IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 007097

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Janet Louise Cumming
Date of birth:	18 May 1934
Date of death:	22 December 2023
Cause of death:	1a: Aspiration pneumonia and malnutrition 2: Dysphagia, cerebral palsy
Place of death:	9 Blackwood Street Carnegie Victoria 3163
Keywords:	In care, natural causes

INTRODUCTION

1. On 22 December 2023, Janet Louise Cumming was 89 years old when she died at her residence. At the time of her passing, Janet lived in shared supported accommodation operated by Yooralla at 9 Blackwood Street, Carnegie Victoria.

2. Janet was one of three siblings born to parents Harold and Mary Cumming and grew up in the Orbost area. She was born with cerebral palsy which resulted in significant physical impairment, including limiting movement of her arms and legs.[1]

3. Janet's sister, Lori, recalled that Janet was a happy and independent young person, and though her speech was slightly affected, she was able to communicate well. Because of her disability, Janet had assistance from family and friends for her day-to-day living tasks, but she also learnt how to do things herself, such as knitting and typewriting. She enjoyed reading and helped her mother with housework when she could.[2]

4. In 1994, when Janet's mother passed away, a decision was made for Janet to move to Melbourne with Lori. Janet moved into a Yooralla care facility in Armadale, where she remained for approximately six years, before moving to the Blackwood Street residence in September 2003, where she lived until her passing. Janet required 24-hour care and was assisted by Yooralla staff with all tasks of daily living.[3] She required supports to hoist transfer and she used a power wheelchair to mobilise with support from care staff. Her care was funded under the Disability Support for Older Australians Program.[4]

5. Dr Henry Monkus of the Chadstone Road Clinic was Janet's general practitioner (**GP**) from September 2002 to May 2022. Her care was then transferred to Dr Houssam Hobouchi at the Carnegie Central Medical Centre.[5] In addition to cerebral palsy, Janet's medical history also included Type 2 diabetes mellitus, asthma, chronic pain, villous adenomas in the colon, left hemicolectomy, osteoarthritis, gall stones and impaired hearing.[6] In June 2021, Dr Monkus assisted Janet to complete an advance care directive which indicated that she did not wish to

[1] Statement of Lori Fellows, Coronial Brief.
[2] Ibid.
[3] Ibid.
[4] Statement of Birtukan Workneh, Coronial Brief.
[5] Statement of Dr Henry Monkus, Coronial Brief.
[6] Statement of Birtukan Workneh, Coronial Brief.

be resuscitated in the event that she did not have decision-making capacity to make a medical treatment decision.[7]

6. Janet began losing her eyesight in her 20s and underwent a number of cornea transplants, which recovered some of her vision, but eventually developed glaucoma and lost all her vision by around 2018. Janet also developed dysphagia and could not eat solid foods. As a result, she required a specialised diet, which was organised by her sister and delivered to the Yooralla residence.[8]

7. Lori observed that as Janet's health deteriorated, she became depressed and appeared to be tired of her life. In the weeks leading up to her passing she had declined to eat for days at a time.[9] In this period, she was experiencing particularly poor health, including chest and urinary tract infections that were treated with antibiotics, and COVID-19, diagnosed on 5 November 2023 and treated with antiviral medication.[10]

8. Lori regularly visited Janet at Blackwood Street and was attentive to her health and wellbeing. The sisters remained close until Janet's passing.[11]

THE CORONIAL INVESTIGATION

9. Janet's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Parliament has recognised that people who are in care or custody are particularly vulnerable and therefore the death of a person in care or custody is required to be reported to the coroner, even if the death appears to have been from natural causes.[12] Janet was a specialist disability accommodation (**SDA**) resident residing in an SDA enrolled dwelling at the time of her passing and, as such, she is deemed to have been 'in care'[13] and her death is subject to a mandatory inquest, pursuant to section 52(2) of the Act.

