IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 005569

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, CORONER
Deceased:	KD
Date of birth:	9 August 1974
Date of death:	27 September 2022
Cause of death:	1(a) COMBINED EFFECTS OF CARDIAC HYPERTROPHY, CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND END-STAGE RENAL FAILURE 2 WHO CLASS III OBESITY, DIABETES MELLITUS, HYPERTENSION
Place of death:	Sunshine Hospital Furlong Road, St Albans, Victoria, 3021
Keywords:	In care, Mental Health Act, assessment order, natural causes

INTRODUCTION

1. On 27 September 2022, KD was 48 years old when she died in hospital during an admission for increasing psychosis. At the time of her death, KD lived alone in Deer Park. She is survived by her siblings and children, and fondly remembered as a *'kind and loving'* individual with *'the biggest heart'.*

Background

2. KD alleged she experienced childhood sexual abuse by family and associates. It was years before she divulged her experiences and sought assistance from the Centre Against Sexual Assault. Her daughter, ND (**Ms D**), believes that KD's experiences contributed to the development of her mental ill health.

Medical History

3. At around 18 years of age, KD's mental health began to decline. According to her sister, WT (**Ms T**), *'she got very sick mentally, [and] had a very bad psychotic episode where her bipolar and manic depression came out'.* KD experienced several episodes of psychosis and paranoia until the time of her death.

4. Ms D speaks of her mother's instability:

> *'Every year Mum would end up in the [psychiatric] ward. . .for as long as I know she had chronic schizo-affective disorder which is a combination of bi-polar elements and schizophrenia. Basically, her personality could be very manic and hyper-energetic to very depressed and low. She would also see or hear things that weren't there'.*

5. Throughout her life, KD attempted suicide on multiple occasions. In periods of heightened mental lability, she underwent several inpatient admissions including to the Royal Melbourne Hospital and Northern Hospital. Ms D recalls her mother experienced religious delusions and paranoid thoughts that people were trying to kill her.

6. According to Ms D and KD's support workers, she was prescribed several medications including olanzapine and lithium.

7. In addition to her mental ill health, her psychical health also deteriorated. KD was diagnosed with diseases including diabetes and chronic kidney disease. During the COVID-19 pandemic,

KD's health deteriorated further. She was required to commence dialysis treatment and *'never missed her appointments'.*

8. In August 2022, Ms D discovered KD unresponsive at home – which was not uncommon – and contacted emergency services. During the resulting hospital admission, Ms T was informed that KD's kidneys were *'functioning at 4 percent'.* Over the ensuing months, Ms D *'could slowly see her mental and physical health issues interact and get out of control'.*

9. In the lead-up to her death, KD experienced an acute mental health episode. Her paranoia and delusions increased, she became *'increasingly argumentative'* and *'dishonest about taking her medication'*.

THE CORONIAL INVESTIGATION

10. KD's death was reported to the coroner as it fell within the definition of a reportable death in the Coroners Act 2008 (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

11. Section 52(2) of the Act mandates a Coroner hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspect that the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

12. Immediately before her death, KD was a person placed in care as she was the subject of an assessment order under the *Mental Health Act 2014* (Vic)– as then applied.[1] However, section 52(3A) of the Act provides an exception to the position under section 52(2), that the coroner is not required to hold an Inquest if the coroner considers the death to have been due to natural causes. Having considered all the evidence in this matter, pursuant to section 52(3A) of the Act, I determined not to hold an Inquest into KD's death.

13. 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.

[1] The *Mental Health Act 2014* (Vic) has since been replaced by the *Mental Health and Wellbeing Act 2022* (Vic).

14. 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.

15. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of KD's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

16. This finding draws on the totality of the coronial investigation into the death of KD 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.[2]

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

Circumstances in which the death occurred

17. On 22 September 2022, at 9:34pm, KD telephoned emergency services and requested an ambulance. She reported *'feeling out of it and not completely alert'* and paramedics recorded her behaviour as *'bizarre'*.

18. At 10:51pm, KD was admitted to Sunshine Hospital Emergency Department (**ED)** presenting with a relapse in psychosis. On her arrival she felt *'spaced out'*, *'close to God'* and was hearing *'voices telling her to kill people'*. KD's family members visited her in the ED and believed *'it was the worst [they] had seen [her] in ages'*.

19. On 23 September 2022, at 9:15am, KD was placed under an assessment order pursuant to section 351 of the *Mental Health Act 2014*.

20. An assessment order enables a clinician, such as a psychiatrist, to examine the patient without their consent in order to determine whether they have a mental illness and require compulsory mental health treatment. Clinicians determined an assessment order was necessary due to KD's erratic and disruptive behaviours, that she represented a high absconding risk and was

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

experiencing severe delusions. In order to perform the assessment, clinicians administered pharmacological sedation and applied mechanical restraints.

21. On 23 September 2022 at 1:50pm, the assessment order was extended for 24 hours.

22. On 24 September 2022, KD became agitated and was attempting to leave the ED. Shortly after clinicians administered a sedative, she entered respiratory failure and required intubation. KD was transferred to the Intensive Care Unit (**ICU**) and the assessment order was revoked while she was intubated.

