IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 004535

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Louise Jean Dean
Date of birth:	14 August 1971
Date of death:	27 August 2021
Cause of death:	1(a) Subarachnoid haemorrhage 1(b) Ruptured right vertebral artery aneurysm
Place of death:	Ballarat Police Station, 20 Dana Street, Ballarat Central, Victoria, 3350
Keywords:	Death in police custody, Natural causes

INTRODUCTION

1. On 27 August 2021, Louise Jean Dean (**Ms Dean**) was 50 years old when she passed away at the Ballarat Police Station. The day before her death, Ms Dean was arrested in relation to outstanding matters and was remanded in custody.

THE CORONIAL INVESTIGATION

2. Ms Dean'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.[1]

3. Ms Dean was a person in care or custody pursuant to section 3 of the Act. The death of a person in care or custody is a mandatory report to the coroner, even if the death appears to be due to natural causes.

4. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects 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.

5. Immediately before her death, Ms Dean was a person placed in custody. 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 Louise Jean Dean's death.

6. 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.

7. Victoria Police assigned Detective Acting Sergeant Sean Campbell to be the Coroner's Investigator for the investigation of Ms Dean's death. The Coroner's Investigator conducted

[1] Section 4 of the *Coroners Act 2008* (the Act).

inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Louise Jean Dean, 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]

BACKGROUND

9. Ms Dean grew up in Bendigo and was the youngest of five children. Ms Dean is survived by her two daughters.

10. Around 2015, Ms Dean met Richard Gauci (**Mr Gauci**), with whom she was working at the time. Ms Dean and Mr Gauci started a relationship in 2017, and Ms Dean later moved in with Mr Gauci.

11. According to Mr Gauci, Ms Dean would take a lot of Panadol and Nurofen for persistent headaches and migraines. Ms Bergin stated, "*she was always struggling with headaches and migraines*" and that she believed her mother "*was taking either Panadol or Nurofen every day*."[3]

12. In 2017, approximately three months after moving in with Mr Gauci, their relationship ended. However, after their relationship had ended, Ms Deane remained living with Mr Gauci for some time.

13. When Ms Dean eventually moved out of Mr Gauci's home, she stayed with her daughters for a short while. When the living arrangements between Ms Dean and her daughters became untenable, she moved into community housing in Ballarat, where she resided until her death.

14. At the time of her death, Ms Dean had two outstanding criminal matters. There were warrants for her arrest in relation to these outstanding matters.

---

[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.

[3] Ibid, page 38.

Medical History

15. In November 2016, following a series of severe migraines, Ms Dean had an inpatient stay at Western Health under the care of the Rheumatology Department. Ms Dean presented with a right-sided headache associated with significant visual disturbances. Ms Dean was diagnosed with an Undifferentiated Connective Tissue Disease and was prescribed prednisolone 5mg daily and hydroxychloroquine 200mg daily.

16. In a statement provided to the court, General Practitioner Dr Abraham Heydari (**Dr Heydari**) of the Scott Street Medical Clinic stated this was her only formal diagnosis.

17. In a subsequent statement, Dr Heydari stated he treated Ms Dean on 23 November 2021 in relation to a sudden onset headache with blurred vision that lasted for three days. Upon examination, Dr Heydari noted that Ms Dean had left eye visual loss with tenderness on her temporal artery. Dr Heydari provided a provisional diagnosis of Temporal Arthritis.

18. According to Dr Heydari, Ms Dean's compliance with her medical treatment regime was poor. The evidence indicates that Ms Dean did not frequently attend medical professionals around the time of her death.

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

Circumstances in which the death occurred

19. At approximately 10.54am on 26 August 2021, Ms Dean was observed by police riding her bicycle without a helmet in Peel Street, Ballarat, and stopped her from riding further. During this interaction, police discovered that Ms Dean had two outstanding warrants for her arrest.

20. Ms Dean was arrested and transported to the Ballarat Police Station. At approximately 11.20am, Sergeant Joel Dash, who was the rostered Custody Sergeant, conducted an Initial Supervisor Check during which Ms Dean did not note any injuries or health complaints.[4]

21. At approximately 11.54am, Police Custody Officer (**PCO**) Nathan Brown completed a Detainee Risk Assessment (**DTA**). The DTA did not identify any health concerns, and Ms Dean was assessed as requiring the lowest level of observation, requiring observation once every four hours.[5]

[4] CB, Statement of Sergeant Joel Dash, page 70.
[5] CB, Detainee Risk Assessment, page 150.

