IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 000935

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Janelle Maree Lavery
Date of birth:	21 April 1967
Date of death:	16 February 2024
Cause of death:	1(a) Complications of Angelman's syndrome - aspiration pneumonia 2 Intellectual disability, epilepsy, cerebral palsy, dysphagia, chronic hypercapnia in context of severe kyphoscoliosis
Place of death:	Wantirna Hospital 251 Mountain Highway Wantirna Victoria 3152
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 16 February 2024, Janelle Maree Lavery was 56 years old when she died following a one-month long hospital admission due to ongoing medical conditions. She is fondly remembered as a *'gregarious'* person who was *'regularly laughing'.*

2. Janelle was born to parents Norman and Mary Lavery and had multiple medical diagnoses from birth, including Angelman's syndrome (a neurodevelopmental disorder), cerebral palsy, epilepsy and a severe intellectual disability. At three or four years of age, in 1970, Norman and Mary separated, and Janelle was placed into the care of the state.

3. At the time of her death, Janelle was a recipient of the National Disability Insurance Scheme (**NDIS**). She received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by Life Without Barriers in Mont Albert North. Janelle had minimal contact with her family, particularly after her mother's death in 2016. However, she enjoyed spending time with fellow residents and watching television.

4. In the final years of her life, Janelle's health condition significantly deteriorated. She was frequently admitted to hospital due to seizures and episodes of aspiration, hypoxia and hypercapnia. Her most recent hospital admission prior to her death occurred between 17 January and 11 February 2024 29 December 2023 and 16 January 2024 at Box Hill Hospital due to hypoxia and seizure activity.

THE CORONIAL INVESTIGATION

5. Janelle's death fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as she was a 'person placed in custody or care' within the meaning of the Act, as a person in Victoria who was an 'SDA resident residing in an SDA enrolled dwelling' immediately prior to her death. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort, and is reflected in the definition of a '*person placed in custody or care*' in section 3(1) of the Act, read in conjunction with Regulation 7 of the *Coroners Regulations 2019*.

[1] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Janelle's death, is a permanent dwelling that provides long-term accommodation for one or more SDA residents, that is enrolled as an SDA dwelling under relevant NDIS (Specialist Disability Accommodation) Rules in force at the relevant time. An SDA resident means a person who is a NDIS participant funded to reside in an SDA enrolled dwelling, or who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program). .

6. 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.

7. 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.

8. There is a requirement under section 52(2)(b) of the Act to hold an Inquest into the death of a person who was in custody or care immediately prior to passing, though pursuant to section 52(3A) of the Act, the coroner is not required to hold an Inquest if the coroner considers the death was due to natural causes. I exercise my discretion under this provision not to hold an Inquest in the present case on the basis that Janelle's passing was due to natural causes and there are no further issues I have identified that require the hearing of *viva voce* evidence.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Janelle'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 Janelle Maree Lavery 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.[2]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

11. On 17 January 2024, the day after being discharged from Box Hill Hospital, Janelle returned to the emergency department after two episodes of vomiting, with oxygen desaturation and

[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.

periods of unconsciousness. A chest x-ray demonstrated left basal atelectasis – collapsing of the left lower lung – and she was treated for aspiration pneumonia.

12. Over the following days, Janelle's Glasgow Coma Scale (**GCS**)[3] fluctuated with episodes of apnoea and hypercapnia, leading to a Medical Emergency Team (**MET**) call. Her medication was updated and she eventually stabilised.

13. Medical practitioners made plans for Janelle to be discharged, however on 22 January 2024, her condition worsened, and she developed fever. Her condition continued to decline over the ensuing days including becoming hypoxic and hypernatremic, and a further MET call was initiated due to physiological instability.

14. On 9 February 2024, Janelle had a further significant aspiration event. Due to complications of her medical diagnoses, her aspiration events were becoming increasingly frequent and unpreventable. Medical practitioners sought input from the palliative care team, and discussed Janelle's condition with her support workers. It was determined to transition her to a comfort pathway.

15. On 11 February 2024, Janelle was transferred to the Palliative Care Unit of Wantirna Health and on 16 February 2024, she passed away.

IDENTITY OF THE DECEASED

16. On 22 February 2024, Janelle Maree Lavery, born 21 April 1967, was visually identified by her support worker, Mafutaga Tomuli, who completed a Statement of Identification to this effect.

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

MEDICAL CAUSE OF DEATH

18. Forensic Pathologist Dr Brian Beer (**Dr Beer**) from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on the body of Janelle Lavery on 19 February 2024. Dr Beer considered the e-Medical Deposition Form, the post-mortem computed tomography (**CT**) scan, and Victoria Police Report of Death for the Coroner (**Form 83**) and provided a written report of his findings dated 7 March 2024.

[3] The Glasgow Coma Scale is a clinical scale used to reliably measure a person's level of consciousness after a brain injury.

19. The post-mortem examination showed findings in keeping with the clinical history and recent hospitalisation, The post-mortem CT demonstrated marked scoliosis, increased lower love lung markings consistent with aspiration changes.

20. Dr Beer provided an opinion that the medical cause of death was 1 (a) *complications of Angelman's syndrome - aspiration pneumonia*. He opined that the death was due to natural causes.

21. I accept Dr Beer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Janelle Maree Lavery, born 21 April 1967;

    b) the death occurred on 16 February 2024 at Wantirna Hospital 251 Mountain Highway, Wantirna Victoria 3152, from complications of Angelman's syndrome – aspiration pneumonia in the setting of intellectual disability, epilepsy, cerebral palsy, dysphagia, chronic hypercapnia in context of severe kyphoscoliosis; and

    c) the death occurred in the circumstances described above.

23. Having considered all of the circumstances, I am satisfied that Janelle Maree Lavery's death occurred due to natural causes, in the setting of multiple comorbidities.

24. I find that the medical treatment provided by practitioners at Box Hill Hospital and Wantirna Palliative Care was appropriate in the context of an individual with extensive ill health, which significantly complicated her care.

25. The factual matrix of Janelle Maree Lavery's death does not support a conclusion that her being 'in care' at the time of her death – according to the Act – had a causal relationship with her death.

I convey my sincere condolences to those who loved and cared for Janelle for their loss.

ORDERS

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:

Norman Lavery, Senior Next of Kin

Suzanne Lavery

Life Without Barriers

Eastern Health

Senior Constable Scott Ripper

Signature:

Coroner Ingrid Giles

Date: 30 January 2025

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.