IN THE CORONERS COURT **COR 2024 007077**

OF VICTORIA

AT MELBOURNE

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Limei Chen
Date of birth:	26 December 1952
Date of death:	4 December 2024
Cause of death:	Chest sepsis complicating pulmonary fibrosis and cardiac failure
Place of death:	Monash Medical Centre 246 Clayton Road Clayton, Victoria
Keywords:	In care – natural causes

INTRODUCTION

1. On 4 December 2024, Limei Chen was 71 years old when she passed away at the Monash Medical Centre (**MMC**). At the time of her death, Mrs Chen lived alone in Wheelers Hill, having previously lived with her husband, for whom she had been a carer due to his dementia until his move to a residential aged care facility. She is also survived by her daughter, Xiaoyan Wang.

2. Mrs Chen's medical history included heart failure with reduced ejection fraction, atrial fibrillation, pulmonary fibrosis and depression. She also had cardiovascular risk factors of hypertension and dyslipidaemia. Her medications included furosemide, amiodarone, apixaban, metoprolol, and sertraline.

3. Throughout 2024, Mrs Chen became progressively frail and deconditioned from multiple hospital admissions.

THE CORONIAL INVESTIGATION

4. Mrs Chen's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**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. Mrs Chen was a person in care at the time of her death as she was subject to a Temporary Treatment Order (**TTO**) pursuant to the *Mental Health and Wellbeing Act 2022* (Vic) (**MHW Act**). However, an inquest was not required to be held pursuant to section 52(3A) of the Act given that Mrs Chen's death was from natural causes.

5. 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.

6. 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.

7. This finding draws on the totality of the coronial investigation into Mrs Chen's death. 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]

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

Circumstances in which the death occurred

8. On 1 November 2024, at around 1.20am, in the context of upper abdominal pain associated with generalised weakness, vomiting and pool oral intake, Mrs Chen was conveyed by ambulance to the Emergency Department (**ED**) at MMC. She also exhibited signs of fluid overload suggestive of decompensated cardiac failure. ED clinicians provided an initial diagnosis of sepsis, and she was subsequently admitted at 6.40am. She was managed and treated by clinicians including with the administration of antibiotics and diuresis.

9. Over the following days, Mrs Chen's diuresis progressed well. She remained mostly bed bound with significant fatigue and poor appetite. While hospital staff made efforts to improve her physical mobility and dietary intake, her participation in these therapies was noted to be limited. She also expressed constant low mood and intermittent suicidal ideation with no actions or plans.

10. On 8 November 2024, Mrs Chen was reviewed by the Consult and Liaison Psychiatry team, who provided a clinical impression of moderate-severe major depressive disorder. Her sertraline daily dosage was increased from 50mg to 100mg and augmented with olanzapine 1.25mg. Her olanzapine dosage was subsequently increased respectively on 11 November (2.5mg) and 13 November 2024 (5mg). Electrocardiograms were also periodically performed.

11. On 15 November 2024, the psychiatry team prescribed mirtazapine and they noted slight improvements in Mrs Chen's mood and sleep quality although thoughts of hopelessness and helplessness remained. Physically, she remained deconditioned and required assistance for mobility. Her oral intake continued to be minimal and was not meeting her daily nutrition requirements despite dietetics input and nutritional supplements.

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

12. On 19 November 2024, Mrs Chen was noted to be tachycardic, with blood tests showing a rising C-reactive protein. A subsequent chest X-ray demonstrated new and increasing bilateral infiltrates and pleural effusions. Ceftriaxone was commenced to treat hospital-acquired pneumonia, and her diuretic doses were also increased on 21 November 2024.

13. On 26 November 2024, Mrs Chen's sertraline was ceased with her olanzapine dosage reduced to 2.5mg due to an increase in QT-interval with tachycardia.

14. On 27 November 2024, a Medical Emergency Team (**MET**) call was activated due to worsening oxygen saturations. Mrs Chen did not wish any further interventions such as supplemental oxygen and expressed her wishes to cease further therapy. Nonetheless, oxygen and antibiotics were administered given she was hypoxic, and her situation was treated as a medical emergency.

15. On 28 November 2024, Mrs Chen was reviewed by a Psychiatry Registrar with the support of a Mandarin interpreter. During the review, she reported a pervasively low mood for the preceding six months, associated with prolonged deconditioning, medical frailty and extended hospital admission. She also reported a history of caring for her husband during his prolonged illness and expressed guilt about requiring staff care and feeling like a burden on her daughter.

16. Mrs Chen denied having depression and declined treatment for it, expressing a wish to die. Concerned about her depressive symptoms, lack of insight and capacity to consent to treatment, Mrs Chen was placed on an Inpatient Assessment Order under section 142 of the MHW Act. This was converted to a TTO after a review the following day by a Consultant Psychiatrist.[2]

17. Mrs Chen's condition deteriorated over the following days and, in consultation with her daughter, she was transitioned to comfort care. She passed away on 4 December 2024 at 4.53pm.

Identity of the deceased

18. On 4 December 2024, Limei Chen, born 26 December 1952, was visually identified by her daughter, Xiaoyan Wang.

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

[2] *Mental Health and Wellbeing Act 2022* (Vic), s 143.

Medical cause of death

20. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine conducted an external examination on 6 December 2024 and provided a written report of her findings dated 11 February 2025.

21. Dr Francis provided an opinion that the medical cause of death was *1(a) Chest sepsis complicating pulmonary fibrosis and cardiac failure*. Further, Dr Francis expressed the opinion that Mrs Chen's death was due to natural causes.

22. I accept Dr Francis's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Limei Chen, born 26 December 1952;

    b) the death occurred on 4 December 2024 at Monash Medical Centre, 246 Clayton Road, Clayton, Victoria from chest sepsis complicating pulmonary fibrosis and cardiac failure; and

    c) the death occurred in the circumstances described above.

24. As noted above, Mrs Chen'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 Mrs Chen died from natural causes and that no further investigation is required. Further, I am satisfied that the medical care and treatment provided to her at the MMC was reasonable and appropriate. 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 Mrs Chen'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:

Xiaoyan Wang, Senior Next of Kin

Monash Health

Constable Natalie Merola, Coronial Investigator

Signature:

Coroner David Ryan

Date: 05 September 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.