IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 006558

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Larelle Sheridan Dean
Date of birth:	29 October 1973
Date of death:	10 November 2024
Cause of death:	1(a) Multiorgan failure in the setting of WHO Class III obesity, chronic excessive alcohol consumption, and anaemia (palliated) Contributing Factors Recent left tibial fracture
Place of death:	Austin Hospital, 145 Studley Road, Heidelberg, Victoria
Keywords:	Specialist Disability Accommodation, SDA resident, in care, disability, obesity, palliative care

INTRODUCTION

1. On 10 November 2024, Larelle Sheridan Dean was 51 years old when she died in hospital following palliative care treatment. At the time, Ms Dean lived in CLARO Specialist Disability Accommodation (**SDA**) in Heidelberg Heights.

2. Ms Dean was the eldest of four, and her parents were Alida and Graeme Dean. The family resided in Montmorency, and she was described by her mother as a *"healthy"* child.

3. According to her mother, Ms Dean began working as a kitchen hand and then an apprentice chef at the age of 15 years. While working as a chef, she began consuming alcohol socially.

4. Over the following years, her alcohol consumption increased, leading to significant weight gain. In her early thirties, Ms Dean suffered from low self-esteem and weighed about 150 kilograms (**kgs**). During this period, she received care in rehabilitation centres, hospitals and supported residential facilities.

5. Ms Dean's general practitioner (**GP**), Dr Elizabeth Morris at Mount Street Medical Centre, noted that Ms Dean had a significant medical history which included morbid obesity, alcohol addiction, atrial fibrillation, hypertension, anxiety and depression.

THE CORONIAL INVESTIGATION

6. Ms Dean's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Generally, reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable due to their 'in care' status irrespective of the cause of death.[1]

7. Relevantly, section 52 of the Act requires an inquest to be held in respect of all 'in care' deaths, except where the death was due to natural causes. For the purposes section 52(3A) of the Act, I am satisfied that Ms Dean essentially died from natural causes and have exercised my discretion not to hold an inquest into her death. The formulation of the cause of death in Ms Dean's case is discussed below.[2]

[1] See the definition of "reportable death" in section 4 of the *Coroners Act 2008* (the Act), especially section 4(2)(c) and the definition of "person placed in custody or care" in section 3 of the Act.
[2] See paragraphs 14 and following below.

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. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Ms Dean's death. The Coronial 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 Ms Dean's death, 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

Identity of the deceased

12. On 10 November 2024, Larelle Sheridan Dean, born 29 October 1973, was visually identified by her father, Graeme Dean, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

14. Forensic Pathologist, Dr Chong Zhou, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 12 November 2024 and provided a written report of her findings dated 18 November 2024.

[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.

15. The post-mortem computerised tomography (**CT**) scan showed increased lung markings with possible consolidation within the right lower lobe of the lungs and a fracture of the distal left tibial. Dr Zhou noted that the quality of the CT scan was compromised due to the body's habitus.[4]

16. Dr Zhou further noted that the cause of Ms Dean's multi-organ failure, apnoeic episodes, hypoxia, and reduced conscious state are all likely to be multifactorial in the setting of complications of WHO Class III obesity and chronic excessive alcohol consumption. Additional factors that were clinically suggested included fluid overload, pulmonary embolism, a central cause and repeated doses of hydromorphone (an opioid) required for analgesia. The cause the acute kidney injury was deemed likely secondary to right heart failure.

17. In the absence of an internal examination, it was not possible to determine if pulmonary thromboembolism (**PTE**) and deep vein thrombosis (**DVT**) complicated her recent left tibial fracture. However, the extent of Ms Dean's obesity and her hospitalisation is such that she would be at significantly increased risk of developing PTE and DVT even in the absence of this injury.

18. Routine toxicological analysis of ante-mortem samples collected on 7 November 2024, and post-mortem collected on 11 and 12 November 2024 did not detect any alcohol or any commonly encountered drugs or poisons.

19. Dr Zhou provided an opinion that the medical cause of death was *"1(a) Multiorgan failure in the setting of WHO Class III obesity, chronic excessive alcohol consumption and anaemia (palliated)*" and including *"2 A recent left tibial fracture"* as a significant other condition not directly related to the cause or mechanism of death.

20. I accept Dr Zhou's opinion.

Circumstances in which the death occurred

21. On 30 October 2023, Ms Dean began living in an SDA dwelling operated by CLARO. The accommodation is a high physical support facility that provides individuals with supported independent living under the National Disability Insurance Scheme (**NDIS**). Ms Dean required assistance from support workers for all aspects of her daily life but had the mental

[4] Shape.

capacity to make her own decisions. According to Shannon Garett, State Operations Manager at CLARO, that Ms Dean often purchased her own food and alcohol and had them delivered to the facility by a local taxi driver.

22. In about August 2024, Ms Dean was at Northland Shopping centre when she reportedly hit her foot on a door. She was taken to Austin Health by Jhoanna Rago, house manager at CLARO. A subsequent x-ray scan showed a fracture to her left tibia.

23. On 28 October 2024, Ms Dean experienced shortness of breath and was admitted to Royal Melbourne Hospital. Upon assessment, medical staff found the likely cause to be excessive alcohol consumption. She was discharged and returned home on 29 October 2024.

24. According to Ms Dean's mother, Ms Dean was once *"a very happy person"*. Her battle with alcoholism hindered her social life and her friendships but she remained close to her family who continued visiting her while she was in care.

