IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 001528

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Leesa Sandra Higgins
Date of birth:	22 April 1972
Date of death:	14 March 2024
Cause of death:	1(a) Complications of presumed gallbladder adenocarcinoma 2 Tuberous sclerosis, intellectual disability
Place of death:	University Hospital Bellerine Street Geelong Victoria
Keywords:	In care – natural causes

INTRODUCTION

1. On 14 March 2024, Leesa Sandra Higgins was 51 years old when she passed away at the University Hospital in Geelong. At the time of her death, Ms Higgins lived in a residential care facility in Colac managed by Scope Australia. Her medical history included tuberous sclerosis, epilepsy, gallbladder adenocarcinoma, hypercholesterolaemia, constipation and bilateral large angiomyolipomas. She also had an intellectual disability.

THE CORONIAL INVESTIGATION

2. Ms Higgins' 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. Ms Higgins was a person in care at the time of her death and she was a Specialist Disability Accommodation (**SDA**) resident living in an SDA dwelling pursuant to Regulation 7 of the *Coroners Regulations 2019*. However, an inquest was not required to be held pursuant to section 52(3A) of the Act given that Ms Higgins's death was from natural causes.

3. 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.

4. 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.

5. This finding draws on the totality of the coronial investigation into Ms Higgins' death, including information obtained from her health records and the National Disability Insurance Agency. While 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.[1]

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

Circumstances in which the death occurred

6. On 27 February 2024, Ms Higgins was admitted to the University Hospital with persistent fever and suspected intra-abdominal sepsis. A computed tomography (**CT**) scan revealed a retroperitoneal lymphadenopathy and a large centrally hypodense mass thought to be a recurrence of gallbladder adenocarcinoma. In consultation with her family, Ms Higgins was assessed by clinicians as not being an appropriate candidate for further treatment and she was transitioned to comfort care. She passed away on 14 March 2024.

Identity of the deceased

7. On 15 March 2024, Leesa Sandra Higgins, born 22 April 1972, was visually identified by her father, Robert Leonard Higgins.

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

Medical cause of death

9. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine, conducted an examination on 18 March 2024 and provided a written report of her findings dated 21 March 2024.

10. There was no evidence of any injuries found which may have caused or contributed to the death. Dr Ho expressed the opinion that the death was due to natural causes.

11. Dr Ho provided an opinion that the medical cause of death was: 1*(a) Complications of presumed gallbladder adenocarcinoma; 2 Tuberous sclerosis, intellectual disability*.

12. I accept Dr Ho's opinion.

[1] 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.

FINDINGS AND CONCLUSION

13. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Leesa Sandra Higgins, born 22 April 1972;

    b) the death occurred on 14 March 2024 at University Hospital, Bellerine Street, Geelong, Victoria from complications of presumed gallbladder adenocarcinoma with tuberous sclerosis and intellectual disability as contributing factors; and

    c) the death occurred in the circumstances described above.

14. As noted above, Ms Higgins's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before her death, she was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Ms Higgins died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an inquest into her death.

I convey my sincere condolences to Ms Higgins'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.

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

Robert and Sandra Higgins, Senior Next of Kin

Barwon Health

Scope (Aust) Ltd

National Disability Insurance Agency

Senior Constable Melissa Varker, Coronial Investigator

Signature:

Coroner David Ryan

Date : 14 November 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.