IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 3468

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Amended pursuant to section 76 of the Coroners Act 2008 on 3 June 2025 [1]

Deceased:	Anna Lee
Delivered on:	19 May 2025
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	Inquest: 23 January 2024
Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Counsel Assisting the Coroner:	Sergeant Tracy Weir, Police Coronial Support Unit, instructed by Ms Grace Horzitski, Senior Coroner's Solicitor, CCOV
Representation:	Mr Raph Ajzensztat of Counsel instructed by Mr Daniel Lewis of Meridian Lawyers appeared on behalf of Bendigo Health.

[1] This document is an amended version of the Finding into Death With Inquest dated 29 May 2025. A correction has been made to footnote 3 of this document (formerly footnote 2) to correct the name to 'Anna' from 'Shane' and remove the reference to a timeline at pages 42-46 of the inquest brief.

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INTRODUCTION

1. Anna Lee was a seventy-year-old retired woman who died on 2 July 2021 in circumstances suggesting she intended to end her life. At the time, Anna was an inpatient in the Older Persons Unit of the Adult Acute Ward at Bendigo Hospital, 100 Barnard Street, Bendigo.[2] Anna is survived by her sister Helen Lee who attended the inquest supported by her husband Jarrod.

2. Anna was a retired psychiatric nurse and resided alone on a small hobby farm at 52 Blackhill Road, Kyneton. She was described by her sister as a generous person who lived a quiet life supporting herself on her superannuation in retirement.

3. The coronial investigation revealed that in about mid-April 2021, Anna made some investments online with an unregulated trading platform self-styled "Safefund". Anna transferred two sums to Safefund, an initial $2000.00 and then $8000.00 after communicating with a person who claimed to be a Senior Broker at Safefund.

4. Anna later became suspicious of Safefund and reported her experiences to the Commonwealth Bank of Australia (**CBA**). The CBA commenced an investigation, suspecting that those asking Ms Lee to invest in Safefund were "scammers". The CBA made unsuccessful attempts to recover Anna's money. While not confirmed by the CBA until July 2021, Anna was aware from as early as April 2021 that she may have been the victim of a scam. This appears to have been the prime catalyst for a deterioration in her mental state.

5. Anna became increasingly paranoid, believing she was being tracked by someone and that her phone and her computer had been "tapped". She said she had thoughts of 'following the divine' and 'following the light' and wanted to be hypnotised to return to her birth. She reported destroying her computer, her mobile phone and the solar system as she believed hackers were listening to her thoughts. With her sister's assistance, Anna presented to her general practitioner who referred her to Bendigo Health for further assessment and management.

[2] In deference to her family's wishes, the deceased will be referred to as Anna in this finding.

OVERVIEW OF CLINICAL MANAGEMENT[3]

6. Anna presented to the Emergency Department of Bendigo Hospital on 1 May 2021 and, after assessment, was admitted to the Older Persons Unit as a voluntary patient or consumer. It became apparent during the first few days of her admission that Ms Lee was increasingly paranoid and uncooperative with treatment.

7. On 6 May 2021, Anna was made the subject of an Inpatient Assessment Order under the ***Mental Health Act 2014*** (**the MHA**), the first part of the process set out in the MHA for compulsory treatment of a consumer. Following that assessment, on 7 May 2021, Anna was made the subject of an Inpatient Temporary Treatment Order (a compulsory treatment order) from that date until 1 June 2021. As a result of COVID-19 restrictions, the order was extended to 18 June 2021 to enable Anna to obtain legal advice. On 15 June 2021, the Mental Health Tribunal made an Inpatient Treatment Order (a compulsory treatment order) which was to be in place for 16 weeks.

8. On Friday 2 July 2021, Anna had breakfast with other inpatient consumers and then attended a mutual help meeting with the ward Occupational Therapist. At about 11.00am, Anna was seen walking to her bedroom. When she did not attend for lunch, staff went to Anna's room to look for her at about 12.05pm. They found her unconscious, slumped forward against the sink and wall. With the assistance of more staff, cardiopulmonary resuscitation (**CPR**) was commenced. When intubation was attempted, staff found an obstruction in Anna's airway which was removed with the use of forceps, and CPR continued.

9. Unfortunately, Anna could not be revived, and emergency services were called. Anna was verified deceased at the scene and Victoria Police and the Coroner notified accordingly.

