IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002603

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	Suzanne Craig Morter
Date of birth:	5 November 1953
Date of death:	11 May 2024
Cause of death:	1a: Multi-organ dysfunction complicating sepsis of unknown origin in setting of Alzheimer's dementia and Down Syndrome
Place of death:	Austin Hospital 145 Studley Road Heidelberg Victoria 3084
Keywords:	In care, natural causes, Alzheimer’s dementia

INTRODUCTION

1. On 11 May 2024, Suzanne Craig Morter was 70 years old when she died at the Austin Hospital. At the time of her death, Ms Morter lived in Specialist Disability Accommodation (**SDA**) in Macleod, Victoria, and received supported independent living services from Araluen.

2. Ms Morter was born with Down Syndrome and lived most of her adult life in supported residential care. In around 1976, she moved into part-time residential care operated by Araluen disability support services and gradually transitioned to full-time care. In around 1994, she moved to the Macleod residence with four other residents and remained at that address until her passing. Ms Morter was very well supported by carers and in particular the house manager, Sarah Owen, who was very fond of Ms Morter, ensuring that the residence felt like a home for Ms Morter and the other residents.

3. Ms Morter was also supported by her loving family throughout her life. She led a full life, attending church on Sundays, family functions, weddings and the football when her health permitted. Six months before her passing she enjoyed a 70th birthday celebration with her extended family.

4. Approximately four years before her death, care staff began noticing behavioural changes in Ms Morter and she was ultimately diagnosed with Alzheimer's dementia in around 2022. Despite pharmacological treatment and monitoring, she experienced a gradual physical and cognitive decline from this time until her passing. As a result of the Alzheimer's, Ms Morter presented with heightened emotion and mood swings and would sometimes become agitated with care staff and the other residents. Ms Morter's medical history also included type 2 diabetes mellitus, osteoarthritis, psoriasis, dyslipidaemia and hypertension.

5. In May 2023, Ms Morter made an Advance Care Directive (**ACD**) with the assistance of her general practitioner, Dr Ian Sharrock, which stated her preference for limited interventions in the event she became unable to make decisions about her medical care. The ACD detailed Ms Morter's preferences not to be subjected to medical interventions aimed at prolonging or sustaining life, including artificial feeding or respiration, circulatory support, or any surgical procedures.

6. In February 2024, Ms Morter's treating geriatrician, Dr Rohan Wee, noted that Ms Morter had deteriorated significantly over the preceding three to four weeks and was experiencing

increased agitation, confusion and distress. Dr Wee explained that Alzheimer's disease is a frequent complication of Down Syndrome, and recommended involvement of a Behavioural Support worker via her National Disability Insurance Scheme (**NDIS**) plan. Ms Morter was commenced on oxycodone to manage any underlying pain that could have been contributing to her agitation, with a plan to commence risperidone in the alternative if her agitation did not improve.

7. The house manager, Ms Owen, noted that in the week before her passing, Ms Morter had deteriorated further, was sleeping an excessive amount and was difficult to engage.

THE CORONIAL INVESTIGATION

8. Ms Morter's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).[1] 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. Ms Morter was a "person placed in custody or care" pursuant to the definition in section 4 of the Act, as she was "a prescribed person or a person belonging to a prescribed class of person" due to her status as an "SDA resident residing in an SDA enrolled dwelling".[2]

9. 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.

10. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Suzanne's death. The Coronial Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of Suzanne Craig Morter 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

[1] Section 4(1), (2)(c) of the Act.
[2] Pursuant to Reg 7(1)(d) of the *Coroners Regulations 2019*, a "*prescribed person or a prescribed class of person*" includes a person in Victoria who is an "*SDA resident residing in an SDA enrolled dwelling*", as defined in Reg 5. I have received information that Ms Morter resided at an address where the residents meet these criteria.

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

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

Circumstances in which the death occurred

12. At around 7:00 am on 9 May 2024, Ms Morter was found by Ms Owen and care staff to require showering. In the process of being assisted to the shower, she lost consciousness. Staff called an ambulance, and Ms Morter was taken to the Austin Hospital Emergency Department (**ED**).

13. Investigations in the ED revealed that Ms Morter had a decreased conscious state due to acidemia with high lactate levels, severe acute kidney injury associated with deranged electrolytes, and elevated inflammatory markers suggestive of a developing infection. Despite fluid resuscitation and active treatments to correct her electrolytes and hypotension, her level of consciousness did not improve.

14. In accordance with Ms Morter's wishes expressed in her advanced care directives, and following discussions with her family, the focus of care shifted to comfort care as the medical consensus was that further interventions would not have accorded with Ms Morter's advanced care directives.

15. Ms Morter was transferred to the inpatient palliative care unit. She passed away peacefully on 11 May 2024 at 11:42 am.

Identity of the deceased

16. On 11 May 2024, Suzanne Craig Morter, born 5 November 1953, was visually identified by her brother, Stephen Morter.

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

[3] 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.

Medical cause of death

18. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine conducted an external examination of Ms Morter's body on 13 May 2024 and provided a written report of his findings dated 14 May 2024.

19. The external examination revealed findings consistent with Ms Morter's medical history.

20. A post-mortem CT scan showed calcific coronary artery disease and increased lung markings.

21. Dr Lynch noted Ms Morter's recent clinical course, including her admission to hospital on 9 May 2024 with infection, sepsis and multiorgan dysfunction.

22. Having regard to the information available to him, Dr Lynch provided an opinion that the medical cause of death was "1(a) Multi-organ dysfunction complicating sepsis of unknown origin in setting of Alzheimer's dementia and Down Syndrome", and that Ms Morter's passing was due to natural causes.

23. I accept Dr Lynch's opinion.[4]

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Suzanne Craig Morter, born 5 November 1953;

    b) the death occurred on 11 May 2024 at Austin Hospital, 145 Studley Road, Heidelberg, Victoria 3084, from 1(a) Multi-organ dysfunction complicating sepsis of unknown origin in setting of Alzheimer's dementia and Down Syndrome; and

    c) the death occurred in the circumstances described above.

25. Having considered all the available evidence, I find that Ms Morter's death was from natural causes and was not unexpected. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death.

I convey my sincere condolences to Ms Morter's family and carers for their loss.

[4] Pursuant to s 52(3A) of the Act, a coroner is not required to hold an inquest where the deceased was, immediately before death, a person placed in custody or care, if the coroner considers that the death was due to natural causes.

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:

Stephen Morter, Senior Next of Kin

Austin Health

First Constable Ayden McDonald, Coronial Investigator

Signature:

Coroner Catherine Fitzgerald

Date: 23 February 2026

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.