IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 004449

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of IWT[1]

Deceased:	IWT
Delivered on:	10 September 2025
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing date:	9 September 2025
Findings of:	Coroner Sarah Gebert
Counsel assisting the coroner:	Olivia Collings, Solicitor
Keywords:	*In care death, Mental Health Act, involuntary patient*

[1] This finding has been deidentified for publication.

INTRODUCTION

1. On 7 August 2022, IWT was 77 years old when she died at the Alfred Hospital following a lengthy hospital admission.

2. At the time, IWT lived in Mentone with her husband, KUD. She is fondly remembered as a loving grandmother to her many grandchildren.

INVESTIGATION AND SOURCES OF EVIDENCE

3. This finding draws on the totality of the coronial investigation into the death of IWT including evidence contained in the coronial brief as prepared by Coroner's Investigator, Senior Constable Lee Ronkovich, and the inspection report from the Victorian Institute of Forensic Medicine.

4. All of this material, together with the inquest transcript, will remain on the coronial file.[2] 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

5. The purpose of a coronial investigation of a *"reportable death"*[3] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[4]

6. IWT's death falls within the definition of reportable death, specifically section 4(2)(a) of the *Coroners Act 2008* (Vic) (**the Act**) which includes an unexpected or (relevantly) unnatural death. In addition at the time of her death, section 4(2)(d) provided that a reportable death

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[2] From the commencement of the *Coroners Act 2008*, 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.

[3] The term is exhaustively defined in section 4 of 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; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). 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.

[4] Section 67(1).

included the death of a person who immediately before death was a patient within the meaning of the *Mental Health Act 2014* (Vic) (**the MHA**).[5]

7. It is uncontroversial that immediately before her death, IWT was a patient within the meaning of the MHA as she was subject to a compulsory treatment order. Accordingly she was also a person placed in custody or care when she died as defined in section 3(i) of the Act. Section 52(2)(b) of the Act therefore requires that an inquest be held into her death.

8. The *'cause'* of death refers to the *'medical'* cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the *'circumstances'* in which death occurred refers to the context or 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.[6]

9. The broader purpose of any coronial investigations 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.[7]

10. 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.[8] These are effectively the vehicles by which the coroner's prevention role can be advanced.[9]

11. 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.[10]

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[5] As of 1 September 2023, the MHA was replaced by the *Mental Health and Wellbeing Act 2022* (Vic)

[6] 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.)

[7] 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'.

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

[9] 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.

[10] Section 69(1). 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).

BACKGROUND

12. IWT met KUD at a church function in 1963. The couple married in August 1965 and had three children: JWM, QOP, and VBT. IWT worked as a teacher's aide before transitioning to part time work.

13. IWT had a significant history of mental ill health and regularly experienced long periods of depression. In the mid-1980s, IWT spent a significant amount of time in and out of a private psychiatric hospital during which time she became noncommunicative and was known to refuse medication. In 1994, IWT attempted suicide via overdose and was again admitted to a psychiatric ward.

14. IWT believed her mental ill health was caused by undiagnosed physical issues. Her husband reported that she was always very sensitive to pain. After many years it was discovered that IWT had a herniation of her spinal cord. In 2005, clinicians operated in an attempt to prevent further deterioration, however, there was already significant damage.

15. IWT's medical history also included deep vein thrombosis and pulmonary embolism, bowel cancer managed with chemotherapy, breast cancer treated with radiotherapy, obstructive sleep apnoea, interstitial lung disease, pulmonary hypertension, hypothyroidism, recurrent urinary tract infections, spinal cord tethering, spinal canal stenosis, fibromyalgia and osteoporosis.

16. In 2012, IWT underwent a hip replacement after which KUD noticed that her mobility declined and became very poor.

17. Evidence indicates that IWT was historically non-compliant with her treatment. Her husband stated she was a '*very difficult patient*'[11] and would not take medications as prescribed. She also had a history of refusing to eat or drink, regarding which her daughter described her as a *'fussy eater'.* In the lead up to her final hospital admission, IWT mainly ate instant mashed potato or plain cheese sandwiches.[12]

18. In late 2021, IWT had a series of falls which resulted in fractures to her hip and pelvis. She required surgery to address these injuries although was initially extremely reluctant to receive treatment. IWT's family persuaded her to agree to the surgery, which was performed at Cabrini Hospital.

