IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 000237

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Yvonne Eddolls
Date of birth:	27 August 1955
Date of death:	12 January 2024
Cause of death:	1(a) Sepsis (palliated) <u>Contributing factor(s)</u> 2 Decubitus ulcers, reduced oral intake, intellectual disability and hypernatraemia
Place of death:	Eastern Health Wantirna Hospital 251 Mountain Highway Wantirna Victoria 3152
Keywords:	In care death; natural causes; sepsis

INTRODUCTION

1. On 12 January 2024, Yvonne Eddolls was 68 years old when she passed away in the Wantirna Health Supportive and Palliative Care Unit at Eastern Health Wantirna. At the time of her death, Ms Eddolls lived in specialist disability accommodation (**SDA**) in Kew, Victoria and received supported independent living services (**SIL**) from Scope.

2. Ms Eddolls moved from a Lysterfield SDA to her SDA in Kew two months prior to her passing. She had a complex medical history which included schizophrenia, bipolar affective disorder, Parkinson's disease, autism, intellectual disability (with a background of cerebral ischemia), mild hypercalcaemia secondary to hyperparathyroidism, and suspected nephrogenic diabetes insipidus. Ms Eddolls was wheelchair bound and had trouble communicating when in pain. She was entirely dependent on assistance for everyday tasks and required a vitamised diet to reduce the risk of aspiration pneumonia.

3. On 2 June 2022 the Victorian Civil and Administrative Tribunal (**VCAT**) appointed the Office of the Public Advocate (**OPA**) as Ms Eddolls' guardian concerning decisions around accommodation and access to services. On 7 July 2023 a second guardianship order was made relating to decision making for Ms Eddoll' medical treatment.

THE CORONIAL INVESTIGATION

4. Ms Eddolls' death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).[1] 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. Ms Eddolls 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 prescribed class of person*" due to her status as an "*SDA resident residing in an SDA enrolled dwelling*".[2]

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The circumstances are limited to events which are sufficiently proximate and causally related to

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[1] Section 4(1), (2)(c) of the Act.

[2] 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. I have received information that Ms Eddolls resided at an address where the residents meet these criteria.

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 an officer to be the Coronial Investigator for the investigation of Ms Eddolls' death. The Coronial Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Yvonne Eddolls 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.[3]

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

Circumstances in which the death occurred

9. On 24 November 2023, Ms Eddolls attended an appointment with a new general practitioner (**GP**), Dr Hiran Edirisinghe from Guardian Medical in Hawthorn. Previously, she had been under the care of Dr Suyama Jayawardena at Rowville Health when living at her Lysterfield SDA. Dr Edirisinghe only received Ms Eddolls' detailed medical history on 15 December 2023 (three days after her passing), however, was aware of her health conditions and noted evidence of an early pressure area on her buttocks in their first consultation.

10. On 27 November 2023, Dr Edirisinghe reviewed Ms Eddolls and advised Scope staff to prevent worsening pressure areas, and to moisturise daily for the pressure sore on her buttocks.

11. On 5 December 2023, Ms Eddolls' occupational therapist attended her SDA for assessment of her equipment, noting the circumstances of her pressure sores and areas of concern.

[3] 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.

12. On 12 December 2023, Ms Eddolls was transported to Box Hill Hospital by ambulance as she was experiencing reduced consciousness, fever, hypotension and signs of sepsis. Testing revealed that Ms Eddolls had sacral and bilateral heel pressure ulcers and left heel methicillin-susceptible staphylococcus aureus (**MSSA**) osteomyelitis.[4] She remained in hospital for treatment, but began to deteriorate with an acute kidney injury, persistent hypernatremia secondary to diabetes insipidus and dehydration.

13. By 26 December 2023, Ms Eddolls' malnutrition was becoming progressively worse given her refusal to open her mouth for food, drink and medications. Pressure sores on her heels, toes, elbows and buttocks area were severe and being dressed each day by nursing staff. All this information was communicated to Scope staff who continued to visit the hospital to see her.

14. From 27 December 2023, discussions were held with Ms Eddolls' treating medical team and appointed guardian, Ms Maree Ryan from the OPA, regarding her best interests, prognosis and goals of care.

15. Scope staff were informed that there was no short-term plan for discharge of Ms Eddolls back to the SDA as she needed to be repositioned every two hours due to her pressure sores.

16. On 5 January 2024, treating doctors recommended palliative care, which was discussed with Ms Ryan. Ms Eddolls was placed on a wait list.

17. At 10.00am on 10 January 2024, Ms Eddolls was transferred to Wantirna Palliative Care at Eastern Health Hospital. She died two days later.

Identity of the deceased

18. On 24 January 2024, Yvonne Eddolls, born 27 August 1955, was visually identified by her carer, Lukas Lobb.

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

[4] Osteomyelitis is an inflammatory bone infection, caused when bacteria reaches the bones through the bloodstream or nearby infected tissue.

Medical cause of death

20. Forensic Pathologist Dr Hans De Boer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an post-mortem examination on 15 January 2024 and provided a written report of his findings dated 23 January 2024.

21. The post-mortem examination revealed partially desiccated pressure injuries on both heels and the sacral region, consistent with the reported circumstances.

22. Dr De Boer provided an opinion that the medical cause of death was "*1(a) sepsis (palliated)*" with "*2 decubitus ulcers, reduced oral intake, intellectual disability and hypernatraemia"* as contributing factors. He opined that the death was due to natural causes.

23. I accept Dr De Boer's opinion.[5]

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Yvonne Eddolls, born 27 August 1955;

    b) the death occurred on 12 January 2024 at Eastern Health Wantirna Hospital, 251 Mountain Highway, Wantirna Victoria 3152 from sepsis (palliated) with decubitus ulcers, reduced oral intake, intellectual disability, hypernatraemia as contributing factors; and

    c) the death occurred in the circumstances described above.

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:

Naomi Baquing, Scope (Aust) Ltd

Dr Yvette Kozielski, Eastern Health

Ms Maree Ryan, Office of the Public Advocate

[5] Pursuant to s 52(3A) of the Act, a coroner is not required to hold an inquest where the deceased was, immediately before death, a person placed in custody or care, if the coroner considers that the death was due to natural causes.

First Constable Daniel Smith, Coronial Investigator

Signature:

Coroner Catherine Fitzgerald

Date: 17 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.