IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006064

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Melissa Jan Hadland
Date of birth:	12 May 1967
Date of death:	21 October 2022
Cause of death:	1(a) Pneumonia <u>Contributing factors</u> Trisomy 21, Congenital Heart Disease
Place of death:	Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria, 3128
Keywords:	In Care; Natural Causes

INTRODUCTION

1. On 21 October 2022, Melissa Jan Hadland was 55 years old when she died at Box Hill Hospital.

2. Melissa lived with Down Syndrome (Trisomy 21) with intellectual disability, congenital heart defect and a visual impairment. She received support under a National Disability Insurance Scheme (**NDIS**) Participant Plan.

3. At the time of her death, Melissa resided in a Specialist Disability Accommodation (**SDA**) facility operated by Scope Facility in Wantirna South, Victoria. Melissa was nonverbal and communicated by facial expression, body language and vocalising. She required support for all activities of daily living, including meal preparation, personal care, and the administration of medication.

4. Specific Health Management Plans were in place to support and guide Scope Facility staff to provide medical treatment as required. These were signed off by medical professionals and regularly reviewed.

THE CORONIAL INVESTIGATION

5. Melissa's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act).

6. This is because, immediately before death, Melissa was a person "in care", meaning that she was an SDA resident residing in an SDA enrolled dwelling. The death of a person "in care" is a mandatory report to the Coroner even if the death appears to have been from natural causes.

7. Generally, the Coroner must hold an inquest into the death of a person "in care". However, under section 51(3A) and (3B) of the Act, the Coroner is not required to hold an inquest if the Coroner considers that the death was due to natural causes, on the basis of a report from a medical investigator which includes an opinion as such.

8. In this instance, I am satisfied on the basis of a report from Forensic Pathologist Dr Victoria Francis of the Victorian Institute of Forensic Medicine (**VIFM**) dated 21 November 2022 that Melissa's death was due to natural causes and therefore that an inquest is not required. The report of Dr Francis is discussed further below in relation to the medical cause of death.

9. 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.

10. 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.

11. Victoria Police assigned Leading Senior Constable Nathan Emms to be the Coroner's Investigator for the investigation of Melissa'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.

12. This finding draws on the totality of the coronial investigation into the death of Melissa Jan Hadland 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.[1]

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

Circumstances in which the death occurred

13. On Thursday 20 October 2022, Melissa woke with a dry cough and runny nose. That evening, Melissa showed little interest in dinner, spitting her food out and vomiting fluid at approximately 7pn. A home visit was booked in for General Practitioner to attend the following day. Melissa went to bed early at approximately 8.30pm.

[1] 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.

14. Melissa was observed by a staff member early the following morning at approximately 3am, coughing with pale skin and weakness. She developed respiratory distress and was conveyed to Box Hill Hospital Emergency Department, where she was admitted at 6.01am.

15. Melissa was diagnosed with lobar community acquired pneumonia. She was treated with intravenous antibiotics but her condition continued to deteriorate and she began to exhibit discomfort and distress.

16. In consultation with Melissa's sister Jodie Woods and medical staff, and noting Melissa's comorbidities and quality of life, it was determined to initiative a palliative care plan with the goal of minimising pain and optimising dignity.

17. Melissa's condition continued to deteriorate and she died at 9.22am on 21 October 2022.

Identity of the deceased

18. On 27 October 2022, Melissa Jan Hadland, born 12 May 1967, was visually identified by her disability support worker, Catherine Backhouse.

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

Medical cause of death

20. On 24 October 2022, Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and reviewed relevant materials, including medical records from Colchester Medical Centre, the medical deposition from Box Hill Hospital, the Police Report of Death (Form 83) and a post mortem CT scan. Dr Francis provided a written report of her findings dated 21 November 2022.

21. A full post mortem examination was not directed in keeping with wishes expressed by the senior next of kin.

22. The post mortem CT scan showed bilateral basal ganglia calcifications. There were increased bilateral lung markings which were more prominent on the right than the left, as well as a central abdominal hernia with no evidence of complication.

23. Taking into account all available information, and in the absence of a full post mortem examination, Dr Francis provided an opinion that a reasonable formulation for the medical cause of death is:

1(a) Pneumonia

Contributing factors

Trisomy 21, Congenital Heart Disease

24. I accept and adopt Dr Francis' opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Melissa Jan Hadland, born 12 May 1967;

    b) the death occurred on 21 October 2022 at Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria, 3128, from pneumonia, with contributing factors of Trisomy 21 and Congenital Heart Disease; and

    c) the death occurred in the circumstances described above.

26. Having considered all of the circumstances, I am satisfied that Melissa died of natural causes and have not identified any concerns in relation to the quality of care provided in the period proximate to her death.

I convey my sincere condolences to Melissa'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 Hadland, Senior Next of Kin

Yvette Kozielski, Eastern Health

Leading Senior Constable Nathan Emms, Coroner's Investigator

Signature:

Coroner Leveasque Peterson

Date : 18 January 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.