INVESTIGATION AND SOURCES OF EVIDENCE

10. This finding is based on the totality of the material the product of the coronial investigation of and inquest into Anna's death which includes relevant witness statements, photographs, the

[3] This is a broad overview of the circumstances in which Anna's death occurred, intended to assist understanding of the finding. The timeline and broader circumstances will be discussed in more detail below by reference to the evidence. While I understand these to be largely uncontroversial matters, to the extent of any inconsistency, the latter is to be preferred.

forensic pathologist's report and medical records.[4] This finding is also based on the evidence of those witnesses who were required to testify at inquest and any documents tendered through them; and the final submissions of Counsel for each of the parties.

11. All this material, together with the inquest transcript, will remain on the coronial file.[5] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

12. The purpose of a coronial investigation of a *reportable death*[6] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[7]

13. Anna's death clearly falls within the definition of a "reportable death" in section 4 of the ***Coroners Act 2008*** (**the Act**), satisfying both the jurisdictional nexus with the State of Victoria required by section 4(1) of the Act, and section 4(2) which includes (relevantly) –

> *Section 4(2)(a) a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury;*
>
> *Section 4(2)(c) the death of a person who immediately before death was a person placed in custody or care.*

14. The concept of a person placed in custody or care is defined in section 3 of the Act and relevantly includes a person detained in a designated mental health service within the meaning of the the MHA.

15. The *medical* cause of death, incorporates where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or

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[4] The compilation of material sometimes referred to as an inquest brief (designated Exhibit A at inquest) will be referred to as the "brief" in the rest of this finding.

[5] From the commencement of the ***Coroners Act 2008*** (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

[6] The term is exhaustively defined in section 4 of the ***Coroners Act 2008*** [the Act]. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury. Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

[7] Section 67(1).

background and surrounding circumstances but is confined to those circumstances **sufficiently** proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[8]

16. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[9]

17. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[10] These are effectively the vehicles by which the coroner's prevention role can be advanced.[11]

IDENTITY

18. Anna Lee, born 28 September 1950, aged 70, was identified by her sister Helen Lee who signed a formal Statement of Identification to this effect before a Coronial Admissions & Enquiries member of staff on 6 July 2021. Anna's identity was not in issue and required no further investigation.

CAUSE OF DEATH

19. Anna's body was brought to the Coronial Services Centre in Southbank (**CSC**). Forensic pathologist Dr Joanne Glengarry, Victorian Institute of Forensic Medicine (**VIFM**) reviewed the Police Report of Death to the Coroner (VP Form 83), post-mortem CT scanning of the whole body undertaken at VIFM (**PMCT**), the Medical Deposition and the medical records

[8] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.). Note that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence. However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1) of the Act.

[9] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[10] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[11] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

provided by Bendigo Health before performing an external examination of Anna's body in the mortuary.

20. Having done so, Dr Glengarry provided a written report that is included in the inquest brief.[12] Her findings were on external examination were - no significant traumatic injuries; no significant natural disease; there were signs of medical intervention in the form of an endotracheal tube, catheters in the left antecubital fossa and the dorsal of the left hand, bruising associated with a needle puncture wound in the dorsal of the right wrist, defibrillator pads across the chest, right upper chest and left lateral chest; and there was no obstructing material within the mouth.

21. Dr Glengarry's review of the PMCT showed no intracranial abnormality; the endotracheal tube was in the right main bronchus; there were increased lung markings; no foreign airway material remained; and there was coronary calcification.

22. Unfortunately, the foreign material found to be lodged in Anna's airway during CPR was not conveyed to VIFM for examination and its whereabouts remains unknown. This was an omission. Best practice required the item/s to have been transported to the CSC with the deceased for examination. However, the item/s were described by first responders and witnesses at the scene as well as in the medical deposition, they were photographed by police at the scene, and there is no reason to doubt the nature of the items. That is that they are ubiquitous and seemingly harmless in ordinary use and readily availability in the ward and likely also in domestic settings.

23. Having reviewed all the available material and conducted an external examination of Anna's body, Dr Glengarry advised that the *"circumstances are strongly indicative of choking or an obstruction object placed in the airway"* and concluded her report by formulating the cause of Anna's death as *1(a) Asphyxia due to airway obstruction by* [redacted][13]

24. I agree with Dr Glengarry's opinion about the cause of Anna's death and no further investigation of this aspect of Anna's death is warranted.

