IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 3007

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	[redacted]
Date of birth:	[redacted]
Date of death:	6 June 2020
Cause of death:	*Pneumonia in a woman with multiple co-morbidities*
Place of death:	Northeast Health Wangaratta, 35/47 Green St, Wangaratta, Victoria
Other matters	*Person placed in custody or care*, *natural causes*

INTRODUCTION

1. [redacted] was 61 years of age at the time of her death. She had lived in a Department of Health and Human Services managed group home in Olivers Road in Benalla since May 2017. The home was subsequently transferred to Home@Scope in 2018. At the time of her death [redacted] had applied for accommodation closer to her mother in Wodonga.[2]

2. [redacted] was survived by her mother, [redacted] and her younger brother [redacted]. Her father, [redacted] sadly passed away in 2018.

3. [redacted] had a history of congenital hydrocephalus, neonatal meningoencephalitis, stroke, obstructive sleep apnoea, chronic urinary incontinence, syndrome of inappropriate ADH secretion (**SIADH**), hyperthyroidism, and non-ST elevation myocardial infarction and pneumonia leading to respiratory arrest (2017). [redacted] was hearing impaired and required aides for assistance. She also suffered arthritis in her hands which affected her ability to write but was able to communicate verbally.

4. [redacted] was wheelchair bound and required assistance for her daily living needs including overhead tracking/hoist and assistive equipment. She required monthly General Practitioner (**GP**) appointments and monitoring and also received support from Allied Health Services. She was prescribed olanzapine[3] to reduce anxiety and depression.

5. [redacted] attended a group program in Wangaratta 2 days a week and Bella Yooralla 3 days a week.

6. In about 1996, [redacted] started attending Aware Industries where she worked for about 10 years. She loved working and was awarded a certificate for completing manual handling training and an award for her 10 years of service (*Recognition of Outstanding Service to the Company*).

7. [redacted] was noted to have a great sense of humour and liked animals, going out for meals, watching movies, holidays, shopping and socialising. She also loved keeping in regular contact with her mother. Her mother said that despite her disabilities, [redacted] *was usually happy and never let her handicap get her down.*

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[1] Referred to in my Finding as '[redacted]' unless more formality is required.
[2] Regional Disability Advocacy Service (RDAS).
[3] Olanzapine is an antipsychotic drug.

8. [redacted] was in receipt of an NDIS package at the time of her death and her finances were managed by the State Trustee.

9. Just after midnight on 6 June 2020, [redacted] passed away at Northeast Health Wangaratta having been admitted with declining health the day before. She had a previous one week admission on 24 April 2020, after she had been found unresponsive by staff and suffering laboured breathing.

THE CORONIAL INVESTIGATION

10. [redacted]s death was reported to the coroner as she was considered to be *a person placed in custody or care* under section 3(1) of the *Coroners Act 2008* **(the Act)** and so fell within the definition of a reportable death under the Act.

11. 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.

12. 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.

13. Victoria Police assigned Leading Senior Constable Jodi Clayton (**LSC Clayton**) to be the Coroner's Investigator for the investigation into [redacted]'s death. LSC Clayton conducted inquiries on my behalf, including taking statements from witnesses and submitting a coronial brief of evidence. The brief includes statements from Gillian's mother and brother, the forensic pathologist who examined [redacted] and her carers from Home@Scope.

14. [redacted]s records were also obtained from Home@Scope as well as her medical records from Northeast Health Wangaratta and Benalla Church Street Surgery, where she had been a patient.

15. As advice was received from a pathologist that [redacted]s death was due to natural causes[4], a mandatory inquest was not required.[5]

16. This finding draws on the totality of the coronial investigation into [redacted]'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.[6]

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

Circumstances in which the death occurred

17. In the week leading to her death, [redacted] had reduced oral intake, drowsiness and reduced interaction with staff. Her carers noted she was having 30 second periods of apnoea with noisy breathing overnight.

18. [redacted] was taken by ambulance to Northeast Health Wangaratta in the morning of 5 June 2020, and was found to have type 2 respiratory failure, stridor, intermittent apnoeas and a reduced conscious state. A chest x-ray showed consolidation or oedema in the lungs. A CT scan of the brain showed no acute changes. The clinical impression was of pneumonia. She was treated with antibiotics and steroids without improvement. A decision was made in consultation with [redacted]s family for comfort care measures and she was subsequently palliated.

19. [redacted] was declared deceased at 12.10am on 6 June 2020.

Identity of the Deceased

20. On 7 June 2020, [redacted] visually identified her daughter [redacted]

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

[4] Paragraph 25.
[5] S52(3A) of the Act.
[6] 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.

Medical cause of death

22. Specialist Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 9 June 2020 and provided a written report of his findings dated 11 June 2020.

23. A Toxicological analysis of ante-mortem samples identified the presence of olanzapine and paracetamol in therapeutic quantities.

24. She was found to be negative for COVID-19.

25. Dr Young stated that on the information available to him, he was of the opinion that [redacted]'s death was due to *natural causes*.

26. Dr Young provided an opinion that the medical cause of death was *Pneumonia in a woman with multiple co-morbidities*.

27. I accept Dr Young's opinion.

FINDINGS AND CONCLUSIONS

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

    (a) the identity of the Deceased is [redacted];

    (b) the death occurred on 6 June 2020 at Northeast Health Wangaratta, 35/47 Green St, Wangaratta, Victoria from *Pneumonia in a woman with multiple co-morbidities*; and

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

29. I convey my sincere condolences to [redacted]s family for their loss.

30. Pursuant to section 73(1B) of the Act, I order that this finding be published on the internet.

31. I direct that a copy of this finding be provided to the following:

[redacted] senior next of kin

Leading Senior Constable Jodi Clayton, Victoria Police, Coroner's Investigator

Signature:

SARAH GEBERT

Date: 26 July 2021

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.