IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 3314

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Sarah Gebert, Coroner
Deceased:	Ms H
Date of birth:	October 1965
Date of death:	June 2020
Cause of death:	*Complications of Lennox-Gastaut Syndrome*
Place of death:	McCallum Disability Services, 2 Cornell Court, Lucas, Victoria
Other matters:	*Person placed in custody or care*, *natural causes*

INTRODUCTION

1. Ms H[1], born in 1965, was 54 years of age at the time of her death. Ms H is survived by her parents Mr H and Mrs H.

2. Ms H was diagnosed with Lennox-Gastaut Syndrome[2] on 18 February 1988[3] and had been under the care of McCallum Disability Services since 1991. At the time of her passing she resided in purpose-built accommodation in Lucas[4] with one other resident.[5]

3. Ms H's likes and interests included watching movies, listening to music (Elvis, John Denver), interacting with people, painting and drawing, playing UNO and reading books.

4. Ms H was assisted by a number of professionals including her General Practitioner (**GP**) of 30 years, Dr Rimas Liubinas who noted that her history included epilepsy (Lennox Gastaut type with corpus callosectomy as a child), reduced mobility (motorised wheelchair), intellectual disability, deep vein thrombosis and osteoporosis (with a history of multiple fractures). He said that at most visits, Ms H was *pleasant and happy* with *a background of long standing intellectual disability* but did not believe she suffered a *depressive illness*. Dr Liubinas commented in relation to the care provided to Ms H, that *her carers have been good advocates (as well as her mother Mrs H with whom* [he] *...had multiple discussions with regarding her health needs).*

5. Ms H was last seen at his practice by another GP on 16 June 2020 for acute sinusitis.

6. Ms H's epilepsy was managed by Dr Thomas Kraemer. She would frequently suffer seizures and drop attacks (daily) but more recently, with the addition of Zonasamde, these had been reduced in frequency. Her carers had a documented Epilepsy Management Plan.

7. Ms H required assistance to walk including with a wheelchair, recliner and mobile walker and always wore a helmet and special shoes to assist with movement and with any possible seizures or falls. She was able to eat her meals independently but meals were prepared in accordance with her mealtime management plan.

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[1] Referred to in my Finding as Ms H unless more formality is required.
[2] *Lennox-Gastaut syndrome* is a severe form of epilepsy that typically becomes apparent during infancy or early childhood.
[3] Summary of evidence prepared by the Coroner's Investigator.
[4] Since August 2019.
[5] She was a client of the National Disability Insurance Scheme (**NDIS**).

8. On the morning of 22 June 2020, Ms H was found unresponsive in her bed by a carer and despite assistance was unable to be revived.

THE CORONIAL INVESTIGATION

9. Ms H'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.

10. 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.

11. 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.

12. Victoria Police assigned First Constable Evan McHugh (**FC McHugh**) to be the Coroner's Investigator for the investigation into Ms H's death. FC McHugh conducted inquiries on my behalf, including taking statements from witnesses and submitting a coronial brief of evidence. The brief includes statements from one of her carers, her GPs, an ambulance paramedic, the forensic pathologist who examined her and investigating police as well as the McCallum Disability Care File.

13. As advice was received from the pathologist that Ms H's death was due to natural causes[6], a mandatory inquest was not required.[7]

14. This finding draws on the totality of the coronial investigation into Ms H'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.[8]

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[6] Paragraph 29.
[7] Section 52(3A) of the Act.
[8] 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

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

Circumstances in which the death occurred

15. At about 9.45pm on 21 June 2020, McCallum Care Worker, Chloe Wilson attended Ms H's room to complete her comfort measures before Ms H went to sleep. Chloe said that Ms H *appeared in good health and nothing seemed out of the ordinary and* [Ms H] *did not report anything to* her.

16. It was shortly after 7.00am the following day, 22 June 2020 that Chloe discovered Ms H unresponsive in her bed, when she brought her breakfast and medication to her.

17. Emergency services were called and the Metropolitan Fire Brigade (**MFB**) as well as ambulance paramedics attended. Cardiopulmonary resuscitation (**CPR**) was performed but unfortunately Ms H was unable to be assisted and was declared deceased at her residence.

18. Police arrived at approximately 7.55am and met with her carers who were described as *upset by the circumstances of the situation, but maintained absolute professionalism throughout* [police] *interaction.*

19. Police commenced an investigation and noted that two McCallum care workers were present over the night of 21 to 22 June 2020.

20. Following the police investigation, no suspicious circumstances were found.

Identity of the Deceased

21. On 22 June 2020, Simone Van Bergen, registered nurse/supervisor visually identified Ms H born October 1965, who she had known for 20 years.

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

Medical cause of death

23. Specialist Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 24 June 2020 and provided a written report of his findings dated 25 June 2020.

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evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

24. A toxicological analysis of post mortem samples identified the presence of clobazam[9], lamotrigine[10], valproic acid[11] and paracetamol in quantities which are consistent with therapeutic use.

25. An external examination was conducted, which showed no unexpected signs of trauma.

26. A post mortem CT scan showed increased markings in the lungs, a repaired left tibia, a right frontal craniotomy, and encephalomalacia and dilated ventricles in the brain. There was no evidence of intracranial haemorrhage.

27. Dr Young noted that Lennox-Gastaut syndrome is a form of childhood-onset epilepsy that results in multiple seizures, and is associated with intellectual disability and increased risk of aspiration pneumonia.

28. Dr Young provided an opinion that the medical cause of death was *Complications of Lennox-Gastaut Syndrome*.

29. He also stated that on the information available to him, he was of the opinion that Ms H's death was due to *natural causes*.

30. I accept Dr Young's opinion.

FINDINGS AND CONCLUSIONS

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

    (a) the identity of the Deceased was Ms H, born 1965;

    (b) the death occurred June 2020 at McCallum Disability Services, 2 Cornell Court, Lucas, Victoria from *Complications of Lennox-Gastaut Syndrome*; and

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

32. I convey my sincere condolences to Ms H's family for their loss.

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

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

[9] Clobazam is a 1.5-benzodiazepine derivative used as a sedative, anticonvulsant and anxiolytic.
[10] Lamotrigine is a substituted asymmetric triazine used as an anticonvulsant.
[11] Valproic acid is primarily used for the treatment of epilepsy, but also clinically indicated as adjunct therapy in mania and schizophrenia where other therapy is inadequate.

Mrs H, senior next of kin

First Constable Evan McHugh, Victoria Police, Coroner's Investigator

Signature:

SARAH GEBERT

Date: 25 October 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.