IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 001959

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Marina Norman
Date of birth:	16 September 1976
Date of death:	11 April 2023
Cause of death:	1(a) ASPIRATION PNEUMONIA IN A WOMAN WITH MULTIPLE SCLEROSIS
Place of death:	Dandenong Hospital, 135 David Street, Dandenong Victoria, 3175
Keywords:	In care, natural causes

INTRODUCTION

1. On 11 April 2023, Marina Norman was 46 years old when she passed away from aspiration pneumonia at Dandenong Hospital. At the time of her death, Ms Norman lived in Specialist Disability Accommodation at 10 Springlands Street, Lyndhurst, Victoria, 3975.

2. Ms Norman had progressive multiple sclerosis, which had been diagnosed in 2010. In the period leading up to her death, she was bed bound and non-verbal. She had been a music teacher and her husband remained active in her care.

THE CORONIAL INVESTIGATION

3. Ms Norman'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. 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. Ms Norman was a "person placed in custody or care" within the meaning of section 4 of the Act, as she was "a prescribed class of person"[1] due to her status as an "SDA[2] resident[3] residing in an SDA enrolled dwelling".[4]

4. On 16 May 2023, I determined to discontinue the investigation pursuant to section 17(1) of the Act. I was at that time, and remain, satisfied that Ms Norman's death was due to natural causes[5]. I was also at that time, and remain, satisfied that there are no circumstances of concern in respect of the care or treatment provided to Ms Norman.

5. However, Ms Norman's status as a person "in care" immediately before her death requires that I must hold an inquest into her death[6] unless I consider that the death was due to natural causes.[7] It also requires that I must, if possible, make a finding with respect to the circumstances in which the death occurred[8] and publish such finding.[9]

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1 Section 4(2)(j)(i) of the *Coroners Act 2008* ('the Act').
2 Specialist Disability Accommodation.
3 An "SDA resident" includes a person who is an NDIS participant who is funded to reside in an SDA enrolled dwelling: *Residential Tenancies Act 1997* – section 498B
4 Regulation 7(1)(d) of the *Coroners Regulations 2019*.
5 See paragraph 13.
6 Section 52(2)(b) of the Act.
7 Section 52(3A) of the Act
8 Section 67 of the Act
9 Section 73(1B) of the Act.

ORIGINAL FINDINGS SET ASIDE

6. I am satisfied that the clarification of Ms Norman's status as a person "in care" constitutes a new fact and circumstance that makes it appropriate to set aside the findings made by me on 16 May 2023, without re-opening the investigation. Accordingly, pursuant to section 77(2)(a) of the Act, I set aside those findings.

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

Circumstances in which the death occurred

7. On 2 April 2023, Ms Norman was transported from her Specialist Disability Accommodation at 10 Springlands Street, Lyndhurst and admitted to the Dandenong Hospital with decreased consciousness and fever.

8. In hospital, Ms Norman received treatment for the fever (of unknown origin) but then suffered aspiration pneumonia and did not improve despite one week of active therapy. The decision was then made to withdraw active treatment and provide comfort care. Ms Norman passed away at 7.57pm on 11 April 2023.

Identity of the deceased

9. On 17 April 2023, Marina Norman, born 16 September 1976, was visually identified by her friend, Violet Marion.

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

Medical cause of death

11. Forensic Pathologist, Dr Gregory Young from the Victorian Institute of Forensic Medicine, conducted an examination on 17 April 2023 and provided a written report of his findings dated 19 April 2023.

12. The post-mortem examination revealed bilateral lung consolidation with right lung collapse and mediastinal shift from left to right. The brain showed ventricular dilation. There were no unexpected signs of trauma.

13. Dr Young provided an opinion that the medical cause of death was 1 (a) ASPIRATION PNEUMONIA IN A WOMAN WITH MULTIPLE SCLEROSIS. Dr Young further opined that Ms Norman's death was due to natural causes.

14. I accept Dr Young's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Marina Norman, born 16 September 1976;

    b) the death occurred on 11 April 2023 at Dandenong Hospital, 135 David Street, Dandenong, Victoria, 3175, from ASPIRATION PNEUMONIA IN A WOMAN WITH MULTIPLE SCLEROSIS; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Ms Norman's family and friends 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:

Ross Norman, Senior Next of Kin

Constable Lachlann Boyd, Coroner's Investigator

Signature:

Coroner Paul Lawrie

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.