IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 4539

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**CORONER DARREN J BRACKEN**
Deceased:	**CATHERIN D'ROZARIO**
Date of birth:	19 JULY 2002
Date of death:	25 AUGUST 2019
Cause of death:	COMPLICATIONS OF ACUTE ASTHMA IN THE SETTING OF AN ALLERGIC RESPONSE.
Place of death:	WESTERN HEALTH (SUNSHINE HOSPITAL), FURLONG ROAD, ST ALBANS, VICTORIA 3021

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HIS HONOUR:

BACKGROUND

1. Catherin D'Rozario (**Catherin**) was only seventeen years old when she died on 25 August 2019, at Sunshine Hospital from complications of acute asthma in the setting of an allergic response.

2. Catherin was the much-loved middle child and treasured only daughter of Mathew D'Rozario and Stella D'Rozario and sister to Stalis D'Rozario and Benedict D'Rozario. Immediately prior to her death, Catherin lived with her family at 105 Allenby Road, Hillside. Catherin was a Year 11 student at Catholic Regional College, Sydenham.

3. Mrs D'Rozario provided a statement to the Coroner's investigator (**CI**) detailing Catherin's medical history which included eczema, asthma and allergies to bananas, nuts, sesame seeds and some fish. Catherin had suffered from asthma and allergies since childhood. Mrs D'Rozario explained that Catherin developed a rash at 4-6 months of age and was diagnosed with eczema. At the age of 2-3 years she was diagnosed as allergic to cow's milk and referred to the Royal Children's Hospital for allergy testing. Around this time Catherin was also diagnosed with asthma. She managed her condition by avoiding food allergens and she carried an inhaler and antihistamines (Claratyne) for her asthma. Mrs D'Rozario explained that:

> *"If she did eat something she was allergic to, if she didn't know at the time* [she] *would get itchy and then she would vomit but then she would feel better".*

4. Mrs D'Rozario said that approximately two or three years prior to her death, Catherin had attended a general practitioner at Kings Park Medical Centre in Hillside because of asthma related breathing difficulties. She stated that the general practitioner she saw recommended that Catherin carry an EpiPen for emergency treatment of a severe allergic reaction. Mrs D'Rozario continued:

> *"I told my daughter if she needed an EpiPen we would get one. She said no she didn't need it as she was very careful with what she ate".*

THE CORONIAL INVESTIGATION

Coroners Act 2008

5. Catherin's death was a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**) because her death having occurred in Victoria, was unexpected and not from natural causes.[1]

6. The Act requires a coroner to investigate reportable deaths such as Catherin's and, if possible, to find:

   (a) The identity of the deceased;

   (b) The cause of death; and

   (c) The circumstances in which death occurred.[2]

7. For coronial purposes, "*circumstances in which death occurred*",[3] refers to the context and background to the death including the surrounding circumstances. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death relevant circumstances are limited to those which are sufficiently proximate to be considered relevant to the death.

8. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[4] It is not the Coroner's role to determine criminal or civil liability,[5] nor to determine disciplinary matters.

9. One of the broader purposes of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through comments made in findings and by making recommendations.

10. Coroners are also empowered to:

    (a) Report to the Attorney-General on a death;[6]

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[1] *Coroners Act 2008* (Vic) s 4.
[2] *Coroners Act 2008* (Vic) preamble and s 67.
[3] *Coroners Act 2008* (Vic) s 67(1)(c).
[4] *Keown v Khan* [1999] 1 VR 69.
[5] *Coroners Act 2008* (Vic) s 69 (1).
[6] *Coroners Act 2008* (Vic) s 72(1).

(b) Comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[7] and

(c) Make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[8]

Standard of Proof

11. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities, giving effect to the principles explained by the Chief Justice in *Briginshaw* v *Briginshaw*.[9] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[10] The principles enunciated by the Chief Justice in *Briginshaw* do not create a new standard of proof; there is no such thing as a "*Briginshaw Standard*" or "*Briginshaw Test*" and use of such terms may mislead.[11]

12. Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[12] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[13] Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved and the content of the finding based on those facts.[14]

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

Identity of the Deceased - Section 67(1)(a) of the Act

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[7] *Coroners Act 2008* (Vic) s 67(3).
[8] *Coroners Act 2008* (Vic) s 72(2).
[9] (1938) 60 CLR 336, 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 89, 95.
[10] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[11] *Qantas Airways Ltd v Gama* (2008) 167 FCR 537, [123]-[132].
[12] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[13] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[14] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers' Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.

13. On 25 August 2019, Mrs D'Rozario identified the deceased as her daughter, Catherin D'Rozario, born on 19 July 2002.

14. Catherin's identity is not in dispute and requires no further investigation.

Cause of death - Section 67(1)(b) of the Act

15. On 28 August 2019, Dr Michael Burke, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted a partial autopsy upon Catherin's body. Dr Burke provided a written report, dated 6 November 2019, in which he opined that the cause of Catherin's death was '*Complications of acute asthma in the setting of an allergic response*". I accept Dr Burke's opinion.

