IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006230

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Rona Jean Mccully
Date of birth:	29 July 1939
Date of death:	29 October 2022
Cause of death:	1(a) Acute on chronic renal failure 1(b) Infectious exacerbation of chronic obstructive pulmonary disease
Place of death:	Northeast Health Wangaratta, 35/47 Green Street, Wangaratta, Victoria, 3677
Key words	In care; Renal failure; Natural Causes

INTRODUCTION

1. On 29 October 2022, Rona Jean McCully was 83 years old when she died at the Northeast Health Hospital in Wangaratta. At the time, Ms McCully lived in a supported independent living service called Montgomery House in Wangaratta, Victoria, operated by Home@Scope Pty Ltd (**Home@Scope**).

2. From a young age, Ms McCully suffered from an intellectual disability. At the time of her death, she was receiving funding through the Disability Support for Older Australians Program.

3. Ms McCully was born in 1939 in Carlton, Victoria. Her mother was unwed at the time of Ms McCully's birth, and she was immediately put up for adoption. Little is known of Ms McCully's childhood and early life as she had no contact with her family at this time. It is believed she spent her childhood at the Janefield and Kew cottages before moving to Beechworth.

4. In about 1990, Ms McCully reconnected with her family, in particular her cousin once removed, Ms Margaret Lewis. From that point on they remained in frequent contact and would exchange gifts on birthdays and at Christmas. Ms McCully enthusiastically enjoyed receiving updates and photos about the babies in her extended family.

5. In the early 1990s, Ms McCully moved to live in assisted care at Montgomery House where she received 24-hour care. She lived with four other female residents and received assistance with personal care and grooming, meal preparation, medication administration and accessing the community.

6. She enjoyed group outings, attending church and cooking with the assistance of her carers. According to Ms Lewis, Ms McCully had a good quality of life and she received exemplary care from her carers at Montgomery House.

7. Ms McCully attended General Practitioner Dr Kate Davey of the Ovens Medical Group in Wangaratta for over 20 years. Her medical history included an intellectual disability, chronic obstructive pulmonary disease (**COPD**), renal failure, hypertension, hyperlipidaemia, asthma, lower limb oedema, iron deficiency anaemia, and a history of skin cancer. She had a previous hip replacement and was able to self-ambulate using a four wheeled mobility frame.

8. Dr Davey noted that Ms McCully's health began to deteriorate from 2020. Her renal function continued to decline, and she suffered recurrent respiratory tract infections.

9. In May 2022, Ms McCully tested positive for COVID-19 and received a five-day course of the anti-viral medication molnupiravir 20mg. On 7 October 2022, Ms McCully consulted Dr Davey for the final time. She presented with a recent history of persistent ankle oedema and was more breathless than usual. Dr Davey diagnosed Ms McCully with an exacerbation of her pre-existing COPD and prescribed a course of steroids and diuretics.

THE CORONIAL INVESTIGATION

10. Ms McCully'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. However, if a person satisfies the definition of a person placed in care immediately before the death, the death is reportable even if it appears to have been from natural causes.[1]

11. 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.

12. 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.

13. Victoria Police assigned Senior Constable Michael Ibbott to be the Coroner's Investigator for the investigation of Ms McCully's death. The Coroner's 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.

14. This finding draws on the totality of the coronial investigation into the death of Rona Jean McCully including evidence contained in the coronial brief. Whilst I have reviewed all the

[1] See the definition of '*reportable death'* in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of *'person placed in custody or care'* in section 3(1) of the Act.

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

Identity of the deceased

15. On 29 October 2022, Rona Jean Mccully, born 29 July 1939, was visually identified by her long-time carer, Jo-Ann Sturzaker, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

17. Forensic Pathologist Dr Hans De Boer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination of Ms McCully's body in the mortuary on 1 November 2022 and provided a written report of his findings dated 6 November 2022.

18. The post-mortem examination showed evidence of marked generalised oedema (fluid retention). There was no intracranial haemorrhage or any other signs of injury that could have caused or contributed to death.

19. Toxicological analysis of samples was not performed and considered unnecessary for this matter.

20. Dr De Boer provided an opinion that the medical cause of death was *1(a) acute on chronic renal failure* secondary to *1(b) infectious exacerbation of chronic obstructive pulmonary disease.*

21. Dr De Boer considered that Ms McCully's death was due to natural causes.

22. I accept Dr De Boer's opinion.

[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.

Circumstances in which the death occurred

23. On 13 October 2022, Ms McCully presented to the Northeast Health Wangaratta Hospital (**Northeast Hospital**) due to a deterioration of her known medical conditions. She had ineffective exacerbation of COPD and an acute exacerbation of chronic kidney disease. She received treatment in hospital for several days and was discharged on 17 October 2022 with oral antibiotics (amoxicillin and doxycycline) and plan for GP management.

24. The symptoms persisted after her discharge and the evidence suggests did not respond effectively to antibiotics. At 11.00am on 21 October 2022, her condition deteriorated at home, and she suffered shortness of breath and a cough. Ventolin was administered in accordance with her asthma plan, initially with good effect.

25. Her symptoms returned multiple time throughout the day. By the afternoon, Ventolin provided little relief. At 4.17pm, an ambulance was called, and Ms McCully was conveyed to the Northeast Hospital, arriving at 5.10pm.

26. On arrival at the Northeast Hospital, Ms McCully presented with increasing shortness of breath, cough, and bilateral leg oedema to knees. She was mildly hypoxic, and oxygen was administered via nasal prongs. Her renal function was assessed as poor, and a chest x-ray showed lung congestion and chronic airway disease.

27. During her stay, Ms McCully was provided a further course of antibiotics (ceftriaxone and azithromycin) administered intravenously. Her kidney function continued to decline, and her oedema progressed to her hips.

28. Her condition further deteriorated and following discussions with family, on 27 October 2022 Ms McCully was transferred to palliative care prioritising comfort care. Ms McCully was kept comfortable until she passed away and was formally pronounced deceased at 7.02pm on 29 October 2022.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Rona Jean Mccully, born 29 July 1939;

    b) the death occurred on 29 October 2022 at Northeast Health Wangaratta, 35/47 Green Street, Wangaratta, Victoria, 3677;

c) the cause of Ms McCully's death was acute on chronic renal failure secondary to infectious exacerbation of chronic obstructive pulmonary disease.; and

d) the death occurred in the circumstances described above.

30. The available evidence does not support a finding that there was any want of clinical management or care on the part of staff at Montgomery House or the Northeast Hospital that caused or contributed to Ms McCully's death.

31. Ms McCully'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 McCully 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 McCully's death on the papers.

I convey my sincere condolences to Ms McCully's family and her carers for their loss. I wish to acknowledge the love and care provided by Ms Lewis and the other members of her family who reconnected with Ms McCully in the later part of her life having previously had no contact. It is clear this provided Ms McCully with a sense of family and belonging which she clearly enjoyed.

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

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

Margaret Lewis, senior next of kin

Home@Scope

Northeast Health

National Disability Insurance Scheme (NDIS)

Senior Constable Michael Ibbott, Victoria Police, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date : 24 July 2023

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.