IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 006743

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:	Maryanne Gordon
Date of birth:	01 July 1954
Date of death:	04 December 2023
Cause of death:	1(a) COMPLICATIONS OF OESOPHAGEAL SQUAMOUS CELL CARCINOMA (PALLIATED)
Place of death:	Caritas Christi Hospice 104 Studley Park Road Kew Victoria 3101

INTRODUCTION

1. On 04 December 2023, Maryanne Gordon was 69 years old when she died at the Caritas Christi Hospice 104 Studley Park Road Kew. Prior to her admission to Caritas Christi Hospice Ms Gordon had lived in supported accommodation at 6 Canopy Avenue Kew Victoria. The National Disability Insurance Service (NDIS) had provided a Care Package for Ms Gordon and the Care package included funding of her accommodation at 6 Canopy Avenue Kew.

2. The National Disability Insurance Agency (NDIA) had approved a NDIS Care plan for Ms Gordon and the plan was approved to commence on 11 May 2023 for a period of one year.

3. In her NDIS plan Ms Gordon stated:

   I would like support to engage in community and social activities of choice.

   I would like to access allied health professionals to improve my health and wellbeing and maintain my independence.

   I would like to get support to live where my needs can be well supported.

   I would like to be supported to ensure that I can adopt pro-social behaviour and for my carers to better understand my support needs.[1]

4.

THE CORONIAL INVESTIGATION

5. Ms Gordon'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.

6. 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

[1] NDIS plan

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

7. 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.

8. This finding draws on the totality of the coronial investigation into the death of Maryanne Gordon. 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

9. Ms Gordon lived in specialist disability accommodation and had a medical history of intellectual disability and Lewy body dementia. In November 2023 she presented to St Vincent's Hospital with a two-week history of dysphagia, regurgitation, malnutrition, and weight loss. A gastroscopy was undertaken on 17 November 2023 showed a severe oesophageal stricture due to squamous cell carcinoma. Ms Gordon was not deemed a candidate for curative surgery and chemotherapy. Palliative stenting was thought to be technically possible but of limited utility.

10. During a family meeting on 22 November 2023, it was agreed to initiate end of life comfort care. Ms Gordon was transferred to Caritas Christi Hospice on 24 November 2023. There she slowly declined and passed away on 4 December 2023.

Identity of the deceased

11. On 6 December 2023, Maryanne Gordon, born 01 July 1954, was visually identified by her sister, Marjorie Eleanor Black.

[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.

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

Medical cause of death

13. Forensic Pathologist Dr Hans De Boer from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 6 December 2023 and provided a written report of his findings dated 12 December 2023.

14. Dr De Boer provided an opinion that the medical cause of death was 1 (a) COMPLICATIONS OF OESOPHAGEAL SQUAMOUS CELL CARCINOMA (PALLIATED).

15. Dr De Boer was of the opinion that this death was due to natural causes.

16. I accept Dr De Boer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Maryanne Gordon, born 01 July 1954;

    b) the death occurred on 04 December 2023 at Caritas Christi Hospice 104 Studley Park Road Kew Victoria 3101, from COMPLICATIONS OF OESOPHAGEAL SQUAMOUS CELL CARCINOMA (PALLIATED); and

    c) the death occurred in the circumstances described above.

18. The available evidence does not support a finding that there was any want of clinical management or care on the part of the supported accommodation operator that caused or contributed to Ms Gordon's death.

19. I note that Ms Gordon'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. 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 Gordon 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 her death and to finalise the investigation of Ms Gordon's death on the papers.

20. I convey my sincere condolences to Ms Gordon's family

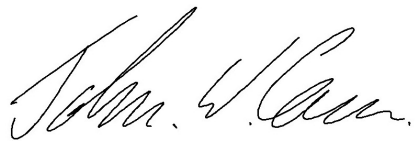
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Marjorie Black & Patricia Hurley, Senior Next of Kin's

Coroner's Investigator, Constable Natasha Todor

Signature:



Judge John Cain
STATE CORONER
Date:25 January 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.