[11] Statement of KUD dated 23 February 2023, coronial brief pg 7.
[12] Statement of VBT dated 14 March 2023, coronial brief pg 13.

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

Circumstances in which the death occurred

19. In early 2022, IWT and KUD's daughter, VBT, visited them and was concerned that IWT had not been eating or drinking. When VBT returned the next week, IWT's health had deteriorated, and she was experiencing diarrhoea. She was also in significant pain and told VBT that she wanted to die by ceasing to eat or drink.

20. VBT contacted emergency services and IWT was subsequently transported and admitted to Cabrini Hospital. At this time, she was found to be malnourished and identified as at risk of heart failure. IWT's admission was characterised by ongoing confusion and delusions including that she was being poisoned, and as such, she refused to eat and drink. She also refused to take her medications unless her daughter was present to persuade her.

21. On 17 March 2022, due to her escalating needs, IWT was transferred to the Alfred Hospital pursuant to an Assessment Order under the MHA. She was administered a 2.5mg intramuscular dose of the anti-psychotic, olanzapine.

22. An Assessment Order allows for a person to be compulsorily taken to a mental health service to be examined by an authorised psychiatrist.[13] In IWT's case, the Assessment Order provided for further investigation(s) and management of paranoid delusions and challenging behaviours in the setting of multifactorial delirium with likely underlying cognitive impairment.[14] This Order was revoked the following day.

23. On admission, IWT was documented to be hostile, erratic, irritable and confused and following assessment, she was very frail, thin and largely bedbound. IWT maintained that her food and drink was being poisoned and was distrusting of clinical staff and resistant to treatment, medication, food and drink. She also reported that she believed that voices in the corridor were criticising her.

24. On 24 March 2022, IWT was transferred to Caulfield Hospital's aged care geriatric ward (**the geriatric ward**), also under the Alfred Health network. She continued to demonstrate delirium and some executive dysfunction. At the time, IWT's primary psychiatric diagnosis of delirium was indicated by fluctuating demeanour, fluctuating paranoid ideation, misinterpretation of

[13] See Part 4, Div.1 of the MHA.
[14] Statement of Dr Deborah Sahhar dated 7 March 2023, coronial brief pg 25.

voices with likely contributors being pain, her new location, marked weight loss and probable metabolic dysregulation due to poor intake.

25. IWT remained on the geriatric ward throughout the remainder of her admission. In April, anti-depressant medication was changed from duloxetine 30 mg to fluoxetine due to its longer half-life with the aim to minimise her delirium. Improvement was initially seen, however, dissipated due to her poor compliance.

26. On 23 April 2022, IWT demonstrated sudden clinical deterioration and was discovered hypotensive and tachycardic. Investigations supported a diagnosis of Takotsubo cardiomyopathy.[15]

27. IWT's clinical condition continued to deteriorate, and she frequently and sternly refused care including observations, medications, blood tests as well as food and drink. She was reviewed regularly by a dietician however continued to refuse a range of oral nutritional supplements and other nutritional interventions.

28. Clinicians considered adopting a nasogastric feeding tube for more effective nutrient delivery. Her treating team met with her family, who reported that IWT's goals of care would be to prioritise comfort. As such, clinicians decided against a nasogastric tube due to the distress it would likely cause.

29. Clinicians formed the impression that delirium was the primary cause of IWT's deterioration, and they prescribed a 5.6 mcg rivastigmine patch[16] with some good effect.

30. On 16 June 2022, a further family meeting was held with IWT's husband, daughter and son. Clinicians indicated their belief that a depot anti-psychotic medication may help alleviate IWT's psychosis and improve her quality of life. Clinicians explained that this treatment would require the initiation of a Treatment Order under the MHA on the basis that *'treatment is needed so that with amelioration of persecutory fears, IWT will be able to sustain nutrition and tolerate interactions with staff to meet her physical care needs'.*

31. On 23 June 2022, the psychiatry team implemented a further Inpatient Assessment Order, followed by an Inpatient Temporary Treatment Order under the MHA and on 28 June 2022,

[15] Takotsubo cardiomyopathy, also known as *'stress-induced cardiomyopathy'*, is a temporary heart condition that develops in response to an intense emotional or physical experience during which there is a weakening of the heart muscle.

[16] Rivastigmine transdermal patches are used to treat dementia.

administered the first dose of depot paliperidone. They administered the second dose on 5 July 2022.

