IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005224

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	BCA[1]
Date of birth:	2 August 1963
Date of death:	16 September 2023
Cause of death:	1(a) Complications of urinary tract disease in the setting of COVID pneumonitis Contributing factors Stroke, hypertension, diabetes mellitus
Place of death:	Royal Melbourne Hospital 300 Grattan Street Parkville, Victoria 3052
Keywords:	In care, SDA resident, natural causes death

[1] This Finding has been de-identified for the purposes of publication. The name of the deceased and the names of any family members have been replaced with pseudonyms of randomly generated three letter sequences.

INTRODUCTION

1. On 16 September 2023, BCA was 60 years old when she died at the Royal Melbourne Hospital in Parkville. At the time of her death, BCA was a resident at 43 Winifred Street Oak Park **(Winifred House)**, a Specialist Disability Accommodation **(SDA)** dwelling managed by Aruma. BCA also received support from the National Disability Insurance Scheme.[2]

2. BCA commenced residing at Winifred House on 1 July 2022. She had previously been an inpatient at the Aged Care Ward of the Royal Melbourne Hospital for approximately 11 months. Winifred House contained four other residents *"all with complex, high needs"* and with whom BCA *"[got] along well"*.[3]

3. BCA's five sisters, FTD, TWL, SNB, KJN, and QMV, were in frequent contact with her, would visit Winifred House and were *"very supportive of her"*.[4]

4. BCA's medical history included diagnoses of Type-2 diabetes mellitus, post-stroke paralysis, hypertension, gastroesophageal reflux disease, hyperlipidaemia, ischaemic heart disease, depression, sleep apnoea and transitional cell carcinoma.[5]

5. An external nurse visited BCA daily at Winifred House to manage her diabetes, administer insulin and accompany her to medical appointments. She was under the supervision of multiple specialist medical practitioners and was on an extensive medication regime to manage her symptoms. At the time of her death, BCA had received four vaccinations against the SARs-CoV-2 (**COVID-19**) virus.[6]

THE CORONIAL INVESTIGATION

6. BCA's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).[7] 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. In this instance, BCA was a *"person placed in custody or care"* pursuant to the definition in section 4 of the Act, as she was *"a prescribed person or a person belonging to a*

[2] Coronial Brief (**CB**), Statement of Magnolia Moreno.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Section 4(1), 4(2)(c) of the Act

prescribed class of person" due to her status as an *"SDA resident residing in an SDA enrolled dwelling."*[8]

7. 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.

8. 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.

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

10. This finding draws on the totality of the coronial investigation into the death of BCA, 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.[9]

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

Circumstances in which the death occurred

11. On 31 August 2023, BCA tested positive for COVID-19 and commenced a seven-day quarantine. In a statement provided by Ms Magnolia Moreno, Aruma Manager of Shared Living, it was noted that BCA was symptomatic, though *"remained stable"* and was being supervised by General Practitioner (**GP**), Dr Immi Jayawardena, who administered her antibiotics.[10]

[8] Pursuant to Reg 7(1)(d) of the *Coroners Regulations 2019*, a *"prescribed person or a prescribed class of person"* includes a person in Victoria who is an *"SDA resident residing in an SDA enrolled dwelling",* as defined in Reg 5.

[9] 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.

[10] CB, Statement of Magnolia Moreno.

12. On 7 September 2023, BCA remained unwell and continued to test positive for COVID-19. She reported to her external nurse that she felt *"drowsy and had a low appetite"*. At approximately 9:00 am the nurse called for a non-urgent ambulance.[11]

13. BCA was relayed to the Royal Melbourne Hospital and was assessed as having a decreased appetite, increased lethargy, and shortness of breath. A computed tomography (**CT**) scan revealed a kidney stone in the right uterovesical junction, the narrowest part of the ureter, causing hydronephrosis, an accumulation of urine in the kidneys. Medical practitioners diagnosed BCA with *"COVID pneumonitis and pre-renal oligoanuric renal failure"*. Oligoanuria refers to a condition of low urine output, consistent with BCA's blocked ureter.[12]

14. Treating medical practitioners commenced BCA on a course of intravenous antibiotics and dexamethasone. Practitioners liaised with the urology team and determined that owing to BCA's poor health, she was not a suitable candidate for surgery. Hospital staff met with BCA's sisters, QMV and FTD, who relayed her wishes against medical intervention in preference for comfort care. It was determined to transfer BCA to palliative care once she returned a negative COVID-19 test result.[13]

15. On 14 September 2023, BCA was transferred to the palliative ward and died peacefully on 16 September 2023.[14]

Identity of the deceased

16. On 20 September 2023, BCA, born 2 August 1963, was visually identified by her sister, QMV.[15]

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

Medical cause of death

18. Forensic Pathologist Dr Yeliena Baber (**Dr Baber**) from the Victorian Institute of Forensic Medicine conducted an external examination on 22 September 2023 and provided a written report of her findings dated 25 September 2023.[16]

[11] Ibid.
[12] Court File (**CF**), Medical Records of The Royal Melbourne Hospital.
[13] Ibid.
[14] CB, Statement of Magnolia Moreno, CF, e-Medical Deposition completed by Dr Marcus Choi.
[15] CF, Statement of Identification dated 20 September 2023.
[16] CF, Medical Examiner's Report of Dr Yeliena Baber dated 25 September 2023.

19. The post-mortem CT scan revealed cerebral atrophy, coronary artery calcifications, possible bilateral lower lobe pneumonias, streaking around the right kidney with mild hydronephrosis and an irregular mass with focal calcifications on the left kidney, as is consistent with medical records.[17]

20. Due to the extended hospital admission, there were no suitable ante-mortem nor post-mortem samples for toxicological analysis.

21. Dr Baber provided an opinion that the medical cause of death was 1(a) Complications of urinary tract disease in the setting of covid pneumonitis on the background of (2) a previous stroke, hypertension and diabetes mellitus.[18] Dr Baber considered the death was due to natural causes.

22. I accept Dr Baber's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was BCA, born 2 August 1963;

    b) the death occurred on 16 September 2023 Royal Melbourne Hospital 300 Grattan Street, Parkville, Victoria 3052, from natural causes, namely, complications of urinary tract disease in the setting of covid pneumonitis on the background of a medical history of stroke, hypertension and diabetes mellitus; and,

    c) the death occurred in the circumstances described above.

24. I note that section 52 of the Act requires that an inquest be held, except in circumstances where the death was due to natural causes. I am satisfied that BCA died from natural causes, and I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into the death.

I convey my sincere condolences to BCA'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.

[17] Ibid.
[18] Ibid.

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

QMV, Senior Next of Kin

The Royal Melbourne Hospital

Senior Constable Christopher Andrews, Coroner's Investigator

Signature:

Coroner Kate Despot

Date: 12 December 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.