[12] Dr Glengarry's formal qualifications and qualifications are set out in the autopsy report at pages 9-13 of the brief.
[13] The precise items found to have been used by Anna to obstruct her airway are redacted in this finding for reasons that should be obvious, in particular because this finding is to be published on the court's website and will be publicly available thereafter, as is the practice in this jurisdiction with findings made after an inquest.

FOCUS OF THE CORONIAL INVESTIGATION & INQUEST

25. The main focus of the coronial investigation including the inquest into Anna's death was on the circumstances in which the death occurred, specifically, the clinical management and care provided to her whilst she was an inpatient, noting that her sister Helen Lee raised concerns with the court about aspects of the clinical management and care provided to Anna while she was an inpatient.

26. A secondary focus of the investigation was on scene preservation and the collection of evidence from the scene where a coronial death occurred in the interests of ensuring the coronial investigation is informed by the best available evidence.

27. Four witnesses were called to give evidence and be cross-examined about these aspects of the circumstances – Dr Joanna Glengarry, Forensic Pathologist, to expand on aspects of her report of the external examination of Anna in the mortuary; Dr Ajith Vidanagama, Consultant Psychiatrist, to speak to the clinical management and care provided to Anna during her admission; Detective Senior Constable Russell March (**DSC March**), the Coronial Investigator, to provide an overview of the coronial investigation; and Mr Tim Lenten, Director of Nursing/Mental Health Services, Bendigo Health, primarily to speak to the evidence gathering and scene preservation issues.

Dr Ajith Vidanagama's evidence

28. Dr Vidanagama is a Consultant Psychiatrist employed by NorthWestern Mental Health at the material time and by Western Health at the time of the inquest. He provided a statement setting out a summary of the clinical management and care provided to Anna and gave evidence at inquest in which he expanded on his statement and clarified aspects of his management.[14]

29. Anna was a 70-year-old retired nurse of Malaysian descent who lived in Kyneton. Anna presented to the Kyneton Hospital emergency department with her sister Helen on 29 April 2021 and was assessed by the Bendigo Health Older Person Community Mental Health Team. Anna described paranoid thoughts of people hacking her computers and accessing her money; listening to her thoughts through electronic equipment; experienced delusions with thoughts of 'following the divine' and 'following the light' and asked to be hypnotised to 'return to her birth'; and reported destroying her computer and mobile phones as a result.

[14] Dr Vidanagama's statement dated 8 July 2021 is at pages 38-40 of the brief while his evidence is at transcript pages 17-36.

30. After medical clearance, Anna was admitted to the Older Person Unit (**OPU**) at Bendigo Hospital on 1 May 2021 as a voluntary consumer. Anna had no history of previous mental illness, nor did she have any known problem with substance use disorder. During her admission, Anna became more paranoid and was not cooperative with treatment. She also started presenting with manic symptoms, including grandiosity of ideas and became increasingly preoccupied with spirituality.

31. On 6 May 2021, Anna was "sectioned" under the MHA and was thereafter treated as a compulsory patient. After periodic reviews by psychiatric staff, Anna was diagnosed with first episode of mania with psychotic features and was commenced on olanzapine (an antipsychotic) and sodium valproate (a mood stabilizing drug) with the dosage gradually increased (titrated). The treating team continued to provide updates about Anna's progress to her nominated contact, her sister Helen.

32. Anna showed some improvement of her mood symptoms around mid-May although the level of her paranoid thoughts fluctuated, and she repeatedly refused medications. Overall, she showed improvement of her mental state by late May and started to use ground leave with family or staff members without incident.

33. On 17 June 2021, Anna refused to continue taking sodium valproate although she continued to be compliant with olanzapine 15mg at night. As Anna showed no major affective symptoms, the dose of olanzapine was increased from 15mg to 20mg on 21 June 2021 to address her ongoing paranoid thoughts.

34. Anna was reviewed by Dr Vidanagama and Dr Palmer, the psychiatric registrar, on 28 June 2021. She reported gradual improvement in her paranoid thoughts and was future-focused with a plan that she might return to Malaysia and start a not-for-profit venture 'greening the environment' while living off her savings in the meantime. Anna was worried about identity theft as she felt she had given too much information to scammers and was fearful for her safety at times. When specifically asked, Anna confirmed she did have some thoughts to die because of those concerns but said she would not act on those thought while in hospital or if out of hospital. She disclosed no specific plan or intent and asked for leave to go home the following weekend. When the practicalities of this were discussed, due largely to the distance from hospital, Anna agreed with a two hour leave with a family member or friend instead.

