IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000053

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Tamara Kudeviita
Date of birth:	12 March 1963
Date of death:	3 January 2023
Cause of death:	1(a) Pneumonia 2 Down's syndrome
Place of death:	Calvary Health Care Bethlehem, 152 Como Parade West, Parkdale, Victoria, 3195

INTRODUCTION

1. On 3 January 2023, Tamara Kudeviita was 59 years old when she died in hospital. At the time of her death, Tamara lived at Fewster House, a Supported Disability Accommodation (**SDA**) home owned and managed by Bayley House.

2. Tamara had a close and loving relationship with her mother, Shirley, and visited her weekly until her death in July 2022.

3. Tamara's medical history included Down's Syndrome, seizures, reflux oesophagitis and spondylolisthesis. In 2019, she was diagnosed with Alzheimer's disease.

4. On 24 March 2022, Tamara's general practitioner referred her to Bethlehem Community Palliative Care Service in the context of an 18-month period of decline in her health. Her Alzheimer's disease had progressed to a severe condition, and she had declining mobility, communication and cognition.

5. During 2022 Tamara had very limited communication, was immobile, suffered frequent seizures and required full assistance for activities of daily living.

THE CORONIAL INVESTIGATION

6. Tamara's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Specifically, Tamara was immediately before her death 'a person placed in custody or care', as she was an SDA resident residing in an SDA enrolled dwelling.[1]

7. 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, and the finding made following an investigation of a death of a person in care must be published on the internet[2]. 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 Tamara's death was due to natural causes, I am not required to hold an Inquest.[3]

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

[1] Regulation 7(d) of the *Coroners Regulations 2019* (Vic).
[2] Section 73(1B) of the *Coroners Act 2008* (Vic).
[3] Section 52(3A) of the *Coroners Act 2008* (Vic).

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

11. This finding draws on the totality of the coronial investigation into the death of Tamara Kudeviita 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.[4]

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

Circumstances in which the death occurred

12. On 28 December 2022, the manager of Fewster House contacted the Community Palliative Care Service as Tamara's health had further deteriorated and she was unable to swallow food and medications. She was assessed at home before being admitted to the inpatient palliative care unit of Calvary Health Care Bethlehem for end-of-life care.

13. Tamara was commenced on a continuous subcutaneous infusion of midazolam to replace her regular oral anti-seizure medication which she could no longer swallow. She was regularly reviewed and noted to be comfortable.

[4] 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. On 3 January 2023 Tamara was noted to be febrile and required a dose of morphine subcutaneously for breathlessness. She died later that afternoon.

Identity of the deceased

15. On 3 January 2023, Tamara Kudeviita, born 12 March 1963, was visually identified by her support worker, Penelope Scott, who completed a Statement of Identification.

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

Medical cause of death

17. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Tamara Kudeviita on 5 January 2023. Dr Bedford considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan and E-Medical Deposition Form from Calvary Healthcare Bethlehem and provided a written report of his findings dated 23 January 2023.

18. According to Dr Bedford, the external examination was unremarkable. The post mortem CT scan showed hydrocephalus, left hydronephrosis and bilateral pneumonic changes.

19. Dr Bedford provided an opinion that the death was due to natural causes, and ascribed the medical cause of death as 1 (a) PNEUMONIA; 2 DOWN'S SYNDROME.

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 Tamara Kudeviita, born 12 March 1963;

    b) the death occurred on 3 January 2023 at Calvary Health Care Bethlehem, 152 Como Parade West, Parkdale, Victoria, 3195;

    c) I accept and adopt the medical cause of death ascribed by Dr Paul Bedford and I find that Tamara Kudeviita, a woman with Down's Syndrome, died from pneumonia;

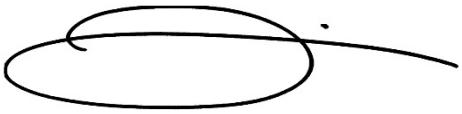
2. AND, I have determined that the application of section 52(3A) of the Act is appropriate in the circumstances as I accept that Tamara Kudeviita's death was due to natural causes and find there is no relationship or causal connection between her death and her status as a person placed in custody or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

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:

Leading Senior Constable Nick Janiw, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 24 October 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.