IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005071

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Hannah Gray
Date of birth:	21 June 1989
Date of death:	11 September 2023
Cause of death:	1(a) Aspiration pneumonia in a woman with cerebral palsy and Lennox-Gastaut syndrome
Place of death:	University Hospital Geelong, Bellerine Street, Geelong, Victoria 3220
Keywords:	In-care; aspiration pneumonia; cerebral palsy; Lennox-Gastaut syndrome

INTRODUCTION

1. On 11 September 2023, Hannah Gray was 34 years old when she died at the University Hospital Geelong following a deterioration in her health. At the time, Ms Gray lived in specialist disability accommodation in Belmont operated by genU.

THE CORONIAL INVESTIGATION

2. Ms Gray'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 or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

3. 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.

4. 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.

5. Victoria Police assigned Senior Constable Mark Arnold to be the Coroner's Investigator for the investigation of Ms Gray'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.

6. This finding draws on the totality of the coronial investigation into the death of Hannah Gray 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.[1]

[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.

BACKGROUND

1. Ms Gray was born in 1989 to parents Deborah and Brian Gray. She was the youngest of five children and was raised in Moriac in a loving family environment with her parents and siblings.

2. When Ms Gray was just six weeks old she began to have seizures. Soon after she was diagnosed with cerebral palsy, Lennox Gastaut syndrome, and a severe intellectual and physical disability. As she grew and developed, she remained non-verbal. Later in life she was diagnosed with dysphagia (difficulty swallowing) and required a Percutaneous Endoscopy Gastronomy commonly referred to as a PEG tube to facilitate oral intake and medication. Ms Gray's medical history also included osteoarthritis recurrent aspiration pneumonia.

3. Growing up, Ms Gray was looked after by her entire family, in particular by her mother who stayed at home to care for her. Tragically, in 2005 Ms Gray's mother passed away in a cycling accident during the Great Victorian Bike Ride. Afterwards, her father Brian and sister Rachael became the primary caregivers for Ms Gray.

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

Identity of the deceased

1. On 11 September 2023, Hannah Gray, born 21 June 1989, was visually identified by her father, Brian Gray, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

3. Forensic Pathologist Dr Judith Fronczek, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 12 September 2023 and provided a written report of her findings dated 13 September 2023.

4. The post-mortem examination did not show any signs of injury which could have caused or contribute to death. The post-mortem computerised tomography (**CT**) scan showed cerebral ventriculomegaly, bilateral pleural effusions, enhanced lung marking with air bronchograms, and scoliosis.

5. Dr Fronczek provided an opinion that the medical cause of death was *1(a) aspiration pneumonia in a woman with cerebral palsy and Lennox-Gastaut syndrome,* which she consider to be a death due to natural causes.

6. I accept Dr Fronczek's opinion.

Circumstances in which the death occurred

7. In 2017, the family arranged for Ms Gray to reside in a purpose-built accommodation with the assistance of NDIS. In partnership with other families, Ms Gray's family purchased land in Belmont and the accommodation itself was built by Ms Gray's brother, Isaac, a professional builder. The family arranged for genU to be the service provider for the site. Ms Gray formally moved in April 2018 where she lived with four other women with disabilities. Although she no longer lived in the family home, Ms Gray kept in close contact with her family who regularly visited.

8. Ms Gray's medical care was managed by General Practitioner (**GP**) Dr Loyala Mendis of Medical One-Waurn Ponds. Most recently in 2022, Dr Mendis prepared a Comprehensive Health Assessment Program for Ms Gray in 2022. Ms Gray also attended Neurologist, Dr John Paul Nicolo, for management of her seizures, and received regular physiotherapy, occupational therapy, and speech pathology.

9. In August 2022, Ms Gray underwent a procedure to insert a Vagus Nerve Stimulator (**VNS**) to reduce the incidence of seizures. The family noted VNS therapy was effective in managing her seizures however led to severe bouts of coughing.

10. In the year or so leading up to her death, Ms Gray's health steadily deteriorated. From January 2023 onwards, Ms Gray had four separate admissions to the University Hospital Geelong. Her penultimate admission was on 16 July 2023 for an unusual cough and aspiration pneumonia. She was treated with antibiotics and discharged home on 23 July 2023 after a week-long admission.

11. On 2 September 2023, Ms Gray was reviewed by her speech pathologist who also reviewed her meal management plan. The speech pathologist noted that Ms Gray's "*interest and ability to swallow oral food consistently has decreased possibly due to increased fatigue and reduced alertness*."[2]

[2] Statement of Rohan White, genU Regional Manager, dated 8 January 2024.

12. On 4 September 2024, Ms Gray experienced shallow and rapid breathing which was noticed by her carers who contacted an ambulance. Ms Gray was conveyed by paramedics to the University Hospital Geelong where she was diagnosed and treated for aspiration pneumonia. On admission, her recent history of a generalised deterioration, worsening cough and progressive difficulty clearing phlegm was noted.

13. Initially, Ms Gray was admitted to the Intensive Care Unit (**ICU**) had significant oxygen requirements and required intravenous antibiotics. In conjunction with advice from the neurology team, some of Ms Gray's anti-seizure medication with sedating properties were reduced, including cannabidiol and midazolam. She was diagnosed presumptively with vocal cord palsy[3] due to increasing and worsening aspiration events.

14. Ms Gray's condition stabilised and on 8 September 2023 she was discharged from the ICU to a medical ward. Due to deterioration in her baseline functioning and health and suspected vocal cord palsy, Ms Gray was deemed not suitable for return to the ICU and her goals of care were adjusted to ward based management at this time.

15. On the ward Ms Gray's condition failed to improve despite maximal ward-based oxygen therapy and antibiotics. On 9 September 2023 she suffered five generalised tonic-clonic seizures.

16. Following discussions with family, on 10 September 2023 Ms Gray was transferred to palliative care prioritising comfort care. She was kept comfortable and was surrounded by her loved ones until she passed away and was formally pronounced deceased at 2.46am on 11 September 2023.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Hannah Gray, born 21 June 1989;

    b) the death occurred on 11 September 2023 at University Hospital Geelong, Bellerine Street Geelong, Victoria 3220;

[3] Paralysis of the vocal cords.

c) the cause of Ms Gray's death was aspiration pneumonia in a woman with cerebral palsy and Lennox-Gastaut syndrome; and

d) the death occurred in the circumstances described above.

18. Ms Gray'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. Section 52 of the Act requires an inquest to be held, except in circumstances where the death was due to natural causes. I am satisfied that Ms Gray's death was from natural causes.

19. The available evidence does not support a finding that there was any want of clinical management or care on the part of Ms Gray's carers at genU, the healthcare professionals involved in her care more broadly, or the clinical staff at University Hospital Geelong that caused or contributed to her death.

20. I convey my sincere condolences to Ms Gray's family for their loss. It is evident from the statement of Ms Gray's sister, Rachael, that Ms Gray was a much-loved member of her family who was well cared for and is deeply missed by many.

PUBLICATION OF FINDING

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.

DISTRIBUTION OF FINDING

I direct that a copy of this finding be provided to the following:

Brian Gray, senior next of kin

Rachael Partridge, senior next of kin

Barwon Health

Senior Constable Mark Arnold, Victoria Police, Coroner's Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date : 17 September 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.