22. At approximately 3.44pm, an online remand hearing was conducted at the Ballarat Magistrates Court while Ms Dean was still in custody at the Ballarat Police Station. The matter was adjourned to the following day, 27 August 2021. Ms Dean was remanded in custody until the next court appearance. Following the remand hearing, at approximately 3.58pm Ms Dean complained to PCO Brown that she had a headache and requested paracetamol. At approximately 4.56pm, Ms Dean was provided with two paracetamol tablets.

23. At approximately 8.30pm, Ms Dean repeatedly pressed the intercom button in her cell and complained of a migraine and again requested paracetamol. At approximately 8.54pm, Ms Dean was provided with two more paracetamol tablets. When she received this second dose of paracetamol, Ms Dean advised PCO Matthew Hunter that she would be asking for paracetamol every two hours.[6] For the next several hours, Ms Dean was periodically monitored on closed-circuit television (**CCTV**). PCO Tarquin Blackburn stated, "*there was nothing I observed during the shift via the CCTV that appeared unusual*."[7]

24. On 27 August 2021 at approximately 4.15am, Ms Dean activated the cell duress alarm and was attended to by PCO Blackburn. Ms Dean again complained of a headache and requested paracetamol. At approximately 4.18pm, Ms Dean was provided with a further two paracetamol tablets.

25. At approximately 7.17am, Ms Dean had a morning coffee and again requested paracetamol. However, because a four-hour period had not elapsed since her last dose, Ms Dean's request was delayed.

26. At approximately 8.59 am, Ms Dean was taken from her cell to the Custody Charge Counter where she was given two additional paracetamol tablets. CCTV footage depicted Ms Dean walking freely without assistance.

27. At approximately 9.01am, when Ms Dean was returned to her cell, CCTV footage depicted her lying down on the mattress and pulling a blanket over her head.

28. At approximately 9.08am, Ms Dean suffered what appeared to be a medical episode. The CCTV footage depicted Ms Dean's body shifting under the blanket.

29. At approximately 9.22am, when PCO Nathan Brown and several other PCOs entered Ms Dean's cell to take her the interview room for her court hearing at the Ballarat Magistrates

[6] CB, Statement of Police Custody Officer Matthew Hunter, page 93.
[7] CB, Statement of Police Custody Officer Tarquin Blackburn, page 41.

Court, they were unable to wake her. PCO Brown stated that as he entered the cell, it appeared Ms Dean was sleeping and that Ms Dean was "*making noises that sounded like snoring*."[8]

30. After numerous attempts to wake her, it became apparent to the PCOs that Ms Dean was not breathing and did not have a pulse.

31. At approximately 9.28am, the attending PCOs commenced cardiopulmonary resuscitation (**CPR**) on Ms Dean. At approximately 9.30am Senior Constable Patrick Cincotta, who is also a qualified paramedic, assisted with resuscitation efforts. Senior Constable Cincotta stated that a defibrillator was applied as well as a bag-valve-mask to deliver air to Ms Dean's lungs.[9]

32. At approximately 9.32am, Ambulance Victoria (**AV**) Paramedics arrived and took over CPR efforts. They continued with resuscitation efforts for over an hour. Fire Safety Victoria also attended shortly afterwards and rendered assistance. However, despite all resuscitation efforts, AV paramedics were unable to revive Ms Dean.

33. At 10.46 am, AV paramedics declared Ms Dean deceased.

Identity of the deceased

34. On 30 August 2021, by *Form 8*, then Deputy State Coroner Caitlin English determined the identity of the deceased to be Louise Jean Dean.

Medical cause of death

35. On 28 August 2021, Forensic Pathologist Dr Joanne Ho[10] from the VIFM conducted an autopsy and provided a written report of her findings dated 23 March 2021.

