IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 000568

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Gayle Dianne Ireland
Date of birth:	04 August 1960
Date of death:	30 January 2024
Cause of death:	1(a) SEPSIS WITH MULTIORGAN FAILURE IN THE SETTING OF LIMB CELLULITIS COMPLICATING A LEG LACERATION 1(b) 1(c) 2 WHO CLASS III OBESITY, CHRONIC LUNG DISEASE, OBSTRUCTIVE SLEEP APNOEA, HEMIPARESIS DUE TO CEREBROVASCULAR DISEASE
Place of death:	Barwon Health Bellerine Street Geelong Victoria 3220

INTRODUCTION

1. On 30 January 2024, Gayle Dianne Ireland was 63 years old when she died at Geelong Hospital (Barwon Health). At the time of her death, Gayle lived at Apartment 106, Level 1, 44 Ryrie Street, Geelong.

2. The National Disability Insurance Service (NDIS) had provided a Care Package for Gayle and the Care package included funding of her SDA accommodation at Apartment 106, Level 1, 44 Ryrie Street, Geelong.

3. Gayle had a Cerebrovascular accident in 2015 which left her with right sided weakness. She had a complex medical history but was capable of living semi independently with support.

4. The National Disability Insurance Agency (NDIA) had approved the most recent NDIS Care plan for Gayle and the plan was approved to commence from 13 September 2023 to 12 September 2024.

5. In her NDIS plan Gayle stated:

   That she had recently moved out of aged care with her cat Pipah and was enjoying having more independence and that she liked living in the Geelong area as this was familiar to her. She enjoyed spending time socialising with people being outside in the garden and doing arts and crafts.

THE CORONIAL INVESTIGATION

6. Gayle'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. [1]

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

[1] See the definition of *"reportable death*" in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of *"person placed in custody or care"* in section 3 of the Act.

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 Gayle's death. The Coroner's Investigator conducted inquiries on my behalf. I have also obtained the report from the forensic pathologist and treating clinicians. I am satisfied that I have sufficient information to enable me to finalise this investigation.

10. This finding draws on the totality of the coronial investigation into Gayle's death. 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.[2]

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

Circumstances in which the death occurred

11. Gayle sustained a 4cm laceration on her right shin understood to have been sustained after an accident with her motorised wheelchair at her supported accommodation. She had been attempting to use her chair to reach an item on the top shelf in her kitchen when her leg became wedged between the wheelchair and 'island' bench. Gayle was initially transferred to the Barwon Health Emergency Department (ED) on 20 of January 2024 for treatment of this wound. The wound was assessed and treated and she was discharged and advised to consult her general practitioner in one week.

12. Gayle returned to the ED on 24 January 2024. On arrival in ED she was hypoxic and hypotensive and treated with intravenous fluids and empirical antibiotics Ceftriaxone and Azithromycin for a presumed chest source of infection. She was transferred to the Intensive

[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.

Care Unit with a diagnosis of hypoxia and hypotension, presumed secondary to sepsis from a wound on her leg.

13. Gayles condition continued to deteriorate over the next five days due to the infection and her other comorbidities. Consistent with Gayle's advanced care plan a decision was made to palliate her and sadly she died on 30 January 2024.

Identity of the deceased

14. On 30 January 2024, Gayle Dianne Ireland, born 04 August 1960, was visually identified by her son Justin Leigh Ireland.

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

Medical cause of death

16. Dr Joanna Glengarry Forensic Pathologist from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 1 February 2024 and provided a written report of her findings dated 2 February 2024

17. Dr Glengarry provided an opinion that the medical cause of death was

1 (a) Sepsis with multiorgan failure in the setting of limb cellulitis complicating a leg laceration.

Contributing Factors

WHO Class III obesity, chronic lung disease obstructive sleep apnoea, hemiparesis due to cerebrovascular disease

18. I accept Dr Glengarry's opinion.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Gayle Dianne Ireland, born 04 August 1960;

b) the death occurred on 30 January 2024 at Barwon Health. Bellerine Street Geelong Victoria 3220, from Sepsis with multiorgan failure in the setting of limb cellulitis complicating a leg laceration; and

c) the death occurred in the circumstances described above.

20. I extend my sincere condolences to Gayle's family

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.

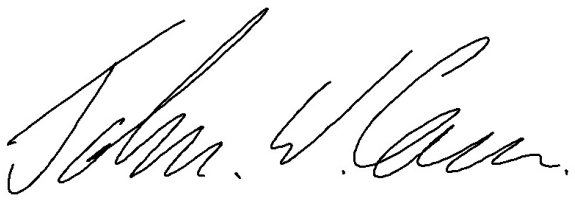
I direct that a copy of this finding be provided to the following:

Justin Leigh Ireland, Senior Next of Kin

Barwon Health

Coroner's Investigator, Senior Constable Vicki McLean

Signature:



Judge John Cain
State Coroner
Date: 14 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.