IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005033

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Narelle Gay Sanders
Date of birth:	21 December 1975
Date of death:	25 August 2024
Cause of death:	1(a) Pneumonia 2 Anaphylaxis (treated), cerebral palsy, epilepsy
Place of death:	Wimmera Base Hospital 83 Baillie Street Horsham Victoria
Keywords:	In care – natural causes

INTRODUCTION

1. On 25 August 2024, Narelle Gay Sanders was 48 years old when she passed away in hospital at Wimmera. At the time of her death, Ms Sanders lived in a disability residential care facility in Haven. Her medical history included cerebral palsy and epilepsy. She also had an intellectual disability.

THE CORONIAL INVESTIGATION

2. Ms Sanders' 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 Sanders 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 s52(3A) of the Act given that Ms Sanders' 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 Sanders' 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]

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[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

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

Circumstances in which the death occurred

6. On 16 August 2024, Ms Sanders was admitted to Wimmera Base Hospital with increasing shortness of breath and cough on a background of a recent hospital admission for severe pneumonia. She was administered azithromycin (which had been tolerated on a previous admission as she had a known allergy to penicillin). During the administration she developed an urticarial rash and hypotension. Ms Sanders was treated for anaphylaxis and transferred to the Intensive Care Unit where her condition continued to deteriorate with the development deranged liver function attributed to pneumonia and antibiotics. In consultation with family, she was transitioned to comfort care and passed away on 25 August 2024.

Identity of the deceased

7. On 26 August 2024, Narelle Gay Sanders, born 21 December 1975, was visually identified by her sister, Dianne Rudolph.

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

Medical cause of death

9. Dr Vianney Rajakarunanaike, a legally qualified medical practitioner and specialist pathology fellow from the Victorian Institute of Forensic Medicine, conducted an examination on 30 August 2024 and provided a written report of her findings dated 7 October 2024.

10. Dr Rajakarunanaike found no signs of injury.

11. Toxicological analysis of post-mortem samples identified the presence of a number of drugs consistent with recent treatment in hospital.

12. Dr Rajakarunanaike provided an opinion that the medical cause of death was *1(a) Pneumonia, 2 Anaphylaxis (treated), cerebral palsy, epilepsy*. Further, she expressed the opinion that the death was due to natural causes.

13. I accept Dr Rajakarunanaike's opinion.

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evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Narelle Gay Sanders, born 21 December 1975;

    b) the death occurred on 25 August 2024 at Wimmera Base Hospital, 83 Baille Street, Horsham, Victoria, from pneumonia with anaphylaxis (treated), cerebral palsy, and epilepsy as contributing factors; and

    c) the death occurred in the circumstances described above.

15. As noted above, Ms Sanders' 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 Sanders 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 Sanders' 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:

Dianne Rudolph, Senior Next of Kin

Wimmera Health Care Group

National Disability Insurance Agency

Constable Samual Salisbury, Coronial Investigator

Signature:

Coroner David Ryan

Date : 27 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.