IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 001802

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Jill Hughes
Date of birth:	19 July 1948
Date of death:	Between 26 March 2024 and 29 March 2024
Cause of death:	1a : INFECTIVE COMPLICATIONS OF A LEFT HAND INJURY WITH DIABETIC KETOACIDOSIS
Place of death:	5/116 Beach Street Frankston Victoria 3199

INTRODUCTION

1. On 29 March 2024, Jill Hughes was 75 years old when she collapsed beside her dining table, with a putrifying wound to her left hand. At the time of her death, Jill lived by herself at 5/116 Beach Street, Frankston, Victoria, 3199.

2. Jill was born in England but immigrated to Australia in 1969. She was married for 30 years, then separated. Although she didn't have a drivers licence, she used public transport to get to and from work and to support herself. She retired at age 74 but still filled in occasional shifts at her old work.[1]

3. Her daughter Gemma explain that her mother had a needle phobia and preferred natural products to formal medications. She only had a COVID vaccination so she could help her daughter at work. With this background, it is no surprise that she had only a scant medical history.[2]

4. Jill was not a big eater, but her daughter visited her every weekend with extra food.[3]

5. In November of 2023, her neighbour Jennifer Bain saw Jill performing pruning work on a ladder that was approximately three steps high.[4] When Gemma arrived for her usual visit the following Sunday, Jill confessed she had fallen off the ladder and suffered a wound.[5]

6. She initially deflected Gemma's entreaties that she seek medical attention, then later claimed to have in fact seen a doctor and to be taking antibiotics.[6]

7. During a Christmas visit in 2023, Jill's sister Julie noticed the decline in Jill's health and hygiene. Julie was also concerned that Jill was deflecting her request to take the bandage off and show her the wound.[7]

8. In February 2024, when Julie's brother Martin was also encouraging her to seek medical treatments during his visit, she displayed some signs of paranoia, believing they were all ganging up on her.[8]

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[1] Statement of Julie Hollowell, Coronial Brief.
[2] Statement of Gemma Hughes, Coronial Brief.
[3] Ibid.
[4] Statements of Ron & Judith Hookway, Coronial Brief.
[5] Ibid.
[6] Ibid.
[7] Statement of Julie Hollowell, Coronial Brief.
[8] Ibid.

THE CORONIAL INVESTIGATION

9. Jill'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.

10. 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.

11. 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.

12. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Jill's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from eye witnesses, family, the forensic pathologist, investigating officers and medical records – and submitted a coronial brief of evidence.

13. This finding draws on the totality of the coronial investigation into the death of Jill Hughes 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.[9]

14. In considering the issues associated with this finding, I have been mindful of Jill's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

[9] 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.

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

Circumstances in which the death occurred

15. On 26 March 2024, Jill's neighbours noted that her bins were out on the street in the morning but by about 5:00 pm, the bins were taken in and appeared to be inside her garage. This was the last known observations of movement from Jill's residence.[10] Gemma reported last seeing Jill on Sunday, 24 March 2024.[11]

16. On Friday the 29 March 2024, Gemma went to Jill's unit as she had not heard anything from her for several days. She found Jill was on the floor, face down in the dining room/lounge area. Blood had pooled around her hands which were placed around her head.[12] The unit was unkept and on arrival police observed that the guinea pig straw/bedding and food was kept inside the house which had invited mice which were running freely around the unit including on the kitchen bench.[13]

17. After careful initial consideration by the Homicide Squad, the wounds were assessed as nonsuspicious, and my assigned coronial investigator took over the investigation.[14]

18. Medicare and PBS records were requested and showed that Jill did not attend a doctor or purchase any pharmaceutical items for a two year period from the 29 March 2022 until her passing.

Identity of the deceased

19. On 29 March 2024, Jill Hughes, born 19 July 1948, was visually identified by her daughter, Gemma Hughes.

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

Medical cause of death

21. Senior Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 1 April 2024 and provided a written report of her findings the next day.

[10] Statement of Jennifer Bain, Coronial Brief.
[11] Statement of Gemma Hughes, Coronial Brief
[12] Ibid.
[13] Statement of A/Sgt Caitlin Jones, Coronial Brief.
[14] Ibid.

22. Examination of a post-mortem CT scan showed no skull, facial or cervical spine fracture and no intracranial haemorrhage, but the left hand was clearly injured at the 3rd metacarpal head, with surrounding gas and skin breach. There was no other skeletal trauma. There was also peripheral coronary artery and aortic calcification. The liver appears fatty but had no intrahepatic gas.

23. The external examination showed extensive maggot infection of the left hand, but it could not be conclusively determined whether this had occurred antemortem. Nonetheless, the wound showed ulceration, exposure of the underlying bone, swelling of the finger, cellulitis extending up the arm and swelling of the lymph nodes on the left side, in keeping with severe infection, which was likely to be a consequence of the injury to the hand which appeared to have been exposed to the air.

24. Toxicological analysis of post-mortem samples revealed elevated levels of acetone and isopropanol in keeping with a degree of ketosis. In addition, biochemical testing revealed an elevated level of glucose (14.5 mmol/L) which is in keeping with the range seen in those with poorly controlled diabetes. The combination of elevated glucose and acetone suggests diabetic ketoacidosis. Diabetic ketoacidosis may cause dehydration, fluid loss and acidosis of the blood and effects on the body at a cellular level. It is a severe medical disorder and may cause death. A common trigger for the development of diabetic ketoacidosis is sepsis or severe infection, which is consistent with the circumstantial history ascertained during this investigation.

25. The Toxicology did not identify the presence of any alcohol or other common drugs or poisons.

26. Dr Glengarry provided an opinion that the medical cause of death was 1(a) INFECTIVE COMPLICATIONS OF A LEFT HAND INJURY WITH DIABETIC KETOACIDOSIS, and I accept her opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Jill Hughes, born 19 July 1948;

    b) the death occurred on between 26 March 2024 and 29 March 2024 at 5/116 Beach Street, Frankston, Victoria, 3199, from 1(a) INFECTIVE COMPLICATIONS OF A LEFT HAND INJURY WITH DIABETIC KETOACIDOSIS; and

c) the death occurred in the circumstances described above.

28. Having considered all of the circumstances, I am satisfied that Jill's death was the unintended consequence an accidental wound to her hand, for which she declined to seek treatment, despite the encouragement to do so by her family.

I convey my sincere condolences to Jill's family for their loss.

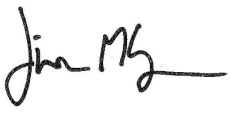
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Gemma Hughes, Senior Next of Kin

Leading Senior Constable Liza Shields, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 24 July 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.