23. While in the ICU, KD received continuous renal replacement therapy and mechanical ventilation. She was reviewed the ICU, Renal, Cardiology and Psychiatry teams.

24. On 26 September 2022, during the morning, KD's condition had somewhat improved, and she attempted to abscond from the hospital. In response, at 10:00am, clinicians executed a second mandatory assessment order. At 7:45pm, KD was discharged from the ICU and returned to the ward.

25. On 27 September 2022, at 5:56am, nursing staff heard KD suddenly stop snoring. Nurses discovered her to be unresponsive and at 5:58pm, called a '*Code Blue'*. Cardiopulmonary resuscitation was commenced and continued for approximately one hour. At 6:51am, KD was declared deceased.

Identity of the deceased

26. On 27 September 2022, KD, born 9 August 1974, was visually identified by her daughter, Ms D, who completed a formal Statement of Identification.

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

Medical cause of death

28. Forensic Pathologist Dr Hans de Boer (**Dr De Boer**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of KD on 3 October 2022. Dr de Boer considered materials including the Victoria Police Report of Death for the Coroner (**Form 83**), e-Medical Deposition Form of Sunshine Hospital and post-mortem computed tomography (**CT**) scan and provided a written report of his findings dated 7 February 2023.

29. The post-mortem examination revealed substantial natural disease.

30. The lungs were consistent with chronic obstructive pulmonary disease (**COPD**) and pulmonary hypertension. These findings indicated a severely limited respirator reserve, placing KD at risk of low blood oxygen – *'hypoxia'* – which if uncorrected, can induce acidosis, organ failure and death.

31. The kidneys were atrophic, with evidence of end-stage renal failure. Dr de Boer considered this was most likely due to a combination of focal segmental glomerulosclerosis,[3] hypertension and diabetes. Though dialysis can replace kidney function, end-stage renal disease remains a significant risk factor for severe physiological derangement.

32. The heart was severely enlarged – *'hypertrophic'* – and weighed 675 grams. Dr de Boer considered this most likely due to the combined effects of hypertension, pulmonary hypertension and obesity. Severe hypertrophy limits cardiac function and places the individual at risk of congestive cardiac failure. Hypertrophy of this severity can induce cardiac arrythmias, causing sudden death.

33. KD had a BMI of 43.3 kg/m^2 and accordingly, was categorised under WHO Class III obesity.[4] Obesity is associated with a wide range of complication, including hypertension and sudden death.

34. Dr de Boer considered the identified natural disease was sufficient, on its own, to have caused death. As the fatal complications of these diseases are functional, not structural, it was difficult to determine the precise mechanism of death.

35. Dr de Boer continued that other mechanisms may have caused, or contributed to the death, but that they could not be definitively proven post-mortem. These include an aspiration event, or unexpected death due to schizophrenia.

36. Toxicological analysis of ante-mortem samples collected on 24 September 2022 by Sunshine Hospital identified the presence of the following compounds:

Acetone	~ 21 mg/L
Olanzapine	~ 0.03 mg/L

[3] Scarring of the tiny filtering units inside the kidneys.

[4] The World Health Organisation (**WHO**) provides stratifies Body Mass Index (**BMI**) into categories of obesity. These categories range from underweight to Class I Obesity (with a BMI of 30.0–34.9 kg/m^2), Class II Obesity (with a BMI of 35.0–39.9 kg/m^2) and Class III obesity (with a BMI greater than 40 kg/m^2).

Haloperidol	~ 0.008 mg/L
Ketamine	Detected

37. Dr de Boer stated that haloperidol and olanzapine can have a sedative effect, which may have added to the mechanism of death.

38. Dr de Boer provided an opinion that the medical cause of death was due to natural causes, specifically 1 (a) COMBINED EFFECTS OF CARDIAC HYPERTROPHY, CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND END-STAGE RENAL FAILURE with contributing factors - 2 WHO CLASS III OBESITY, DIABETES MELLITUS, HYPERTENSION.

FINDINGS AND CONCLUSION

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

    a. the identity of the deceased was KD, born 9 August 1974;

    b. the death occurred on 27 September 2022 at Sunshine Hospital Furlong Road, St Albans, Victoria, 3021; and

    c. I accept and adopt the medical cause of death ascribed by De de Boer and I find that KD died from combined effects of cardiac hypertrophy, chronic obstructive pulmonary disease and end-stage renal failure with contributing factors of WHO class III obesity, diabetes mellitus, hypertension.

2. AND I find that KD's status as a person 'placed in custody or care' did not have a causal or contributory relationship to her death.

3. AND FURTHER I have reviewed the medical treatment provided to KD between 22 and 27 September 2022 by Sunshine Hospital. I find that clinicians acted appropriately in managing KD's multiple diagnoses and by executing an assessment order to undertake a clinical assessment.

I convey my sincere condolences to KD's family for their loss.

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

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

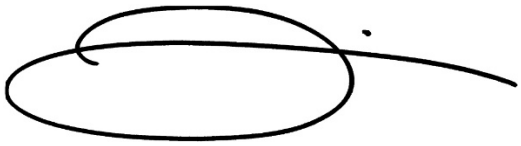
Ms D, Senior Next of Kin

Western Health

Northwestern Mental Health

Constable Lauren Holcombe, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 8 July 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.