35. On mental state examination, Anna showed reduced spontaneity of speech and gave short answers. She described her mood as 'not myself due to anxiety around scammers' and had a

restricted affect. She reported a reduction of her paranoid thoughts around scammers during her admission; had no perceptual disturbances; showed some degree of improvement in insight and agreed to recommence sodium valproate to help with her mood symptoms. The plan was for Anna to be reviewed again by the treating team on 2 July 2021 ahead of her planned weekend leave.

36. The following day, 29 June 2021, the Occupational Therapist discussed coping skills and safety planning with Anna on the ward and a Coping and Safety Plan was completed.[15] In the days that followed, Anna was superficially engaged with nursing staff and showed some underlying irritability but had been compliant with medication and did not express any thoughts of ending her life.

37. Anna attended breakfast with other consumers on the morning of 2 July 2021 and nursing staff noted an adequate intake of food and fluid. At 10.00am she was noted to be watching television in the lounge area. Later, Anna attended a mutual help meeting with the ward Occupational Therapist and contributed to that meeting saying that she was 'grateful for the rain'. Nothing was noted during these interactions to suggest she was at risk of self-harm. Later still, Anna was seen walking towards her room.

38. When she did not attend for lunch, one of the nurses performed a safety check of Anna's room at 12.06pm and found Anna unconscious on the bathroom floor. The nurse immediately commenced **CPR** with assistance from a member of the medical staff who came to assist until a Code Blue was called and CPR was taken over by a responding anaesthetist and the emergency medical team. That team found items obstructing Anna's airway when they attempted intubation. Unfortunately, Anna could not be resuscitated and was formally verified deceased at 12.45pm on 2 July 2021.[16]

39. At inquest, Dr Vidanagama clarified that his first consultation with Anna was on 28 June 2021.[17] In preparing his statement he relied on the medical records in terms of the earlier parts of her admission, in particular, the treatment plan documented by her earlier treating

[15] This plan is at pages 152-154 of the brief.
[16] Anna's family were informed of her death, as were Victoria Police and the Coroner. Dr Vidanagama notified Dr Tesema Taye, Acting Clinical Director of the mental health service and the Chief Psychiatrist was notified as required due to Anna's compulsory patient status immediately before her death. The relevant notification (MHA125) is at pages 116 and following of the brief.
[17] Exhibit B was the detailed note of this consultation in the medical record made by Dr Millie Palmer on 28 June 2021, time-stamped 13:07.

psychiatrist[18] and the second opinion of Associate Professor Paul Cammell,[19] as well as a lengthy discussion with Dr Palmer, the psychiatric registrar who had been involved in Anna's management from the outset.[20]

40. Dr Vidanagama agreed with the diagnosis of first episode of mania with psychotic features which also corresponded with his own clinical judgement of Anna's presentation. He noted that she had some prominent psychotic symptoms which were mostly settling. By reference to nursing observations, Anna appeared a bit flat, and he thought her presentation at the time was more in keeping with mixed agitation with some depression.

41. In terms of the family's issues with medication, Dr Vidanagama explained that olanzapine was a second-generation antipsychotic which also has a good effect on mood symptoms. He considered it a good choice in the short term but one which had long term side-effects which would support to a change of medication 'down the track' when she had stabilized. The long term risk was of metabolic syndrome which indicated careful monitoring in someone of Anna's age who was already borderline diabetic with high blood pressure and high cholesterol. Nevertheless, he maintained that olanzapine was a good choice at the time, in particular, when coupled with sodium valproate for its mood stabilizing effects. Given Anna was acutely unwell and still having some paranoid thoughts and delusions, it was not the time to change medications due to concerns about their longterm side-effects or impact on her broader health.[21]

42. It was apparent in his evidence, that although espousing the diagnosis of first episode mania with psychotic symptoms, Dr Vidanagama's differential diagnosis for Anna, indeed his likely preferred diagnosis 'down the track' would have been bipolar affective disorder and that his choice of medications during her admission was also informed by that possibility.[22]

43. In addition to medication, Dr Vidanagama explained that although there was no psychologist available on the ward, nursing staff and occupational therapists provided supportive

