| IN THE CORONERS COURT<br>OF VICTORIA<br>AT MELBOURNE | **COR 2024 005100** |
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**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

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| Findings of: | Coroner Kate Despot |
| Deceased: | Heather Joan Moody |
| Date of birth: | 18 July 1947 |
| Date of death: | 29 August 2024 |
| Cause of death: | 1a: PNEUMONIA<br>2: ACQUIRED BRAIN INJURY, PARKINSON'S DISEASE, EPILEPSY |
| Place of death: | Frankston Hospital, 2 Hastings Road Frankston Victoria 3199 |
| Keywords: | In care, SDA resident, pneumonia, acquired brain injury, Parkinson’s disease, epilepsy, natural causes death |

## INTRODUCTION

1. On 29 August 2024, Heather Joan Moody **(Ms Moody)** was 77 years old when she died at Frankston Hospital. She is survived by her sister, Ms Kaye Barter.

2. At the time of her death, Ms Moody was a Specialist Disability Accommodation **(SDA)** resident in an SDA enrolled dwelling at 5 Walkers Road, Carrum, 3197 Victoria. She had resided at this dwelling since 1998 and received Supported Independent Living services from Scope.

3. Ms Moody's medical history included an acquired brain injury, intellectual disability, dysphasia, epilepsy, Parkinson's disease, sleep apnoea, arthritis, and hypertension. She required 24-hour care and support for all daily living activities due these conditions.

4. Ms Moody participated in Scope's Social Connections Day Program where she attended group activities, learned new skills and made meaningful connections. In a statement from Lisa Evans, Chief Operating Officer of Scope, she noted that Ms Moody presented as well in the months leading up to her hospitalisation in August 2024. Scope staff reported that they had no concerns about her general health and demeanour.

5. On 6 July 2024, Ms Moody had a medical appointment for a swollen upper lip. A thorough check was conducted, and her breathing was assessed to be normal. She was prescribed short term Prednisolone tablets and there were no further concerns regarding this swelling.

## THE CORONIAL INVESTIGATION

6. Ms Moody's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**)[1]. 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.
7. In this instance, Ms Moody was a *"person placed in custody or care"* pursuant to the definition in section 4 of the Act, as she was *"a prescribed person or a person belonging to a*

[1] Section 4(1), 4(2)(c) of the Act.

*prescribed class of person"* due to her status as an *"SDA resident residing in an SDA enrolled dwelling."*[2]

8. 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.

9. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Ms Moody's death. The Coronial Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Heather Joan Moody 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.[3]

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

### Circumstances in which the death occurred

11. On 16 August 2024, Scope staff were providing Ms Moody with her bedtime medications when their concerns were prompted by her level of responsiveness.

12. Staff contacted emergency services.

13. Whilst waiting for an ambulance, staff noted that Ms Moody had difficulty breathing and her body movements indicated that she was experiencing a seizure.

14. Paramedics arrived and Ms Moody was transported to Frankston Hospital.

15. At Frankston Hospital, Ms Moody was admitted under the care of Consultant Neurologist Associate Professor Ernest Butler **(A/P Butler)** with breakthrough seizures and aspiration

[2] Pursuant to Reg 7(1)(d) of the Coroners Regulations 2019, a "prescribed person or a prescribed class of person" includes a person in Victoria who is an "SDA resident residing in an SDA enrolled dwelling", as defined in Reg 5.

[3] 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.

pneumonitis. There were also concerns about Ms Moody possibly having an upper gastrointestinal bleed. She was commenced on intravenous medications. As Ms Moody was considered a high anaesthetic risk, no gastroscopy could be performed.

16. On 18 August 2024, Ms Moody was reviewed by A/P Butler. She was found to have worsening of her right lung opacification. A/P Butler advised to continue with intravenous antibiotics. Ms Moody was also found to be positive for rhinovirus, which contributed to her poor respiratory function.

17. On 19 August 2024, Ms Moody developed more hypoxia and laboured respiration. The goals of care were decided to not perform cardiopulmonary resuscitation or give mechanical ventilation treatment. Ms Moody was commenced on high flow nasal oxygen.

18. On 19 August 2024, Ms Moody's family were advised that she continued to have seizures, and her respiratory function was also deteriorating. A/P Butler provided an opinion that ongoing care would likely prolong her suffering and Ms Moody's family agreed that she should be for palliative care.

19. On 21 August 2024, Ms Moody appeared to be somewhat stable, and her breathing was also better. She was once again provided with active treatment in the form of intravenous antibiotics and anti-epileptic therapy.

20. On 24 Aug 2024, Ms Moody again deteriorated and developed hypoxia. At review, she appeared to be agitated and breathless as well as in pain. Her deteriorating condition was once again discussed with her family, and she was re-commenced on palliative care.

21. Ms Moody passed away on 29 August 2024.

22. Ms Moody's family have indicated that they were very satisfied with the care provided to Ms Moody.

**Identity of the deceased**

23. On 29 August 2024, Heather Joan Moody, born 18 July 1947, was visually identified by Ms Hayley Watson, the manager of the SDA dwelling where Ms Moody resided.

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

## Medical cause of death

25. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine conducted an external examination on 2 September 2024 and provided a written report of his findings dated 4 September 2024.

26. The post-mortem examination and full body post-mortem CT scan were consistent with the reported circumstances. There was no evidence of substantial trauma.

27. Dr de Boer provided an opinion that the medical cause of death was *1(a) Pneumonia, 2) Acquired brain injury, Parkinson's Disease, Epilepsy.* Dr de Boer considered that the death was due to natural causes.

28. I accept Dr de Boer's opinion.

## FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Heather Joan Moody, born 18 July 1947;

    b) her death occurred on 29 August 2024 at Frankston Hospital, 2 Hastings Road Frankston Victoria 3199, from pneumonia with contributing factors of acquired brain injury, Parkinson's disease and epilepsy; and

    c) her death occurred in the circumstances described above.

30. Having considered all the circumstances, I am satisfied that Ms Moody's death was due to natural causes.

I convey my sincere condolences to Ms Moody's family, carers and loved ones 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:

**Kaye Barter, Senior Next of Kin**

**Kathleen Jansen, Peninsula Health**

**Naomi Baquing, Scope Australia**

**Senior Constable Robyn Murton, Coronial Investigator**

Signature:

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Coroner Kate Despot

Date: 07 March 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.