IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 003551

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Tammie Lou Arnel
Date of birth:	3/12/1961
Date of death:	24/06/2025
Cause of death:	1a : Acute on chronic lung disease in the setting of multiple comorbidities including cerebral palsy, lennox-gastaut syndrome and west syndrome
Place of death:	19 Vincent Street Deer Park Victoria 3023
Keywords:	Specialist Disability Accommodation resident, reportable deaths, natural causes

INTRODUCTION

1. On 24/06/2025, Tammie Lou Arnel **(Ms Arnel)** was 63 years old when she died at 19 Vincent Street, Deer Park, Victoria.

THE CORONIAL INVESTIGATION

2. Ms Arnel's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as she was a 'person placed in custody or care' within the meaning of the Act, as a person with disability who received funded daily independent living support and resided in a Specialist Disability Accommodation (SDA) enrolled dwelling immediately prior to her death.[1] The coroner is required to investigate these death, and publish their findings, even if the death has occurred as a result of natural causes.

3. 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.

4. This finding draws on the totality of the coronial investigation into the death of Tammie Lou Arnel. 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]

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[1] This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

[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.

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

Circumstances in which the death occurred

5. Ms Arnel had a relevant past medical history which included Cerebral palsy, Hemiplegia, Epilepsy - Lennox-Gastuat Syndrome and West Syndrome, Chronic kidney failure, Dysphagia and Recurrent urinary tract infections (UTI).

6. Ms Arnel was non-verbal but her carers had become familiar with her body language and facial expressions to understand her needs. Ms Arnel required support for all daily living activities.

7. On 18 June 2025, Ms Arnel was supported by carers to attend a medical appointment. A palliative care referral due to her blood results showing progressive decline in her kidney function and an ultrasound of her liver showed the beginning of cirrhosis. On 19 June 2025 the Western Health Community Palliative Care team contacted Ms Arnel's carers to discuss the referral. It was determined that once Ms Arnel had completed treatment for her UTI, they would commence comfort care.

8. On 23 June 2025 Ms Arnel enjoyed time at home. After attending for blood tests during the day, she listened to music before being assisted to bed at about 7.20pm.

9. At 6.45am on 24 June 2025, Ms Arnel's carers entered her room where they found her unresponsive. The staff contact Triple Zero and Cardiac Pulmonary Resuscitation (CPR). Ambulance Victoria paramedics attended but sadly Mr Arnel could not be assisted and she was pronounced deceased at the scene.

Identity of the deceased

10. On 24 June 2025, Tammie Lou Arnel, born 3 December 1961, was visually identified by Mr Walker.

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

Medical cause of death

12. Dr Yeliena Baber a legally qualified medical practitioner and specialist forensic pathologist, practising at the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy and provided a written report of her findings dated 8 October 2025.

13. Dr Baber stated in her report:

The cause of death in this 63 year old lady was acute on chronic lung disease in the setting of multiple co-morbidities including cerebral palsy and Lennox-Gastaut syndrome.

West syndrome, or Infantile Epileptic Spasms Syndrome (IESS), comprises a constellation of symptoms characterized by epileptic/infantile spasms, abnormal brain wave patterns called hypsarrhythmia and intellectual disability.

Lennox-Gastaut syndrome is a severe form of epilepsy that typically becomes apparent during infancy or early childhood. Affected children experience several different types of seizures, most commonly atonic, tonic and atypical absence seizures. Children with Lennox-Gastaut syndrome may also develop cognitive dysfunction, delays in reaching developmental milestones and behavioural problems. Lennox-Gastaut syndrome can be caused by a variety of underlying conditions, but in some cases no cause can be identified.

At autopsy the kidneys were small and firm with hydronephrotic changes in the right. Histology confirmed chronic kidney disease with possible acute tubular necrosis.

There was no evidence of trauma or injury that may have caused or contributed to death.

14. Dr Baber provided an opinion that the medical cause of death was 1(a) Acute on chronic lung disease in the setting of multiple comorbidities including cerebral palsy, lennox-gastaut syndrome and west syndrome.

15. Dr Baber provided an opinion that the cause of death was due to natural causes.

16. I accept Dr Baber's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased is Tammie Lou Arnel, born 3/12/1961;

    b) her death occurred on 24/06/2025 at 19 Vincent Street Deer Park Victoria 3023 from 1a Acute on chronic lung disease in the setting of multiple comorbidities including cerebral palsy, lennox-gastaut syndrome and west syndrome; and

    c) her 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 that caused or contributed to Ms Arnel's death.

19. Having considered all the available evidence, I find that Ms Arnel's death was from natural causes and that no further investigation is required. As such, 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 Arnel's death in chambers.

I convey my sincere condolences to Ms Arnel's family, friends and carers 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:

Jennifer Arnel, Senior Next of Kin

Naomi Baquing, Scope (Aust) Ltd

Senior Constable Alban Almeida, Coronial Investigator

Signature:

Coroner Kate Despot

Date: 06 July 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.