[18] This plan is at pages 149-151 of the brief.
[19] This second opinion is dated 4 June 2021, is at pages 155-158 of the brief and, broadly, supports the diagnosis and therapeutic approach adopted for Anna's management and care. There is another report at pages 159-162 of the brief compiled by Anna's treating team for the purpose of a Mental Health Tribunal Hearing. This sets out the rationale for the therapeutic approach adopted although it is not a document reviewed by Dr Vidanagama in preparation for his statement compilation or attendance at the inquest.
[20] Transcript at pages 23-24.
[21] Transcript at pages 25-28.
[22] Transcript at pages 27-30.

psychotherapy, helped develop improving coping skills, sleep hygiene and activities during the day as well as psychoeducation.[23]

Detective Senior Constable March's evidence

44. The Victoria Police Member assigned as coronial investigator in relation to Anna's death was DSC March, stationed at Bendigo Police Station and attached to the Bendigo Crime Investigation Unit. DSC March received a notification of Anna's death at 1.15pm on 2 July 2021 and was one of seven police who responded, arriving at the OPU at 1.30pm.

45. He spoke to Dr Palmer and to the nurse who had found Anna unresponsive in the bathroom and entered Anna's room where she remained on the floor following cessation of CPR. He observed a small manicure tool found by the nurse underneath Anna which was suspected of having been used to force an item down her airway. He also observed the item/s identified as having been removed from Anna's airway which he inspected without interfering with them.

46. DSC March was present as the scene was examined and photographed while Anna was in situ before being taken to the hospital mortuary. Prior to leaving, DSC March gave instructions for the item/s removed from Anna's airway during CPR to remain with her body which was to be conveyed to the Coroner's Court.[24]

47. DSC March made a second statement about his attempts to obtain security records and CCTV footage from Bendigo Hospital.[25] DSC March's first request was made when he was at Bendigo Hospital on 2 July 2021. It was a verbal request made to Tim Lenten, Director of Nursing, and was a broad request for the CCTV footage and fob records for the morning leading to Anna's death. He left a card with his contact details and confirmed he did not receive the requested items on the day.

48. On returning to Bendigo Police Station on 2 July 2021, DSC March sent an email formally requesting the CCTV footage and security fob records. Having identified an error in the email address he had used for Mr Lenten, DSC March sent a further email on 26 July repeating his

[23] Transcript pages 29-31. Note that prior to the inquest I asked a Mental Health Investigator from the Coroners Prevention Unit to review Anna's medical records and to advise if they had any concerns about the clinical management and care provided to her. As they had no such issues, I did not obtain an independent expert report from a psychiatrist or other healthcare professional, and none was forthcoming from the family or Bendigo Health.
[24] DSC March's first statement dated 27 September 2021 is at pages 41-43 of the brief and at transcript pages 37-39.
[25] DSC March's second statement dated 3 January 2023 is at pages 48-50 of the brief with diary notes and other relevant documents being at pages 51 and following of the brief. See also transcript pages 42-49.

request. He received a response later the same day saying that the requested items had already been provided to the Coroner.

49. Having confirmed that the items had *not* been received by the Coroners Court, DSC March made enquiries with the Victorian Institute of Forensic Medicine (**VIFM**) and made another request of Bendigo Health on 29 September 2021 addressed to its Clinical Director. On 26 October 2021, the VIFM advised that the security logs and/or CCTV footage had not been provided to them. Despite further requests and activity on DSC March's behalf, no CCTV footage, security logs or security fob records (howsoever described) have been located, and the coronial investigation is the poorer for this.[26]

50. While not ideal, the items used by Anna to obstruct her airway were viewed by DSC March at the scene and photographed and sufficiently described to be considered by Dr Glengarry and included by her in the formulation of the cause of death.

51. On the other hand, CCTV footage of the corridor and entrance to Anna's room and potentially of her return to her room shortly before her death has not been available to the coronial investigation and this is less than ideal.[27] Photographic images of Anna when she returned to her room may have shed light on her mood or otherwise elucidated the circumstances in which she died. While there is no suggestion that anyone else was involved in Anna's death, the CCTV footage would have been a valuable piece of evidence to address this possibility. Review of the security logs or fob records could potentially have served the same purpose, consequently their unavailability to the coronial investigation is similarly less than ideal.[28]

Director of Nursing, Tim Lenten's evidence

52. Tim Lenten provided a statement that was included in the brief[29] and attended the inquest to give evidence.[30] The statement was in response to a specific request from the Police Coronial Support Unit (**PCSU**) to address the processes relating to CCTV and security log access at Bendigo Health.