36. In her report, Dr Ho stated:

    i. *The post-mortem examination showed subarachnoid haemorrhage covering both cerebral and cerebellar hemispheres, ruptured aneurysm of the right vertebral artery with adherent fibrin. Hemosiderin (an iron-storage complex) that can be used to estimate timing of haemorrhage, was not identified on a Perls Prussian Blue stain. Detectable hemosiderin typically takes at least 48 hours.*

[8] CB, Statement of Police Custody Officer Nathan Brown page 47.
[9] CB, Statement of Senior Constable Cincotta, page 61.
[10] Dr Ho was supervised by Forensic Pathologist and Head of Forensic Pathology, Dr Linda Iles.

ii. *Subarachnoid haemorrhage refers to bleeding beneath the arachnoid, a wispy thin layer of connective tissue which lies directly onto the brain. Bleeding was due to a rupture of an aneurysm of the vertebrobasil artery. An aneurysm is an "outpouching" and thinning of a vessel wall which may spontaneously rupture and cause bleeding.*

37. Toxicological analysis of post-mortem samples identified the presence of methylamphetamine (~0.06 mg/L) and amphetamine[11] (~0.03 mg/L). Paracetamol (~10 mg/L) was also detected in toxicological samples within therapeutic ranges.

38. Dr Ho provided the following comments in relation to subarachnoid haemorrhage and aneurysms in the setting of methylamphetamine use:

iii. *Methylamphetamine is a stimulant reactional drug that has been associated with subarachnoid haemorrhage (the majority being secondary to aneurysms). The use of methylamphetamine in the setting of underlying aneurysm, may increase the risk of a rupture.*

39. The post-mortem examination did not reveal any injuries which may have caused or contributed to death. Dr Ho determined that Ms Dean's death was due to natural causes.

40. Dr Ho provided an opinion that the medical cause of death was:

1(a) Subarachnoid haemorrhage;

1(b) Ruptured right vertebral artery aneurysm

41. I accept Dr Ho's opinion.

INVESTIGATIONS

42. Victoria Police conducted an investigation. The investigation was overseen by Victoria Police Professional Standards Command (**PSC**).

43. While the investigation identified deviation from protocol in the Victoria Police Manual (**VPM**), *Management of People in Police Care or Custody*, relating to non-adherence to the requirements of properly documenting medication dispensed, the PSC's investigation did not

[11] Amphetamines is a collective word to describe central nervous system (CNS) stimulants structurally related to dexamphetamine.

identify any issues with Ms Dean's supervision by the attending police officers while in custody at the Ballarat Police Station which may have contributed to her death.

44. The PSC investigation did not identify any causal connection between the conduct of Victoria Police officers who attended to Ms Dean while she was in custody at Ballarat Police Station and her death.[12]

45. The evidence indicates that Ms Dean did not appear to be affected by alcohol or drugs at the time of her arrest. She disclosed her history of anxiety and depression, that she was allergic to Amoxycillin, an antibiotic drug, and that she was currently on a course of Prednisone, a steroidal drug prescribed by her doctor.

46. After her medical history was taken, it was electronically uploaded to Victoria Police systems and reviewed by the Custodial Health Advice Line (**CHAL**). I note further that attending police officers subsequently contacted the CHAL for advice when Ms Dean complained of her headaches and followed the advice given by the CHAL call-taker.

47. There is no evidence to indicate that Ms Dean considered that her headaches might be a symptom of a more serious underlying illness or a related impending medical event.

48. Based on the available evidence, I am satisfied that the actions of the attending police officers at the Ballarat Police Station were reasonable and appropriate in the circumstances. The available evidence does not support a conclusion that the attending police officers conducted themselves in a manner inconsistent with the relevant VPM, *Management of People in Police Care or Custody.*

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased is Louise Jean Dean, born 14 August 1971;

    b) her death occurred on 27 August 2021 at the Ballarat Police Station, 20 Dana Street, Ballarat Central, Victoria, 3350, from subarachnoid haemorrhage and ruptured right vertebral artery aneurysm; and

[12] CB, PSC Interim Final Report, Oversight Review.

c) her death occurred in the circumstances described above.

50. Having considered all the evidence, I am satisfied that Ms Dean's death was due to natural causes. Despite the tragic outcome, I am unable to identify any prevention opportunities arising in relation to her death.

I convey my sincere condolences to Ms Dean's loved ones 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 Danielle Bergin, Senior Next of Kin

Victorian Government Solicitor's Office on behalf of the Chief Commissioner of Police

Detective Sergeant Gerry Fabbro, Victoria Police Professional Standards Command

Detective Acting Sergeant Sean Campbell, Coroner's Investigator

Signature:

Coroner Kate Despot

Date: 26 August 2026

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.