16. Toxicological analysis revealed a serum tryptase of 23 H ug/L. Serum tryptase levels can be used as an indicator of possible antemortem anaphylaxis. The reference range is ≤ 12. According to the toxicology report, elevated tryptase levels reflect increased mast cell degranulation or increased mast cell numbers. Elevated levels of tryptase are seen acutely after anaphylaxis. Post-mortem tryptase may be elevated due to increasing post-mortem interval. Post-mortem tryptase levels should be interpreted with caution unless grossly elevated and supported by clinical history and circumstances of death when investigating anaphylaxis.

17. Dr Burke noted that:

> "*It would appear likely, given the history of Ms D'Rozario's acute illness that she suffered an allergic response resulting in an acute allergic reaction with acute asthma*".

Circumstances in which the death occurred - Section 67(1)(c) of the Act

18. On 23 August 2019, at approximately 3.30pm, Catherin telephoned her mother and told her that after school she was going to the City with friends. At approximately 3.40pm, Catherin left school with her friends, Chananchida (Cathy) Phonham, Mary Vu and Chiara Vallescas. They walked to Watergardens station and boarded a City bound train which arrived shortly after 4.00pm.

19. The friends walked from Melbourne Central station to the Dragon Hot Pot restaurant (**the restaurant)** at 251 Swanston Street. Ms Vallescas provided a statement to the CI in which she stated that Catherin told her she had eaten at this restaurant before with her brother.

20. Mr Louis Kuo, Director of Dragon Pot Restaurants, provided a statement to the CI in which he explained how the restaurants are set up. On entering, the customer collects a bowl and tongs used to pick out various ingredients on display in a grocery style open fridge. The customer proceeds to the counter, where the bowl of chosen ingredients is weighed and the customer chooses a soup base from a choice of traditional Malatang, Chinese pickle, pork bone, sour and spicy or vegan.

21. In her statement, Ms Vallescas stated that Catherin selected beef, pork, potato, chicken giblets, squid, rice cakes and quail eggs from the fridge/buffet and took her bowl to the counter to obtain the soup base. Ms Vallescas said that:

> *"Catherin asked for spicy soup and I'm pretty sure she asked to take away the sesame oil and sesame seeds".*

22. Catherin and her friends sat down to eat, but before commencing, Ms Phonhan told Catherin to *"make sure you tell them again as they may put it in".* Catherin got up and went to the counter. When she returned to the table she told her friends:

> *"Guy's*[sic] *I'll be fine. I will still eat it".*

23. According to Ms Vallescas, Catherin ate only the soup base. The friends remained in the restaurant for about an hour and then Catherin left to buy *Gong Cha* (iced bubble tea) from a different food outlet. At about the same time, Ms Phonhan left the restaurant to go home. Catherin returned to the restaurant and together with Ms Vu and Ms Vallescas, commenced the journey home.

24. At approximately 5.00pm, while walking towards Melbourne Central station, Catherin complained of feeling unwell and, Ms Vallescas said, went into nearby toilets to vomit.

25. At approximately 5.30pm, Catherin telephoned her mother. She told her she was feeling unwell and asked her mother to meet her at Sunshine station and to bring antihistamines. A short time later, Catherin again contacted her mother and said that she was struggling to breathe.

26. Catherin and her friends boarded a train at approximately 5.50pm and Catherin began using her inhaler, saying that she could not breathe properly. Another passenger in the train contacted the train driver via the intercom system requesting medical attention for Catherin, who fell to her knees and *"passed out"* on the floor of the train. Another passenger commenced cardiopulmonary resuscitation until the train arrived at Sunshine station where Protective

Services Officers and members of Victoria Police boarded the train and continued with CPR. At approximately 6.30pm, a crew from Ambulance Victoria arrived at the station and Catherin was transported to Sunshine Hospital, arriving at 7.34pm.

27. According to the hospital records, on admission, it was noted that Catherin had been intubated by paramedics at the scene; that ventilation had been difficult and that there was an interval of approximately 24 minutes before spontaneous circulation was restored. She had bilateral decompressed pneumothoraces. Intercostal catheters were inserted. Catherin's pupils were fixed and dilated and there was no motor response. She was initially treated with intravenous adrenalin, salbutamol and ketamine and transferred to the intensive care unit (**ICU**). Catherin's family were advised that the situation was grave and the prognosis likely to be poor.

28. On 24 August 2019, a CT scan of the brain was reported as showing severe global hypoxic ischaemic encephalopathy with evidence of cerebellar tonsillar herniation which was noted to be consistent with the clinical findings and with the increasing level of haemodynamic supports required.

29. On 25 August 2019, following a further meeting with Catherin's family, formal brain testing was undertaken by two ICU consultants who confirmed brain death at 11.52am. Catherin's family generously agreed to organ and tissue donation.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Catherin's medical history

30. It is apparent from the evidence that Catherin was allergic to some foods and suffered from asthma. I have noted Mrs D'Rozario's reference to advice from a GP (identified in her statement as "*Dr Euzine*") that Catherin carry an EpiPen.