[26] Transcript at pages 39-42
[27] As Anna did not attend for lunch it was possible that she had been in her room from as early as 11am.
[28] Transcript at pages 47-
[29] Mr Lenten is a registered psychiatric nurse and had been the Director of Nursing Mental Health Service at Bendigo Health for eight years as at the time he signed his statement dated 28 September 2023 at pages 70-75 of the brief, including copies of emails passing between DSC March and Mr Lenten.
[30] Transcript at pages 57-77.

53. In his statement, Mr Lenten explained that the security logs of swipe access to rooms (security logs, elsewhere referred to as fob records) within the OPU can be accessed via software called "Durasuite" on a designated computer in each inpatient unit (including the OPU). Durasuite is owned by Downer Security who are contracted to provide non-clinical services for Bendigo Health including security services and the maintenance and storage of CCTV footage and security logs.

54. Unless a specific request is made for its retention, CCTV footage is retained for 30 days and, at the time of Ms Lee's death, requests were mostly made verbally. Following discussion with DSC March on 2 July 2021, Mr Lenten made a verbal request to the Security Manager to bookmark (save) the CCTV security footage for the relevant cameras, providing a description of the incident but no specific instructions about the period of time over which the CCTV footage was required.[31]

55. When DSC March sent a follow-up email on 26 July 2021 asking for the medical records, CCTV footage and security logs, Mr Lenten responded that the medical records had been provided to the Coroner, and that the CCTV footage and security logs would be provided on receipt of a coroner's authority.[32] DSC March indicated that he would make a request when he received a coronial direction to prepare a brief in relation to Ms Lee's death.[33]

56. As he was not aware that the swipe access logs were periodically deleted after 30 days, Mr Lenten did not make a specific request for the security logs to be retained pending receipt of a formal request to provide the records to the Coroner.[34]

57. The upshot was that by the time a request was made by DSC March deemed to be with coronial authority, the CCTV footage and security logs had been deleted, and the coronial investigation of Anna's death has not been informed by their content.

58. At inquest, Mr Lenten expanded on his recollection of events on 2 July 2021 and reiterated that he made a verbal request to the Security Manager that day for the CCTV footage to be bookmarked. There was no further investigation of what happened in response to his request.

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[31] Page 70 of the brief.

[32] It is tolerably clear that Mr Lenten was not referring to a Coroner's Authority issued under section 39 of the Act, a formal document akin to a search warrant but any documentary confirmation that DSC March required the items for the purpose of the coronial investigation. That said, Anna clearly died in reportable circumstances; it should have been apparent that a coronial investigation would ensue; and DSC March's presence on behalf of the coroner should have been obvious.

[33] Pages 70, 72-75 of the brief.

[34] Mr Lenten's statement and his adoption of it as true and correct is at transcript pages 57-61.

Mr Lenten did not make a similar request for the security logs as he was unaware that they would also be deleted after 30 days unless their retention was requested.

59. The other important aspect of Mr Lenten's evidence was his ability to speak to changes made at Bendigo Health that should improve the prospects that valuable evidence will be retained/preserved to inform internal reviews by the health service as well as coronial investigations where appropriate.[35] The development of a Bendigo Health "Preservation and Request of Surveillance Data" Policy (**the Policy**) is set out in Mr Lenten's statement. While not yet ratified and in its final form as at the date of the inquest, the policy has three features that are relevant here:

    a. A requirement that consideration be given to the window of time requested to be bookmarked, and if it appears additional footage on either side of an incident may be required then it should be identified and requested – this applies to both Bendigo Health staff requesting the data and Downer Security staff processing the request.

    b. All requests for preservation of CCTV footage must be made via a form in Bendigo Health's internal portal (QFM) that includes a checklist of evidence to be retained and the date and time relevant to the request which is then processed by Downer Security.

    c. A separate form to be completed on QFM for requests to release bookmarked date which records the staff member from Bendigo Health authorising the release and to whom the data is to be released.

60. According to Mr Lenten's evidence, the policy was developed in response to the circumstances of Anna's death. However, he also drew attention to the Victorian Health Incident Management System, with statewide operation, which requires reporting of certain incidents including Level 1 serious adverse events involving death or serious harm; Level 2 incidents involving some actual harm, and Levels 3 and 4 which Mr Lenten categorised as "near misses".