32. On 19 July 2022, the Mental Health Tribunal ordered that an Inpatient Treatment Order be implemented for 18 weeks to allow for the administration of depot paliperidone injections. The rivastigmine patch would also be continued with the view that the paliperidone injection would provide sufficient stability for IWT to return home or to a care facility.

33. Clinicians and the family observed improvement in IWT's mental health following the paliperidone injections and she experienced no adverse side effects. Despite initial improvement, IWT's overall clinical state continued to decrease. In the week leading up to her passing, her treating team observed that she appeared '*physically very frail and physically compromised*.'[17]

34. On the morning of 7 August 2022, IWT was discovered unresponsive in her hospital bed by a nurse. At 8.11am, a Medical Emergency Team (**MET**) call was activated, and clinicians arrived shortly thereafter. Due to IWT's goals of care being not for resuscitation, life saving measures were not commenced and she was verified deceased at 8.15am on 7 August 2022.

Identity of the deceased

35. On 7 August 2022, IWT, born 1945, was visually identified by her daughter, VBT, who signed a formal Statement of Identification to this effect

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

Medical cause of death

37. Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 10 August 2022 and provided a written report of her findings dated 15 August 2022.

38. The post-mortem examination showed bilateral hip replacements, large faecal mass in rectum, and increased lung markings.

[17] Statement of Dr Deborah Sahhar dated 7 March 2023, coronial brief pg 33.

39. Toxicological analysis of post-mortem samples detected hydroxyrisperidone (paliperidone)[18] and no other common drugs or poisons.

40. In the absence of an autopsy,[19] Dr Parsons provided an opinion that the medical cause of death was *'1(a) Complications of malnutrition in a woman with paranoid delusions'.*

41. I accept Dr Parson's opinion.

FAMILY CONCERNS

42. Following IWT's death, her daughter VBT raised concerns regarding the communication and quality of food provided during IWT's admission at the geriatric ward of Caulfield Hospital.

43. Whilst these are important considerations of a person's care, the role of the coroner is limited; the coroner can only examine matters that are sufficiently proximate and causative, or contributory, to a death.

CORONERS PREVENTION UNIT

44. As part of my investigation, I sought advice from the Coroners Prevention Unit (**CPU**) regarding the management of both IWT's physical and mental health proximate to her death.

45. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided to the deceased by reviewing the medical records, and any particular concerns which have been raised.

46. As part of their review, the CPU were assisted by the medical records from Western Health, Cabrini Health and IWT's General Practitioner[20] (**GP**), the coronial brief, and the court file. The CPU noted IWT's clinical history, which I have outlined above, which included paranoid delusions contributing to a refusal of care.

[18] Paliperidone (9-hydroxyrisperidone) is a benzisoxazole derivative and active metabolite of risperidone indicated for schizophrenia.
[19] An autopsy was not directed due to the family's strong objection to such a procedure.
[20] IWT attended the Highett Medical & Dental Centre for many years.

47. Medical records documented several occasions of staff offering IWT a variety of food options, and she was referred to a dietician. Despite nursing encouragement, there was an ongoing refusal to eat or drink.

48. The CPU stated that IWT's medical record and psychiatry report indicated comprehensive treatment including seeking a secondary psychiatric opinion and trialling different medication, all of which were clinically indicated. It stated that IWT had a complex presentation including a history of poor nutritional intake and likely disordered eating which predated her admission to Alfred Hospital.

49. Following their review, the CPU provided advice that in their opinion, there were no shortcomings in the care provided to IWT in the lead-up to her death, and they did not identify any areas of concern in the medical or mental health management. Nor were any prevention opportunities identified.

50. I accept the advice of the CPU on these matters.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was IWT, born 1945;

    b) the death occurred on 7 August 2022 at Caulfield Hospital, 260-294 Kooyong Road, Caulfield, Victoria, from *1(a) complications of malnutrition in a woman with paranoid delusions*; and

    c) the death occurred in the circumstances described above.

52. I consider that the treatment provided to IWT by clinicians at Alfred Health was reasonable and appropriate. In the context of her extended history of mental ill health and reluctance to accept medical treatment, it is apparent that clinicians acted in her best interests to explore treatment options and ultimately made an appropriate decision in accordance with her final wishes.

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 convey my sincere condolences to IWT's family for the loss of their much loved family member.

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

KUD, Senior Next of Kin

Cabrini Hospital

Alfred Health

Senior Constable Lee Ronkovich, Coronial Investigator

Signature:

Date: 10 September 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.