25. According to Mr Garett, on 1 November 2024, Ms Dean complained of pain on the right-hand side of her stomach. She stated that she felt *"stressed"* and *"anxious"*. Support workers offered to call emergency services, but she declined and requested they call her GP. Following this, Ms Dean had a telehealth consultation with Dr Morris where she reported abdominal wall pain and anxiety. To manage these symptoms, Dr Morris prescribed her with paracetamol and increased the frequency of her valium.

26. On 3 November 2024, Ms Dean was unable to swallow her medication and reported pain. Support workers called emergency services and Ambulance Victoria (**AV**) arrived at about 8.00am. Upon examination, paramedics found her vitals to be stable and did not transport her to hospital. They advised her to contact her GP.[5]

27. The following day, on 4 November 2024, Ms Dean continued to experience pain on the right-hand side of her abdomen. Support workers called emergency services and AV paramedics arrived a short time later. She presented with reduced responsiveness, prompting paramedics to transport her to the Emergency Department (**ED**) at Austin Health.

28. According to Dr Bridget Rodkin, General Medicine (**GM**) Registrar at Austin Health, on arrival to ED, Ms Dean was in type 2 respiratory failure and briefly placed on a BiPAP[6] ventilator. She was treated for community acquired pneumonia and commenced on oral

[5] No evidence to indicate she had a follow up appointment with her general practitioner or any other doctor.
[6] BiPAP is a type of non-invasive ventilator.

antibiotics. Ms Dean was also given naloxone and thiamine for alcohol withdrawal. On admission, she weighed about 254.5kgs.

29. On 5 November 2024, she was reviewed by the GM team who found she had an acute kidney injury, constipation and was hypothermic with type 2 respiratory failure.

30. At about 5.00pm that night, Ms Dean had a medical emergency team (**MET**) call for oxygen saturation and a decreased Glasgow Coma Scale (**GCS**) score of 10 to 13.[7] She was commenced on diuresis and switched to intravenous antibiotics. Medical staff held discussions with her family and advised that further interventions may be ineffective. It was determined that the ceiling of treatment would be non-invasive ventilation (**NIV**) with invasive ventilation to be considered if there was cause for reversibility.

31. On 6 November 2024, Ms Dean's GCS score lowered to 9, with a respiratory rate of 9.[8] In the afternoon, she was reviewed by the respiratory unit and commenced on NIV. At about 10.26pm, a code blue was called for hypoxia due to the NIV machine failing. Nursing staff acted immediately to remove the mask and manually ventilated Ms Dean with high flow oxygen, achieving an immediate improvement in the oxygen saturation. A new machine was sourced and ventilation continued.

32. At about 6.30am, on 7 November 2024, Ms Dean cried out in pain, leading medical staff to increase the frequency of hydromorphone.[9] In the afternoon, she was reviewed by the renal unit who suggested the acute kidney injury was due to right heart failure and diuresis continued. Medical staff provided further updates to her family.

33. At about 5.55am, on 8 November 2024, there was a further MET call for hypoxia and periods of apnoea. Ms Dean required bag-valve mask assisted ventilation on 100% oxygen to improve her saturation. Her family were informed of her ongoing deterioration and poor prognosis. Following discussions with medical staff, they agreed to palliative care.

34. Throughout the day, Ms Dean continued to deteriorate. The ICU consultant and GM consultant acknowledged her poor clinical trajectory with no clear reversable cause for her persistent drowsiness. A subsequent plan to transition her to comfort care was made.

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[7] The Glascow Coma Scale (GCS) is a common scoring system used to describe a person's level of consciousness following a brain injury. A GCS of 8 or below is considered to be a 'severe' brain injury. A GCS of 9 to 12 indicates a moderate brain injury, and a score of 13 to 15 indicates a mild brain injury.

[8] A respiratory rate is the number of breaths you take per minute. In adults, the normal respiratory rate is about 12 to 20 breaths per minute.

[9] Hydromorphone is opioid medication for managing moderate-to-severe acute and severe chronic pain in patients.

35. Later that day, she was reviewed by the palliative care team and commenced on medications for comfort.

36. In the days that followed, Ms Dean's family stayed by her bedside and she passed away peacefully on 10 November 2024, at about 1.16pm.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Larelle Sheridan Dean, born 29 October 1973;

    (b) the death occurred on 10 November 2024 at Austin Hospital, 145 Studley Road, Heidelberg, Victoria;

    (c) immediately before death, Ms Dean was a *"person placed in custody or care"* as defined in section 4 of the Act;

    (d) the cause of Ms Deans's death was multiorgan failure in the setting of WHO Class III obesity, chronic excessive alcohol consumption and anaemia (palliated), with a recent left tibial fracture as a contributing factor; which I consider to be a death from natural causes for the purposes of section 52(3A) of the Act; and

    (e) the death occurred in the circumstances described above.

38. The available evidence does not support a finding that there was any want of clinical management or care on the part of staff at CLARO, Royal Melbourne Hospital or the Austin Health that caused or contributed to Ms Dean's death.

I convey my sincere condolences to Ms Dean's family 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:

Graeme Dean, senior next of kin

Alida Dean, senior next of kin

Austin Health

Meridian Lawyers

First Constable Andrew Gatt, Victoria Police, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 01 December 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.