IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002798

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Hayley Michelle Impey
Date of birth:	29 September 1972
Date of death:	26 May 2023
Cause of death:	1(a) Aspiration pneumonia 1(b) Epilepsy with frequent seizures
Place of death:	University Hospital Geelong, Bellerine Street, Geelong, Victoria
Keywords:	In care - disability services - natural causes

INTRODUCTION

1. On 26 May 2023, Hayley Michelle Impey was 50 years old when she passed away in hospital. At the time of her death, Ms Impey lived in Supported Disability Accommodation (**SDA**) in Colac managed by Scope Australia, from whom she received National Disability Insurance Scheme (**NDIS**) funded and regulated support. She is survived by her parents, Frank and Anita Impey.

2. Ms Impey's medical history included autism, dysphagia, recurrent aspiration pneumonia and epilepsy with frequent seizures. She was prescribed medication including clonazepam, olanzapine, sodium valproate and melatonin. Ms Impey's seizures had been reportedly well controlled on her medication regime.

THE CORONIAL INVESTIGATION

3. Ms Impey's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Ms Impey's death was reportable as she was a person placed "*in care*" under section 4(2)(c) of the Act.[1] This category of deaths is reportable to ensure independent scrutiny of the circumstances given the vulnerability of the deceased and the level of power and control exercised by those who care for them. If such deaths occur as a result of natural causes, a coronial investigation must take place, but the holding of an inquest is not mandatory

4. 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.

5. 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.

[1] She was an SDA resident residing in an SDA enrolled dwelling before the time of her death: Reg 7(1)(d), *Coroners Regulations 2019*.

6. This finding draws on the totality of the coronial investigation into Ms Impey's death including evidence contained in the coronial brief. While 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]

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

Circumstances in which the death occurred

7. On 24 May 2023 at around 11.30am, Ms Impey was transported to Colac Hospital in an ambulance after staff at her home observed that she was experiencing multiple seizures. Paramedics administered midazolam and the seizure activity ceased. At Colac Hospital, she was administered moxifloxacin for a chest infection, sodium valproate and further midazolam.

8. Later that evening, after experiencing further seizure activity, Ms Impey was assessed as having developed status epilepticus and, after consultation with her parents, she was intubated and transported to University Hospital in Geelong. After arriving at hospital in Geelong, Ms Impey underwent a computed tomography (**CT**) scan of the brain.

9. At around 2.00am on 25 May 2023, Ms Impey was extubated and she was transferred to the ward that afternoon where she was routinely observed and monitored over the following hours. At around 11.45pm, Ms Impey was found unresponsive by nursing staff. She was pronounced deceased at 12.20am on 26 May 2024.

Identity of the deceased

10. On 26 May 2023, Hayley Michelle Impey, born 29 September 1972, was visually identified by her father, Frank Impey.

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

[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.

Medical cause of death

12. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine conducted an examination on 29 May 2023 and provided a written report of her findings dated 26 June 2023.

13. A post-mortem CT scan showed bilateral aspiration pneumonia and widespread peripheral oedema.

14. Dr Baber provided an opinion that the medical cause of death was *1(a) Aspiration pneumonia; 1(b) Epilepsy with frequent seizures*. She also expressed the opinion that the death was due to natural causes.

15. I accept Dr Baber's opinion.

CONCLUSION

16. Having carefully considered the available evidence, I am satisfied that the care Ms Impey received in the period proximate to her death was reasonable and appropriate.

17. As noted above, Ms Impey's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before her death, she was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Ms Impey died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an inquest into her death

FINDINGS

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

    a) the identity of the deceased was Hayley Michelle Impey, born 29 September 1972;

    b) the death occurred on 26 May 2023 at University Hospital Geelong, Bellerine Street, Geelong, Victoria, from aspiration pneumonia and epilepsy with frequent seizures; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Ms Impey'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:

Frank and Anita Impey, Senior Next of Kin

Barwon Health

Senior Constable Gordon Jones, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 21 August 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.