IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005889

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Anne-Maree Tammy Carr
Date of birth:	10 May 1980
Date of death:	6 October 2024
Cause of death:	1(a): COVID-19
Place of death:	Maryborough District Health Service 75/87 Clarendon Street Maryborough Victoria 3465
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, natural death, COVID pneumonia

INTRODUCTION

1. On 6 October 2024, Ms Anne-Maree Tammy Carr was 44 years old when she died at Maryborough Hospital.

2. Prior to entering Hospital, Ms Carr lived in Specialist Disability Accommodation (**SDA**)[1] with 5 other residents and a pet cat called Socks. Ms Carr's accommodation was funded through her National Disability Insurance Scheme (**NDIS**) plan.

3. Ms Carr received these supports due to her medical history which included intellectual disability, cerebral palsy, high cholesterol and type 2 diabetes mellitus.

THE CORONIAL INVESTIGATION

4. Ms Carr's death was reported to the Coroner as she was a 'person placed in … care' within the meaning of section 4 of the *Coroners Act 2008* (**the Act**).

5. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The Coroner is therefore required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

6. The role of the 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

[1] SDA enrolled dwelling is defined under the Residential Tenancies Act 1997 (Vic). The definition, as applicable at the time of Ms Carr's death, is a permanent dwelling that provides long-term accommodation for one or more SDA residents, that is enrolled as an SDA dwelling under relevant NDIS (Specialist Disability Accommodation) Rules in force at the relevant time. An SDA resident means a person who is an NDIS participant funded to reside in an SDA enrolled dwelling, or who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program). The definition of SDA resident was amended on 1 July 2024 pursuant to the Disability and Social Services Regulation Amendment Act 2023 to extend to include persons who are residing, or propose to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement.

the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. This finding draws on the totality of the coronial investigation into the death of Ms Carr included information from the National Disability Insurance Agency (**NDIA**), the Medical Certificate Case of Death (**MCCD**) completed by Ms Carr's General Practitioner, Dr Daniel de Villiers. 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

8. On 2 October 2024, Ms Carr was admitted to the Maryborough Hospital with COVID-19.

9. Following her admission, Ms Carr slowly deteriorated.

10. On 5 October 2024 Ms Carr developed respiratory failure and after a discussion with family, Ms Carr was commenced on end-of-life care. Ms Carr passed away on 6 October 2024.

Identity of the deceased

11. On 7 October 2024, Ms Anne-Maree Tammy Carr, born 10 May 1980, was visually identified by their sister.

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

Medical cause of death

13. On 7 October 2024, Dr de Villiers completed a MCCD. Dr de Villiers provided an opinion that the medical cause of death was COVID-19.

14. On 8 October 2024, Forensic Pathologist, Dr Hans de Boer from the Victorian Institute of Forensic Medicine (**VIFM**) reviewed the MCCB and post-mortem computed tomography

[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.

(**CT**) scan. Dr de Boer also conducted, at my direction, an external examination of the body and provided a written report of his findings dated 10 October 2024.

15. The results from both the post-mortem CT scan and external examination were consistent with the reported circumstances by Dr de Villiers as Dr de Boer did not find any evidence of skeletal injury or other substantial injury.

16. Dr de Boer provided an opinion that the medical cause of death was due to natural causes.

17. I accept Dr de Boer's opinion.

FINDINGS AND CONCLUSION

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

    a. the identity of the deceased was Anne-Maree Tammy Carr, born 10 May 1980;

    b. the death occurred on 06 October 2024 at Maryborough District Health Service 75/87 Clarendon Street, Maryborough, Victoria, 3465, from COVID-19.

    c. the death occurred in the circumstances described above.

19. I am satisfied that Ms Carr's death was due to natural causes, and no person or entity did anything to cause or contribute to her death. As such, I have exercised my discretion under section 52(3A) of the Act, not to hold an inquest into her death and to finalise Ms Carr's death by way of a finding without inquest.

20. I convey my sincere condolences to Ms Carr's family for their loss.

21. 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.

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

Ivan Carr, Senior Next of Kin

Julie Mitchell, Senior Next of Kin

Maryborough District Health Service

Signature:

Coroner Leveasque Peterson

Date: 24 February 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.