IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 005900

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Susan Maree Lawless
Date of birth:	13 March 1961
Date of death:	14 October 2022
Cause of death:	1(a) Complications of a rectal prolapse
Place of death:	Wesley Central Mission, 5 Smith Street, Carrum, Victoria, 3197

INTRODUCTION

1. On 14 October 2022, Susan Maree Lawless was 61 years old when she died from natural causes. At the time of her death, Susan lived at Wesley Central Mission, supported disability accommodation in Carrum.

2. When Susan was 12 months old her parents noticed she was falling behind developmentally, and she was later diagnosed with phenylketonuria (**PKU**), an inherited disorder that causes a build-up of phenylalanine in the body. PKU can cause intellectual disability if not treated early. Susan was born before the introduction of the 'heel prick test' and as a result her PKU was not detected early, leading to her intellectual disability.

3. Susan attended schools for children with a disability and particularly enjoyed physical education, playing cricket and folk dancing. Following school, Susan attended workshops during the week and regularly volunteered to visit aged care facilities and deliver meals.

4. In 1996, Susan's parents made the decision to move her into supported independent living accommodation as they were concerned about what would happen when they were no longer able to care for her. She moved to a home in Screen Street, Frankston, where she lived with four other residents.

5. In 2006, Susan moved to the home in Carrum where she lived until her death. She was very independent and was able to manage her own personal care and make food without assistance. She required support for financial matters.

6. Due to her PKU, Susan had to maintain a strict diet as her body was unable to break down protein.

7. Susan liked shopping and doing her makeup, getting her nails done and going out for coffee. She loved her little dog, Tammy, and enjoyed taking her out.

8. Susan's brother Neil sadly passed away in a motor vehicle collision in 2002. Her father passed away in 2011, and her mother in 2015.

THE CORONIAL INVESTIGATION

9. Susan'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. Moreover, Susan was considered a

"person placed in custody or care" as defined in section 4 of the Act as she was an SDA resident residing in an SDA enrolled dwelling at the time of her death.[1] The death of a person in care requires a mandatory report to the coroner, even if that death is due to natural causes.

10. Section 52(2) of the Act prescribes when a Coroner must hold an Inquest into a death. This includes where the deceased was immediately before death, a person placed in custody or care. However, as Susan's death was due to natural causes, I am not required to hold an Inquest.[2]

11. 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.

12. 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.

13. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Susan'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.

14. This finding draws on the totality of the coronial investigation into the death of Susan Maree Lawless 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.[3]

[1] Regulation 7 of the *Coroners Regulations 2019* (Vic).
[2] Section 52(3A) of the *Coroners Act 2008* (Vic).
[3] 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.

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

Circumstances in which the death occurred

15. On 13 October 2022, Susan spent the day out with her support worker. At around 11pm, support worker Ms Silver said good night to Susan, who was in bed watching television.

16. At around 5am, Susan's dog Tammy ran into the staff room where Ms Silver was sleeping during the overnight portion of her shift. She got up and noticed that Susan's bedroom light was on and the door open, and the bathroom light was on, but the door closed. Ms Silver returned to the staff room to get ready for the day.

17. Around half an hour later, Ms Silver noticed the bathroom light was still on. She knocked and called out to Susan but did not receive a response. Concerned, she called her supervisor, who advised her to call police.

18. Police arrived at around 6:45am and entered the bathroom, locating Susan unresponsive on the floor. She was sadly declared deceased at 7:07am.

Identity of the deceased

19. On 14 October 2022, Susan Maree Lawless, born 13 March 1961, was visually identified by her support worker, Nuha Al'Attabi, who completed a Statement of Identification.

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

Medical cause of death

21. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Susan Lawless on 20 October 2022. Dr Ho considered, among other materials, the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, VIFM toxicology report and medical records and provided a written report of her findings dated 17 April 2023.

22. The autopsy showed a large rectal prolapse with excoriated mucosa, areas of thickened mucosa and dilated vessels. Histologically, there was dilated vessels, focal thrombi and areas of haemorrhage throughout.

23. Mild hepatic steatosis and benign nephrosclerosis were also identified.

24. Toxicological analysis of post mortem blood samples identified the presence of sertraline (~ 0.3 mg/L).

25. Dr Ho provided an opinion that the medical cause of death was 1 (a) COMPLICATIONS OF A RECTAL PROLAPSE.

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 Susan Maree Lawless, born 13 March 1961;

    b) the death occurred on 14 October 2022 at Wesley Central Mission, 5 Smith Street, Carrum, Victoria, 3197;

    c) I accept and adopt the medical cause of death ascribed by Dr Joanne Ho and I find that Susan Maree Lawless died of natural causes, from complications of a rectal prolapse.

2. AND, I have determined that the application of section 52(3A) of the Act is appropriate in the circumstances as I accept that Susan Maree Lawless' death was due to natural causes and find there is no relationship or causal connection between her death and her status as a person placed in custody or care

I convey my sincere condolences to Susan'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.

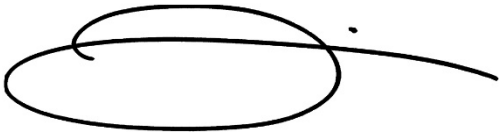
I direct that a copy of this finding be provided to the following:

Michael Laycock, Senior Next of Kin

National Disability Insurance Agency, Other Applicants

Senior Constable Sarah Osborne, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 11 November 2024

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.