IN THE CORONERS COURT OF VICTORIA AT MELBOURNE	**COR 2023 005934**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Gretchen Heidi Anastasia Van Lunenburg
Date of birth:	14 September 1978
Date of death:	24 October 2023
Cause of death:	1(a) COVID pneumonia complicated by severe electrolyte abnormalities
Place of death:	Eastern Health Wantirna Hospital, 251 Mountain Highway, Wantirna Victoria 3152
Keywords:	In care, natural causes death, COVID pneumonia, palliative care

INTRODUCTION

1. On 24 October 2023, Gretchen Heidi Anastasia Van Lunenburg **(Gretchen)** was 45 years old when she died at Wantirna Hospital.

2. At the time of her death, Gretchen resided in a supported disability accommodation facility managed by Life Without Barriers in Doncaster East. Her medical history included cerebral palsy, Smith-Lemli-Opitz syndrome, scoliosis and HER 2 positive breast cancer. Gretchen was also legally blind. She received funding from the National Disability Insurance Scheme **(NDIS)**.

THE CORONIAL INVESTIGATION

3. Gretchen'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.

4. The death of a person in care or custody as defined in Section 3(1) of the Act is a mandatory report to the Coroner, even if the death appears to have been from natural causes. In October 2022, the definition of what constitutes a person to be 'in care or custody' was amended by the Coroners Regulations 2019 to include *'a person in Victoria who is an SDA resident residing in an SDA enrolled dwelling.'*[1] As a result of this amendment, Gretchen was considered to be 'in care.'

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. This finding draws on the totality of the coronial investigation into the death of Gretchen Heidi Anastasia Van Lunenburg including the medical evidence provided to the Court. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or

[1] Sub-regulation 7(1)(d)

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 19 September 2023, Gretchen was admitted to the oncology department at Box Hill Hospital with a febrile illness with no localising symptoms. She was found to be influenza PCR positive, and a chest x-ray revealed peribronchial thickening in the right lower zone. She was commenced on medications and monitored over the next few days. Following improved oral intake and resolution of her febrile episode, she was discharged back to her supported living accommodation on 24 September 2023.

8. On 28 September 2023, Gretchen was subsequently re-admitted to Box Hill Hospital following a change in her cognitive state. She was reported by her carer to be increasingly drowsy, less responsive and with poor oral intake. Blood investigations revealed hyperlactaemia, hypokalaemia and hypernatraemia. The treating team considered that Gretchen likely had electrolyte disturbance in the setting of poor oral intake after recent infection. A clear infective source could not be identified.

9. Between 1 October to 3 October 2023, there was difficulty in effectively monitoring Gretchen's electrolytes due to difficult venous access, and a decision was made for a PICC line to be inserted. However, there were difficulties gaining IV access due to Gretchen's contractures and the impression from the anaesthetic registrar was that Gretchen would likely require general anaesthetic or sedation to obtain adequate access. This was not considered appropriate or safe in the circumstances. Consequently, the treating team decided that as Gretchen's oral intake improved and she was not in distress, that further invasive replacement of and monitoring of electrolytes was not in her best interests. She was subsequently discharged back to her supported accommodation facility.

10. On 10 October 2023, Gretchen was re-admitted to Box Hill Hospital as a result of reduced oral intake and lack of urine output. Blood test results revealed hypernatremia, hypokalaemia, and metabolic alkalosis. She also tested positive for COVID-19. The treating team again noted

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[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.

that it was very difficult to obtain regular bloods and that without this, appropriate electrolyte replacement could not be done.

11. Over the following days, Gretchen continued to have persistent and severe electrolyte disturbance and poor oral intake in the setting of a likely delirium caused by ongoing infection. A decision was made to transition her to palliative care and on 18 October 2023, she was admitted to the Wantirna Health Palliative Care Unit.

12. Gretchen subsequently passed away on 24 October 2023 in the presence of her support worker.

Identity of the deceased

13. On 24 October 2023, Gretchen Heidi Anastasia Van Lunenburg, born 14 September 1978, was visually identified by her support worker, Malvinder Malhi.

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

Medical cause of death

15. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an external examination on 25 October 2023 and provided a written report of his findings dated 1 November 2023.

16. The post-mortem CT scan revealed increased peribronchial markings in the left lung, atrophic brain - calcification basal ganglia, left kidney nodule HU ~70. The external examination was otherwise unremarkable.

17. Dr Burke provided an opinion that the medical cause of death was *1(a) COVID pneumonia complicated by severe electrolyte abnormalities.* It was further noted by Dr Burke that there was no evidence to suggest that Gretchen's death was due to anything other than natural causes.

18. I accept Dr Burke's opinion.

FINDINGS

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

    a) the identity of the deceased was Gretchen Heidi Anastasia Van Lunenburg, born 14 September 1978;

b) her death occurred on 24 October 2023 at Wantirna Hospital, 241 Mountain Highway Wantirna, 3152 Victoria from natural causes, namely COVID pneumonia complicated by severe electrolyte abnormalities; and

c) her death occurred in the circumstances described above.

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

The Proper Officer, State Trustees Victoria

Life Without Barriers

Dr Yvette Kozielski, Medico-Legal Officer Eastern Health

The Proper Officer, National Disability Insurance Agency

Leading Senior Constable James Rushton, Coroner's Investigator

Signature:

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Coroner Kate Despot

Date : 09 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.