IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 5546

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, CAITLIN ENGLISH, Coroner having investigated the death of Dorothy May Williams

without holding an inquest:
find that the identity of the deceased was Dorothy May Williams
born on 18 January 1928
and the death occurred on 3 December 2013
at 1/28 Highland Street, Kingsbury, Victoria
from:

1 (a) COMPLICATIONS OF OESOPHAGEAL CANCER

Pursuant to section 67(1) of the **Coroners Act 2008**, there is a public interest to be served in making findings with respect to **the following circumstances**:

1. Dorothy Williams was 85 years of age at the time of her death. Since 1996, she had resided at Highland Group Home in Kingsbury, having spent the majority of her life in the care of the Department of Human Services. She had regular contact with her sister, Louise Gregory, (who in later years was suffering from dementia) and her brother in law, Robert Gregory.
2. Ms Williams had an intellectual and hearing impairment. She had very little verbal speech and communicated with basic sign language or gestures.
3. At the time of her death, Ms Williams was 'in care' pursuant to s 3 *Coroners Act 2008* (the Act).
4. A coroner must hold an inquest if the deceased was, immediately before death, a person placed in care, in accordance with section 52(2)(b) of the Act.

5. Pursuant to section 52(3A) of the Act, I am not required to hold an inquest in these circumstances, if I consider that the death was due to 'natural causes'.

6. In accordance with section 53(3B) of the Act, a death may be considered to be due to 'natural causes' if the coroner has received a report from a medical investigator, in accordance with the rules, that includes an opinion that the death was due to 'natural causes'. I have received a report in this case.[1]

7. I also note that no issues were identified regarding the health management of Ms Williams, which affected her cause of death. Therefore, I make my findings with respect to the circumstances and exercise my discretion not to hold a public hearing through an inquest.

8. A police investigation was conducted into the circumstances of her death.

9. A brief prepared by Victoria Police for the coroner includes statements obtained from Ms Williams' treating health practitioner, the supervisor of her group home, her brother in law and the coroner's investigator. I have drawn on all of this material as to the factual matters in this finding.

Health History

10. In 2006, Ms Williams was diagnosed with progressive brain atrophy, a form of dementia.

11. In 2012, after a decline in health, and spates of vomiting, she was referred by her GP, Dr Brett Hunt to geriatrician, Dr Rabin Sinnappu.

12. On 5 June 2012 Dr Sinnappu ordered a gastroscopy, which returned a diagnosis of oesophageal cancer. The cancer was deemed inoperable and treated palliatively following a care plan meeting at the Austin hospital. A stent was inserted and Ms Williams was cared for at home.

13. After the cancer diagnosis, in July 2012, Ms Williams' status was confirmed to be not for resuscitation following review by Dr Hunt and discussion with family and the recommendation from Melbourne City Mission.

14. Ms Williams was on symptomatic treatment and as she became unwell, Dr Hunt would prescribe medications to relieve pain or discomfort.

[1] Dr Michael Burke, Supplementary Report, 24 June 2014.

Events Proximate to Death

15. From 2 December 2013, Ms Williams became bed ridden due to decreased physical strength and mobility.

16. On 3 December 2013, Ms Williams' breathing became laboured. She was administered two drops of Rivotril in an attempt to relieve her breathing distress, initially without effect. Her breathing then slowed.

17. Emergency services were contacted. Ambulance arrived and confirmed death at 8.20pm.

18. Police attended the scene.

Post Mortem Examination

19. Forensic Pathologist Dr Michael Burke at the Victorian Institute of Forensic Medicine completed a post mortem inspection and report on 8 December 2013. Dr Burke formulated the cause of death. I accept his opinion. Dr Burke confirmed that the death was due to natural causes.[2]

Finding

I find that died Dorothy May Williams died from complications of oesophageal cancer.

I direct that a copy of this finding be provided to the following:
Mr Robert Gregory
Senior Constable Teneille Bamford

Pursuant to section 73(1B) of the **Coroners Act 2008**, I direct that a copy of this finding be published on the internet.

Signature:

CAITLIN ENGLISH
CORONER
Date: 10 September 2015

Coroners Court of Victoria

[2] Dr Michael Burke, Supplementary Report, 24 June 2014.