IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006129

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Catherine Myee Drinkwater
Date of birth:	8 March 1981
Date of death:	24 October 2022
Cause of death:	1(a) METASTATIC OESOPHAGEAL CARCINOMA
Place of death:	5/68 Anderson Street, Lilydale, Victoria, 3140
Keywords:	In Care; Natural Causes

INTRODUCTION

1. On 24 October 2022, Catherine Myee Drinkwater was 41 years old when she died after having been diagnosed in July 2022 with Oesophagus cancer which was managed according to a palliative care pathway.

2. Catherine received support under a National Disability Insurance Scheme (**NDIS**) Participant Plan. At the time of her death, Catherine lived in a single occupancy unit within a Supported Disability Accommodation (**SDA**) complex managed by Melba at 5/68 Anderson Street, Lilydale, Victoria, 3140. Catherine lived with Aspergers Syndrome, Intellectual disability, Social Emotional disorder, Epilepsy, Iritis (a severe eye problem), no sense of smell, and Myasthenia Gravis. She received support with daily living skills and overnight to assist her manage her epilepsy and other health concerns.

3. According to her NDIS Participant Plan, Catherine volunteered at two Op Shops and liked to be out and about in the community. She enjoyed attending community festivals and parades, listening to bands, and watching her favourite footy team, St Kilda, play games.

THE CORONIAL INVESTIGATION

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

5. This is because, immediately before death, Catherine 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.

6. 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.

7. In this instance, I am satisfied on the basis of a report from Forensic Pathologist Dr Yeliena Baber of the Victorian Institute of Forensic Medicine (**VIFM**) dated 28 October 2022 that Catherine's death was due to natural causes and therefore that an inquest is not required. The report of Dr Baber is discussed further below in relation to the medical cause of death.

8. 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.

9. 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.

10. Considering the circumstances of death, I sought information from the National Disability Insurance Agency (**NDIA**) including confirmation that Catherine was before her death an SDA resident residing in an SDA enrolled dwelling, and a copy of her NDIS Participant Plan dated 3 May 2022.

11. This finding draws on the totality of the coronial investigation into the death of Catherine Myee Drinkwater, including information received from the NDIA, the Police Report of Death (Form 83) and the report of Dr Baber. 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

12. On 18 June 2022, Catherine was diagnosed with Stage 4 Oesophagus Cancer which had spread throughout her body. Following this diagnosis, she was reportedly given only months to live.

13. Catherine's parents were informed by oncologists and other medical specialists that her cancer was inoperable and that treatment would be both painful and unlikely to succeed. In these circumstances, it was determined that Catherine would be managed through palliative care.

14. Over the following months, Catherine received care and management from Eastern Palliative Care and her local General Practitioner, Dr Win Bo at Lilydale Medical Centre. Oxycodone

[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.

was prescribed for pain management, to be administered each morning, night and at mealtimes.

15. In the days prior to her death, there was a noticeable shift in Catherine's behaviour. She began to struggle to walk and complete daily activities, expressing that she was in pain.

16. On 24 October 2022, support worker Heidi Jeffrey attended Catherine's home from 5pm. At 6.35pm, Heidi administered a dose of 5mg Oxycodone to assist with pain management.

17. At 7.39pm, Heidi noticed that Catherine was making odd breathing noises while sitting on the couch. Heidi initially believed that Catherine was experiencing a seizure and so contacted Triple Zero (000). Catherine subsequently began to vomit blood, so Heidi transferred her to the ground and commenced cardiopulmonary resuscitation (CPR).

18. A short time later, Emergency Services attended, and Ambulance Victoria paramedics took over CPR. Sadly, Heidi was unable to be resuscitated and was declared deceased at 8.15pm.

19. Family was promptly notified by the support provider and subsequently attended the scene.

Identity of the deceased

20. On 24 October 2022, Catherine Myee Drinkwater, born 8 March 1981, was visually identified by her father, Bruce Drinkwater.

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

Medical cause of death

22. On 26 October 2022, Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and reviewed a post mortem CT scan, the Police Report of Death, and the VIFM contact log. Dr Baber provided a written report of her findings dated 28 October 2022.

23. The examination showed findings in keeping with Catherine's known clinical history. The post mortem CT scan revealed no other findings of note.

24. Taking into account all available information, Dr Baber provided an opinion that the medical cause of death was '1 (a) Metastatic Oesophageal Carcinoma.'

25. I accept and adopt Dr Baber's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Catherine Myee Drinkwater, born 8 March 1981;
    b) the death occurred on 24 October 2022 at 5/68 Anderson Street, Lilydale, Victoria, 3140, from metastatic oesophageal carcinoma; and
    c) the death occurred in the circumstances described above.

27. Having considered all of the evidence, I am satisfied that Catherine's death was due to natural causes and have not identified any opportunities for prevention. In this respect, I note that Catherine was being managed under a palliative care pathway and that no concerns of care have been raised.

I convey my sincere condolences to Catherine'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:

Bruce & Wendy Drinkwater, Senior Next of Kin
National Disability Insurance Agency

Signature:

Coroner Leveasque Peterson

Date : 11 September 2023

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.