IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2014 0735

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of FATIMA LAY

without holding an inquest:
find that the identity of the deceased was FATIMA LAY
born 21 August 1966
and the death occurred on 7 February 2014
at 24 Eppalock Circuit, Caroline Springs, 3023
from:

1 (a) PULMONARY THROMBOEMBOLISM
1 (b) DEEP VEIN THROMBOSIS

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Ms Fatima Lay was 47 years of age at the time of her death. She was born in East Timor. When she was approximately four years old, she suffered from a high fever and was treated by local doctors. She sustained a brain injury at this time.

2. Ms Lay's family moved to Australia in the early 1980s. It was apparent at that stage that Ms Lay had developmental problems. She attended a Psychiatrist in the 1990s who diagnosed her with Schizophrenia with hallucinations, and placed her on Largactil. Ms Lay's health and behaviour deteriorated, she became withdrawn and became tactile defensive. She was admitted as a patient to the Larundel Psychiatric Hospital. Her family requested a second opinion from a Neurosurgeon, who considered that Ms Lay's first cervical vertebrae was damaged due to a

violent muscle spasm, attributed to the Largactil. Ms Lay had surgery at St Vincent's Hospital and a prolonged rehabilitation. In 2004, Ms Lay required assistance with personal activities of daily living and was placed in supported residential accommodation at 24 Eppalock Circuit, Caroline Springs owned by Gellibrand Support Services (the facility).

3. At approximately 6.30am on 7 February 2014, the facility's on-duty Support Worker, Mr Charles Tran, assisted Ms Lay into the shower and back to her room to get dressed. Ms Lay informed Mr Tran that she needed to use the bathroom. Ms Lay was assisted to and from the bathroom, and again informed Mr Tran that she needed to use the bathroom approximately 10 minutes later. Ms Lay was again assisted to the bathroom. After approximately five minutes, Mr Tran knocked on the toilet door, but did not receive a response. Mr Tran opened the door and located Ms Lay lying on the floor, unresponsive, and without a palpable pulse.

4. Mr Tran ran to retrieve the defibrillator and requested other facility staff call for an ambulance. Mr Tran attempted to use the defibrillator, however the machine instructed him to commence cardiopulmonary resuscitation (CPR). Mr Tran performed CPR for approximately 10 minutes before paramedics arrived. Resuscitation efforts continued for approximately one hour, after which time it was determined that Ms Lay was deceased.

INVESTIGATIONS

5. Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM) performed a post mortem examination on the body of Ms Lay, reviewed a post mortem CT scan and reviewed the Victorian Police Report of Death, Form 83. Anatomical findings included widespread pulmonary thromboembolism, pulmonary infarct and deep vein thrombosis.

6. Toxicological analysis of blood retrieved post mortem identified the presence of aripiprazole, used for the treatment of Schizophrenia, within therapeutic concentration parameters. No alcohol was detected. Dr Parsons ascribed the cause of Ms Lay's death to natural causes, being pulmonary thromboembolism secondary to deep vein thrombosis. Dr Parsons commented that the risk factors for the development of thromboembolism include carcinoma, obesity, recent surgery, smoking, prolonged periods of immobilisation, familial clotting disorders, sepsis, dehydration and major fractures.

7. The circumstances of Ms Lay's death have been the subject of investigation by Victoria Police on my behalf. No evidence of third party involvement in Ms Lay's death was identified. Police obtained statements from Support Worker Mr Tran, Ms Lay's sister-in-law Mrs Rosemary Lay, and her sister, Ms Mi Ling Lay.

8. Ms Lay's death was reported to the Coroners Court of Victoria as it was considered a "reportable death", as defined in section 4 the *Coroners Act 2008* (the Act), as her death was "unexpected" and because she was "person placed...in care" as it is defined in the Act. Although Ms Lay was a "person placed...in care", because her death was attributed by Dr Parsons in her report to natural causes, an inquest was not held into Ms Lay's death pursuant to section 52(3A) of the Act.

FACTORS CAUSING OR CONTRIBUTING TO DEATH

9. The evidence supports a conclusion that Ms Lay died on 7 February 2014 and that the cause of her death was pulmonary thromboembolism secondary to deep vein thrombosis. There was no evidence to suggest any other cause or contribution to her death. Ms Lay died from natural causes.

FINDING

I accept and adopt the medical cause of death as identified by Dr Sarah Parsons and find that Ms Fatima Lay died from natural causes, being pulmonary thromboembolism secondary to deep vein thrombosis.

AND I further find that the were no relationship between the cause of Ms Lay's death and the fact that she was "a person placed in care".

As Ms Lay was in care within the meaning of the *Coroners Act 2008*, this Finding will be published on the Internet in accordance with section 73(1B) of the Act.

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

Ms Iaoi Lay

Gellibrand Support Services

Department of Health and Human Services

Senior Constable Mei Jin Ong

Signature:

AUDREY JAMIESON
CORONER
Date: **17 July 2015**