IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 001844

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Karen Lisa Heysham
Date of birth:	12 August 1967
Date of death:	1 April 2024
Cause of death:	1(a) End stage Alzheimer's disease 1(b) Down syndrome
Place of death:	42 Screen Street Frankston Victoria
Keywords:	In care - disability services - natural causes

INTRODUCTION

1. On 1 April 2024, Karen Lisa Heysham was 56 years old when she passed away her home. At the time of her death, Ms Heysham lived in Supported Disability Accommodation (**SDA**) in Frankston managed by Scope Australia, from whom she received National Disability Insurance Scheme (**NDIS**) funded and regulated support. She is survived by her siblings Tess, Jenny and Roy

2. Ms Heysham's medical history included Alzheimer's disease, Down syndrome, depression and anxiety.

THE CORONIAL INVESTIGATION

3. Ma Heysham's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Ms Heysham's death was reportable as she was a person placed *"in care"* under s4(2)(c) of the Act.[1] This category of deaths is reportable to ensure independent scrutiny of the circumstances given the vulnerability of the deceased and the level of power and control exercised by those who care for them. If such deaths occur as a result of natural causes, a coronial investigation must take place, but the holding of an inquest is not mandatory.

4. 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.

5. 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.

[1] She was an SDA resident residing in an SDA enrolled dwelling before the time of her death: Reg 7(1)(d), *Coroners Regulations 2019.*

6. This finding draws on the totality of the coronial investigation into Ms Heysham's death including evidence contained in the coronial brief. 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.[2]

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

Circumstances in which the death occurred

7. On 12 March 2024, Ms Heysham was admitted to Frankston hospital after experiencing a significant functional decline over the previous months. Before her decline she had been able to mobilise with a four-wheel walker but had recently been bedbound and non-verbal.

8. On 22 March 2024, Ms Heysham was discharged back to her residential care facility where, in consultation with her family, she received palliative care. Her condition continued to deteriorate she transitioned to end-of-life care on 28 March 2024. She passed away on 1 April 2024.

Identity of the deceased

9. On 1 April 2024, Karen Lisa Heysham, born 12 August 1967, was visually identified by their carer, Natasha Jones.

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

Medical cause of death

11. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an examination on 3 April 2024 and provided a written report of his findings dated 8 April 2024.

12. The CT scan showed increased lung markings consistent with pneumonia and atrophic brain. Dr Burke expressed the opinion that the death was due to natural causes.

[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.

13. Dr Burke provided an opinion that the medical cause of death *was 1 (a) End stage Alzheimer's disease; 1(b) Down syndrome*.

14. I accept Dr Burke's opinion.

CONCLUSION

15. Having carefully considered the available evidence, I am satisfied that the care Ms Heysham received in the period proximate to her death was reasonable and appropriate.

16. As noted above, Ms Heysham'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 Heysham 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.

FINDINGS

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

    a) the identity of the deceased was Karen Lisa Heysham, born 12 August 1967;

    b) the death occurred on 1 April 2024 at 42 Screen Street, Frankston, Victoria, from end stage Alzheimer's disease and Down syndrome; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Ms Heysham'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:

Tess McMurray, Senior Next of Kin

Peninsula Health

Senior Constable Robyn Murton, Coronial Investigator

Signature:

Coroner David Ryan

Date : 01 October 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.