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

[7] Exhibit 5 – Advance Care Directive dated 23 June 2021, Coronial Brief.
[8] Statement of Lori Fellows, Coronial Brief.
[9] Ibid.
[10] Statement of Birtukan Workneh, Coronial Brief.
[11] Statements of Lori Fellows and Birtukan Workneh, Coronial Brief.
[12] *Coroners Act 2008*, section 4.
[13] See *Coroners Regulations 2019*, regulation 7,

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 Janet's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

13. This finding draws on the totality of the coronial investigation into the death of Janet Louise Cumming 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.[14]

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

Circumstances in which the death occurred

14. On the morning of Thursday 22 December 2023, overnight staff reported to the morning staff at handover that Janet had a calm and peaceful night.[15]

15. At approximately 7:30 am, Yooralla staff member Jai Abraham attended Janet's room to administer her morning medications with a bowl of custard. After these tasks, Janet said she wanted to sleep for a few hours.[16]

[14] 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.
[15] Exhibit 3 – Yooralla Comprehensive Report dated 22 December 2023, Coronial Brief
[16] Ibid.

16. At approximately 10.15 am, Mr Abraham and another staff member, Brian Rotich assisted Janet with using the bathroom adjacent to her room, which required Janet to be hoisted from the bed and assisted to the toilet.[17]

17. Mr Abraham noticed that Janet was having difficulty with her bowel movement. While Mr Rotich remained in Janet's room, Mr Abraham attended the staff office to make a request to the Yooralla acting service manager, Birtukan Workneh, for permission to administer medication, specifically Movicol. Ms Workneh prepared the Movicol and handed it to Mr Abraham. When Mr Abraham returned to Janet's room at approximately 10:50 am, he found Janet sitting on her commode chair and unresponsive. He immediately returned to the staff office and requested assistance from Ms Workneh.[18] Mr Rotich called 000 and another Yooralla staff member to assist.

18. Ms Workneh and Mr Abraham returned to Janet's room and moved her to the ground, where Ms Workneh began cardiopulmonary resuscitation (**CPR**) on instruction from the 000 call-taker.

19. At approximately 11:10 am, Fire Rescue Victoria members arrived and took over CPR. At approximately 11:22 am, Ambulance Victoria paramedics arrived and confirmed that there were no signs of life, and Janet was formally pronounced deceased at 11:24 am.[19]

Identity of the deceased

20. On 22 December 2023, Janet Louise Cumming, born 18 May 1934, was visually identified by her long-term carer, Birtukan Workneh.

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

Medical cause of death

22. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine conducted an external examination on 26 December 2023 and provided a written report of her findings dated 4 March 2024.

[17] Ibid.
[18] Ibid.
[19] Ibid, and Police Report of Death for the Coroner dated 22 December 2023.

23. The external examination showed findings in keeping with Janet's clinical history.

24. A post-mortem computed tomography (**CT**) scan showed cerebral atrophy, bilateral lower lung aspiration changes, mild coronary artery calcifications, and a fatty liver.

25. Toxicological analysis of post-mortem blood samples identified the presence of oxycodone, naloxone, citalopram and loratadine at therapeutic levels.

26. On the basis of her findings and the clinical history, Dr Baber provided an opinion that Janet's death was due to natural causes, specifically, 1(a) aspiration pneumonia and malnutrition, with contributing factors of dysphagia and cerebral palsy. I accept Dr Baber's 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 Janet Louise Cumming, born 18 May 1934;

    b) the death occurred on 22 December 2023 at 9 Blackwood Street, Carnegie, Victoria, 3163, from (1a) aspiration pneumonia and malnutrition, with contributing factors of (2) dysphagia, cerebral palsy; and

    c) the death occurred in the circumstances described above.

28. Janet was in care and her death is therefore *prima facie* subject to a mandatory inquest.[20] I am, however, satisfied by the available evidence that her passing was due to natural causes and, pursuant to section 52(3A) of the Act, have therefore determined not to hold an inquest.

I convey my sincere condolences to Janet'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.

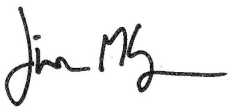
[20] Section 52(2).

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

Lori Fellows, Senior Next of Kin

Senior Constable James Talman, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 27 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.