IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 0645

FINDING INTO DEATH WITHOUT INQUEST

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

I, PETER WHITE, Coroner having investigated the death of GAYLE ROSEMARY HAMILTON without holding an inquest:

find that the identity of the deceased was GAYLE ROSEMARY HAMILTON

born on 17 June 1957

and the death occurred on 7 February 2015

at Box Hill Hospital, 8 Arnold Street, Box Hill

from:

1 (a) SEPSIS IN THE SETTING OF PROBABLE ASPIRATION PNEUMONIA

CONTRIBUTING FACTORS

TRISOMY 21, SEVERE OROPHARYNGEAL DYSPHAGIA

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

1. Gayle Rosemary Hamilton was a 57 year old woman who lived in a Department of Human Services (DHS) care facility. Ms Hamilton was born with trisomy 21 (Downs Syndrome) and had been in care all of her life. She was also blind and had severe oropharyngeal dysphagia. She was further diagnosed with dementia and epilepsy. Her swallowing ability deteriorated and in December 2014, she was thought to be having episodes of aspiration.
2. On 1 February 2015, Ms Hamilton was taken to hospital by her carers due to generalised weakness. She presented with an altered level of consciousness that was thought likely to be due to sepsis from aspiration pneumonia. In consultation with her sister, the decision was made to institute palliative care measures. Ms Hamilton passed away on 7 February 2015.
3. Forensic Pathology Fellow Dr Gregory Young of the Victorian Institute of Forensic Medicine performed a post mortem medical inspection. The post mortem CT scan

showed patchy changes in both lungs. Dr Young was of the opinion that Ms Hamilton's death was due to natural causes and concluded that the cause of death was 1(a) sepsis in the setting of probable aspiration pneumonia with contributing factors of trisomy 21 and severe oropharyngeal dysphagia. I adopt Dr Young's findings in relation to the medical cause of death.

4. As Ms Hamilton was in DHS care, the coroner's investigator provided me with a coronial brief of evidence that I have relied on in setting up the circumstances above. I note that Ms Hamilton's sister had no issues with the care that her sister received. On the evidence available to me, I find that Ms Hamilton died of natural causes. I further find that the care she received was appropriate.

Pursuant to section 73(1B) of the *Coroners Act 2008,* I order that this finding be published on the internet in accordance with the rules.

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

Ms Hamilton's family

Leading Senior Constable Rick Bryan, coroner's investigator

Signature:

PETER WHITE
CORONER
Date: **1 September 2015**