death, Ms Black lived in specialist disability accommodation (**SDA**) in Wollert, Victoria, managed by Claro Aged and Disability Care (**Claro**).

2. Ms Black was diagnosed with Down Syndrome at birth and was placed in care at Janefield Training Centre. At the age of 22, she moved into a care facility at Mill Park, Victoria, where she resided for 24 years. While at the Mill Park residence, one of Ms Black's carers, Louise Stepan, became a close and longstanding friend. Ms Stepan described Ms Black as "like a family friend" and was later appointed as Ms Black's guardian and medical decision-maker.

3. At around 46 years old, Ms Black developed dementia and moved to Bundoora Extended Care. In 2017, following an increase in her care needs and cognitive decline, Ms Black was relocated to Regis Aged Care Facility in Macleod, where she resided for the following five years. In 2022, Ms Black moved to the Claro residence in Wollert, where she remained until her death.

4. Ms Black had a complex medical history which included Down Syndrome, Alzheimer's dementia, epilepsy, hypothyroidism and recurrent aspiration pneumonia, amongst other conditions. She was mostly non-verbal and had limited ability to communicate and was thus often non-responsive when asked questions. She occasionally verbalised one-word answers, but mostly expressed herself through grunts, yells, moans and facial expressions. She was wheelchair-bound and required support for all daily living activities including meal preparation and personal care.

5. In 2023, Ms Black had multiple admissions to hospital for assessment and support in connection with recurrent episodes of seizure-like unresponsiveness. A speech pathology review conducted in June 2023 at the Northern Hospital acknowledged her heightened risk of aspiration when eating due to her cognitive decline.

## THE CORONIAL INVESTIGATION

6. Ms Black's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).[1] Ms Black was a "person placed in custody or care"

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

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".[2]

7. The role of a coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased, the medical cause of death, and the circumstances in which the death occurred. These 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.

8. 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.

9. Victoria Police assigned an officer to be the coronial investigator for the investigation of Ms Black's death. The coronial investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Sandra Susan Black 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.[3]

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

### Circumstances in which the death occurred

11. Approximately four weeks before Ms Black's transition into palliative care, carers at her residence observed she had a persistent and worsening cough and was not her usual self.

[2] 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. I have received information that Ms Black resided at an address where the residents meet these criteria.

[3] 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. On 1 November 2023, Ms Black was seen by general practitioner (**GP**) Dr Philippe Yamouni at the Childs Road Medical Clinic (**CRMC**), who advised that she should present to an emergency department. Ms Black attended the Northern Hospital Epping Emergency Department that evening and was diagnosed with aspiration pneumonia. She was prescribed a five-day course of antibiotics and discharged the same day.

13. On 10 November 2023, Ms Black attended GP Dr David Festa at the CRMC due to another deterioration, presenting with increased coughing and reduced responsiveness. Dr Festa noted that Ms Black was poorly responsive to voice but on examination her chest was largely clear with a few basal rhonchi[4] only. Ms Black was prescribed antibiotics for six additional days.

14. On 13 November 2023, Ms Black was reviewed by GP Dr Darren Fernandes at the CRMC with increasingly rattly breathing, upper airway sounds and apparent distress at times due to secretions. With Ms Stepan's consent, Dr Fernandes initiated a referral to the Banksia Palliative Care team (**Banksia**) at Austin Hospital. Dr Fernandes also initiated an Advanced Care Directive in consultation with Ms Stepan which specified that Ms Black was not for resuscitation, intubation or mechanical ventilation.

15. On 17 November 2023, Ms Black's referral was accepted by Banksia. Following discussion with Ms Black and Ms Stepan, it was agreed that the appropriate pathway for Ms Black would be in Palliative Care.

16. At approximately 7:00 pm on 17 November 2023, Ms Black was transported to Banksia by ambulance, where she received comfort care. Her condition continued to deteriorate and she passed away at 1:27 am on 6 December 2023.

**Identity of the deceased**

17. On 6 December 2023, Sandra Susan Black, born 30 May 1969, was visually identified by her guardian, Louise Stepan.

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

[4] Rhonchi are low-pitched breathing sounds in the larger airways heard during exhalation.

**Medical cause of death**

19. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine conducted an external examination of Ms Black's body on 7 December 2023 and provided a written report of her findings dated 28 December 2023.

20. The findings on examination were consistent with the reported circumstances. There was no evidence of any injuries that could have caused or contributed to the death.

21. A post-mortem CT scan showed enlarged lateral ventricles in the brain but no acute hydrocephalus, lung consolidation or notable opacities.

22. Dr Archer provided an opinion that the medical cause of death was "1(a) aspiration pneumonia", secondary to "1(b) Alzheimer's dementia complicating Down's Syndrome" and that the death was due to natural causes.

23. I accept Dr Archer's opinion.

## FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Sandra Susan Black, born 30 May 1969;

    b) the death occurred on 6 December 2023 at Austin Hospital, 145 Studley Road, Heidelberg, Victoria 3084, from aspiration pneumonia, secondary to Alzheimer's dementia complicating Down's Syndrome; and

    c) the death occurred in the circumstances described above.

25. Having considered all the available evidence, I find that Ms Black's death was from natural causes and was not unexpected. As such, 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 Ms Black's friends and carers 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:

Louise Stepan, Senior Next of Kin

Austin Health

Senior Constable Zoe McGaig, Coronial Investigator

Signature:


Coroner Catherine Fitzgerald

Date: 30 April 2026

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.