IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 002527

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	Ms AC
Date of birth:	[redacted] September 1949
Date of death:	11 April 2023
Cause of death:	1(a) Metastatic oesophageal cancer
Place of death:	Cabrini Hospital Malvern, 183 Wattletree Road, Malvern, Victoria
Key words:	In care, oesophageal cancer, palliative care

INTRODUCTION

1. On 11 April 2023, Ms AC was 73 years old when she passed away in hospital.

2. At the time of her death, Ms AC lived in supported accommodation in Caulfield.

THE CORONIAL INVESTIGATION

3. Ms AC's death 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 or custody[1] is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

4. The Registry of Births, Deaths and Marriages Victoria informed the Court of Ms AC's death and provided a copy of the Medical Certificate of Cause of Death (**MCCD**) completed by Dr Veronica Elias at Cabrini Hospital on 11 April 2023. Cabrini Hospital subsequently submitted an E-Medical Deposition Form on 19 May 2023.

5. 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.

6. 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.

7. Victoria Police assigned Leading Senior Constable Dragos Panoschi to be the Coroner's Investigator for the investigation of Ms AC'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.

[1] See the definition of '*reportable death'* in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of *'person placed in custody or care'* in section 3(1) of the Act. Regulation 7(d) of the Coroners Regulations 2019 provides that the definition in section 3(1) of the Act includes a person in Victoria who is an SDA resident residing in an SDA enrolled dwelling.

8. This finding draws on the totality of the coronial investigation into Ms AC's death, 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.[2]

Background

9. As an infant, Ms AC contracted polio which went on to affect her mobility. According to her sister, Ms L, Ms AC never walked and used a wheelchair from an early age.

10. Ms AC's medical history also included cerebral palsy, poliomyelitis, ischemic heart disease, asthma, scoliosis, cholecystectomy, nephrectomy, and thyrotoxicosis.

11. In her early adult life, Ms AC worked in an office before running a nursery with her brother for several years.

12. Ms AC's family remembered her as a very positive, happy, and witty person who always looked out for others who could not advocate for themselves.

13. In 2000, Ms AC moved to Yooralla shared accommodation in Caulfield where she received assistance for her personal and medical care. Ms AC independently managed her meals, finances, and healthcare needs, including arranging appointments and going to the pharmacy. She regularly accessed the community using public transport, which included going to shopping centres, supermarkets, and sporting venues.

Health issues proximate to death

14. In September 2022, Ms AC was admitted at Alfred Hospital due to coughing, vomiting, and testing positive for COVID-19. She was discharged back to Yooralla after approximately one week.

15. Over the following months, Ms AC experienced intermittent issues with her suprapubic urinary catheter (**SPC**), which required several attendances to Alfred Health.

16. Between December 2022 and late January 2023, Ms AC saw Dr Daniel Makar at Carnegie Central Medical Clinic in relation to exacerbation of asthma, ongoing swallowing difficulties,

[2] 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.

SPC replacement, stomach issues, and blood tests which showed high C-Reactive Protein (referred to as CRP) and white cell count. Dr Makar suspected infection and started Ms AC on a course of antibiotics. However, when Ms AC's symptoms did not significantly improve in response to treatment, Dr Makar suspected hiatus hernia or possible Helicobacter Pylori infection. With further treatment over the following weeks, Ms AC's symptoms improved only minimally.

17. Dr Makar subsequently ordered a barium swallow, which was conducted on 28 February 2023 and demonstrated an irregular abnormality in the distal oesophagus.

18. Concerned by Ms AC's ongoing swallowing issues and weight loss, Yooralla staff also encouraged Ms AC to see a speech therapist. Although she was initially reluctant, she eventually agreed, and an appointment was arranged for 3 March 2023.

19. However, on 1 March 2023, Ms AC was admitted to Cabrini Hospital following further issues with her SPC. Whilst in hospital, Ms AC was diagnosed with a urinary tract infection, VRE bacteraemia, and was started on antibiotics.

20. A CT pulmonary angiogram demonstrated a distal-oesophageal wall mass, a mass adjacent to the gastro-oesophageal junction, as well as mediastinal and upper retroperitoneal lymph node involvement.

21. A gastroscopy conducted 8 March 2023 revealed an obstructive lesion in the mid-distal portion of Ms AC's oesophagus. Biopsies were taken of the mass, which confirmed a poorly differentiated adenocarcinoma.

22. This was followed-up with a CT scan which demonstrated the tumour extending into the gastric cardia with metastases to the mediastinal and para-aortic lymph nodes, as well as a left pleural effusion.

23. Oncology and radiation oncology opinion was sought, and Ms AC's condition was deemed incurable and palliative. She was commenced on Total Parenteral Nutrition (**TPN**) as she was unable to safely eat due to the obstructive lesion.

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

Circumstances in which the death occurred

24. On 12 March 2023, Ms AC was transferred from the acute ward to the Palliative Care Unit at Cabrini Hospital where she received symptom relief medications and treatment.

25. On 16 March 2023, Ms AC underwent a further gastroscope and oesophageal stent placement to enable better oral intake, following which she was able to tolerate a pureed diet and thin fluids. However, Ms AC subsequently stopped eating.

26. On 28 March 2023, she was discharged home for ongoing palliative care. Dr Makar provided prescriptions to assist with her palliative care pathway. Yooralla staff and Ms AC's family continued to provide ongoing care and support.

27. On 8 April 2023, Ms AC returned to Cabrini Hospital and was readmitted to the Palliative Care Unit with increased drowsiness. She received comfort care until she passed away peacefully at 2.35pm on 11 April 2023.

Identity of the deceased

28. I am satisfied following completion of the MCCD that the deceased was Ms AC, born [redacted] September 1949.

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

Medical cause of death

30. As Ms AC's body was not received at Victorian Institute of Forensic Medicine (**VIFM**), a forensic pathologist was unable to conduct an examination.

31. The MCCD completed by Dr Veronica Elias at Cabrini Hospital listed the cause of Ms AC's death as *"Metastatic oesophageal cancer".*

32. Dr David Beer, forensic pathologist at the VIFM, reviewed the relevant material and advised that the cause of death was satisfactory.

33. I therefore accept the cause of death as formulated by Dr Elias.

FINDINGS AND CONCLUSION

34. Pursuant to section 67(1) of the Act I make the following findings:

(a) the identity of the deceased was Ms AC, born [redacted] September 1949;

(b) the death occurred on 11 April 2023 at Cabrini Hospital Malvern, 183 Wattletree Road, Malvern, Victoria, from metastatic oesophageal cancer; and

(c) the death occurred in the circumstances described above.

I convey my sincere condolences to Ms AC's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published in a redacted form 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:

Ms L, senior next of kin
Cabrini Health
Leading Senior Constable Dragos Panoschi, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 07 March 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.