IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004227

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:	Donna Michelle Corlett
Date of birth:	08 July 1971
Date of death:	23 July 2024
Cause of death:	1(a) ASPIRATION PNEUMONIA COMPLICATING CEREBRAL PALSY
Place of death:	Box Hill Hospital 8 Arnold Street Box Hill Victoria 3128

INTRODUCTION

1. On 23 July 2024, Donna Michelle Corlett was 53 years old when she passed away at the Box Hill Hospital, 8 Arnold St Box Hill. At the time, Donna was a resident at Yooralla's shared accommodation facility at 8 Leach Ave, Box Hill where she had been a resident since 25 June 2010.

2. Donna was diagnosed with cerebral palsy and intellectual disability and was non-verbal. Donna used gestures to communicate 'yes' or 'no' answers and a communication board. Donna required a wheelchair to mobilise and could operate the wheelchair independently for most of her life, however, due to her increasing dystonia and involuntary muscle movements, she relied on staff at Yooralla to assist her in the later part of her life.

3. The supports provided by disability support staff at Yooralla included:

    a) full assistance with transfers via hoist;

    b) full assistance with hygiene, toileting and personal care supports;

    c) full support with feeding and food preparation;

    d) support with communication[1]

4. The National Disability Insurance Agency (NDIA) had approved the most recent NDIS Care plan for Donna and the plan was approved and commenced on 13 December 2022.

5. Donna enjoyed time with family, loved music particularly 'Boy Bands'. She also enjoyed outdoor activities, and the Melbourne Marathon was an important annual event for Donna.

THE CORONIAL INVESTIGATION

6. Donna'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] Statement of Fleur Redshaw

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 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. This finding draws on the totality of the coronial investigation into the death of Donna. 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

10. In or around October 2023, Donna's physical health started to decline, she experienced worsening motor coordination, decrease in her ability to speak and stiffening of her muscles. Donna also experienced changes in her behaviour and she would often have outbursts which were out of character.
11. On 18 October 2023, Donna was reviewed by the Eastern Health surgical team for her bowel related issues. The team determined that Donna was not a candidate for surgery. The team also suggested for Donna to start a palliative care pathway for symptom management.

12. After consultation with family, Donna commenced palliative care which was managed by Eastern Palliative Care (EPC). On 18 July 2024 Donna was reviewed by EPC team who determined Donna was in a terminal state. They recommended that Donna should be actively palliated.
13. On 19 July 2024, Donna deteriorated further, she was unable to eat, her conscious state had diminished, and she was showing signs of laboured breathing.

[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.

14. The EPC were contacted, and they advised staff to call paramedics to transfer Donna to hospital for palliative care management. This transfer occurred on 19 July 2024

15. On 23 July 2024 Donna passed away at the Box Hill Hospital.

Identity of the deceased

16. On 23 July 2024, Donna Michelle Corlett, born 08 July 1971, was visually identified by her sister , Tanya Hope Corlett.

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

Medical cause of death

18. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 25 July 2024 and provided a written report of his findings dated 30 July 2024

19. Dr Bourke provided an opinion that the medical cause of death was 1 (a) ASPIRATION PNEUMONIA COMPLICATING CEREBRAL PALSY.

20. I accept Dr Burke's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Donna Michelle Corlett, born 08 July 1971;

    b) the death occurred on 23 July 2024 at Box Hill Hospital, 8 Arnold Street Box Hill Victoria 3128, from ASPIRATION PNEUMONIA COMPLICATING CEREBRAL PALSY; and

    the death occurred in the circumstances described above.

22. The available evidence does not support a finding that there was any want of clinical management or care that caused or contributed to Donna's death.

23. I note that Ms Corlett's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before her death, he was a person placed in care. Section 52 of the Act requires an inquest to be held, except in circumstances where the death was due to natural causes. I am satisfied that Ms Corlett died from natural causes and that no further investigation is required.

Accordingly, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation of Ms Corlett's death on the papers.

I convey my sincere condolences to Donna's family for their loss.

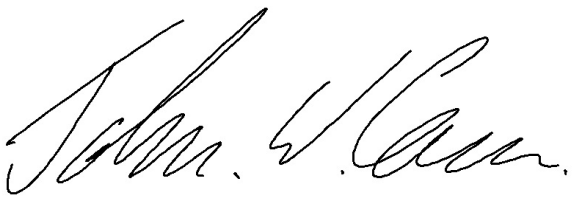
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Tharon Corlett, Senior Next of Kin

Coroner's Investigator

Signature:



Judge John Cain
State Coroner
Date: 8 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.