61. Mr Lenten explained that Level 1 and 2 incidents were reviewed by the Serious Clinical Incident Risk Committee (**SCIRC**) twice weekly and the expectation was that within the context of these reviews consideration would be given, inter alia, to the need to identify and retain evidence, dovetailing with the policy.[36]

[35] Page 71 of the brief and transcript at pages 61 and following.
[36] This is my paraphrasing of Mr Lenten's evidence in this regard.

STANDARD OF PROOF

62. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, having regard to the 'Briginshaw sliding scale'.[37] When finding facts, a coroner has to reach a comfortable or reasonable satisfaction having regard to all of the available evidence relevant to the questions in issue in the investigation.[38] When considering whether that level of satisfaction has been achieved, regard must be had to the seriousness of the allegation; the inherent likelihood or unlikelihood of an occurrence of fact, and; the gravity of the consequences flowing from a particular finding.[39]

63. This is particularly so with regard to adverse comments or findings about an individual in their professional capacity which should only be made when a coroner has reached a state of comfortable or reasonable satisfaction based on the evidence that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death.[40]

64. It is axiomatic that the materiality of any departure from applicable standards must be assessed without the benefit of hindsight, only on the basis of what was known or should reasonably have been known at the time, and not from the privileged position of hindsight. Patterns or trajectories that may become apparent subsequently or may even be obvious once the tragic outcome is known, are to be eschewed in favour of a fair assessment made from the perspective of the individual at the material time.

FINDINGS AND CONCLUSIONS

65. Applying the standard of proof to the evidence before me, I find as follows:

    a. The identity of the deceased is Anna Lee, born 28 September 1950, aged 70.

    b. Anna Lee died in the Older Persons Unit at Bendigo Hospital, 100 Bernard Street, Bendigo, Victoria, on 2 July 2021.

    c. The cause of Anna's death is asphyxia due to airway obstruction by [redacted]

[37] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336.*
[38] *Anderson v Blashki [1993]2 VR 89 at 96; Secretary to the Department of Health and Community Services v Gurvich [1995] 2 VR 69 at 73;*
[39] *Briginshaw v Briginshaw, op cit, at 362.*
[40] *Ibid.*

d. The available evidence does not support a finding that there was any want of clinical management or care on the part of the medical, nursing and allied health staff of Bendigo Health that caused or contributed to Anna's death.

e. While I am satisfied that Anna intentionally obstructed her airway and thereby caused her own death, I am unable to be satisfied that she intended to do as I find it probable her judgement was impaired by mental illness at the time.

f. The item/s used by Anna to obstruct her airway were not inherently dangerous items that should not have been available to her on the ward. Rather, they were ubiquitous items likely to be present in any number of domestic or hospital environments and were used in a novel manner by Anna.

g. It follows that I do not consider it appropriate to make any comments or recommendations aimed at reducing the risk of similar deaths arising from the presence of such items on the ward.

h. The unavailability of the item/s for examination by the forensic pathologist is unfortunate but did not ultimately compromise the coronial investigation.

i. The unavailability of the CCTV footage and the security logs is regrettable and, without knowing what might have been captured or gleaned from this evidence, I cannot determine whether and to what extent the coronial investigation of Anna's death may have been compromised.

j. That said, there is nothing in the available evidence to suggest that anyone else was involved in Anna's death or that she died in suspicious circumstances.

k. I accept that there was a miscommunication between DSC March and Mr Lenten about provision of the CCTV footage and security logs and I make no adverse finding or comment about either of them.

l. The changes made to processes relevant to scene preservation and the retention of exhibits at Bendigo Health following and in response to Anna's death should improve the prospects for adequate scene capture and preservation of exhibits for the purposes of internal reviews and any coronial investigation that ensues.

m. Given those changes I make no comments under section 67(3) or recommendations under 72(2) of the Act in connection with Anna's death.

n. I convey my sincere condolences to Helen Lee and Anna's other family members and friends for their loss.

o. I also acknowledge the impact of Anna's death on the staff of Bendigo Health involved in her care during a significant admission as well as those who provided CPR and urgent medical attention on 2 July 2021.

PUBLICATION OF FINDING

Pursuant to section 73(1) of the Act, unless otherwise ordered by the coroner, the findings, comments and recommendations made following an inquest must be published on the internet in accordance with the rules. I make no such order.

DISTRIBUTION OF FINDING

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

Helen Lee, Senior Next of Kin

Bendigo Health

DSC Russell March c/o OIC Bendigo Crime Investigation Unit

Signature:

Paresa Antoniadis Spanos

Deputy State Coroner

Date: 19 May 2025

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.