31. Mrs D'Rozario recalls the GP suggesting an EpiPen for Catherin some two to three years prior to her death.

32. In his statement, Mr D'Rozario described a situation which occurred when Catherin was seven or eight years old. He said that, on one occasion, while her mother was cooking fish at home, the smell caused Catherin to have a reaction and that she;

> "*...became red, short of breath, her face was swollen and her eyes had tears. We opened up all the windows and she had to have a cold shower as well as taking her asthma puffer. It took a couple of hours before she was back to normal.*"

33. Mr D'Rozario described another occasion when Catherin reacted to an unknown ingredient in her cousin's birthday cake. Mr D'Rozario said that:

> *"...her face and eyes started to swell up, and we took her to the local doctor who gave her an EpiPen and called an ambulance who took her to Sunshine Hospital where she was admitted. I believe she stayed overnight. This scared Catherin and so she was very cautious about not having any contact with any of the foods that she was allergic to.".*

34. He also stated that Catherin's school was advised each year about her allergies.

35. Later in his statement, Mr D'Rozario observed that if Catherin attended an Indian or Bangladeshi party *"she would never eat, as they use fish and nuts for the curry".*

36. In his statement, Catherin's father advised that his youngest son suffers from similar allergies and, that following Catherin's death, Mr D'Rozario requested an EpiPen for his son to carry for emergency use. The general practitioner referred Mr D'Rozario to the Royal Childrens' Hospital. Mr D'Rozario continued:

> *"It was never mentioned to me that Catherin needed one. Because she was so cautious about where she ate, I didn't consider she needed one'.*

Kings Park Medical Centre

37. According to Catherin's medical records from Kings Park Medical Centre (**the medical centre**), she was a regular patient there between October 2012 and June 2019.

38. The first reference to asthma in the records was on 17 February 2013 when Catherin attended Dr David Feng to obtain an asthma action plan for school. In the consultation notes, Dr Feng wrote:

> *"Only uses Ventolin 1-2x week or if doing high intensity sports. No history of hospitalisation, prednisone use, no preventer needed."*

39. Dr Feng noted that he completed an asthma plan and advised Catherin to take Ventolin prior to intense exercise.

40. Catherin's next attendance at the medical centre was on 30 July 2014. She again saw Dr Feng and sought an allergy action plan. Dr Feng wrote:

"Previous severe allergic reaction to nuts at 4 years of age requiring hospital admission. Seen by immunology at that stage ***and did not require epipen according to mum*** [emphasis added]– *"? not true anaphylaxis. No further reactions since as avoiding triggers. Also gets mild tingling in mouth with sesame seeds, bananas and some fish".*

41. At that consultation, Catherin also complained of mild reflux type symptoms when she ate spicy food and drank coke.

42. A further asthma plan was completed by another practitioner at the medical centre in February 2015.

43. On 13 July 2016, Catherin was seen at the medical centre by Dr Adjoa Mensa at the medical centre following an exacerbation of asthma related to a respiratory infection. Dr Mensa noted *"Poorly controlled asthma, generally uses Ventolin daily".* A change was made to her asthma medications (from Seretide to Breo Ellipta) and she was advised to return for review the following day and to present to the emergency department if her symptoms worsened in the interim. Catherin did not return for review. She attended a further fifteen consultations at the medical centre all of which related to conditions unrelated to asthma and/or allergies.

44. I have also noted, for the sake of completeness that in his statement Mr D'Rozario explained that after the initial assessment of her allergies, Catherin had not returned to the RCH. He continued:

"In about 2017 her GP referred her to the Royal Children's Hospital for a follow up allergy assessment appointment, we received a letter and were advised that they would send us a letter with her appointment details. We would call and follow up but they kept saying that when they were able to see her they would send a letter. At her death we were still waiting on the hospital for the appointment"

45. According to the medical centre's records, by letter dated 22 June 2013, Dr Sia Tagerd referred Catherin to the RCH for *"opinion and management of her short stature".* By letter to Dr Tagerd dated 4 March 2014, the Endocrinology Clinic at RCH confirmed Catherin's attendance on that date and advised that her growth would be monitored at a follow up appointment in six months' time.

46. By letter dated 7 September 2015, Dr Astrid Richards of the medical centre (who recorded that Catherin had a follow up appointment with the RCH Endocrinology Clinic in October 2015) wrote to RCH to draw their attention to a fracture of the coccyx Catherin sustained in a fall

while playing soccer. Apart from a proforma letter from RCH acknowledging the referral there is no further reference to, or correspondence with, RCH from September 2015 onwards.

47. I have set out the details of Catherin's attendances at the medical centre in some detail in an attempt to reconcile the history recorded therein with the recollections of her allergies and treatment as set out in her parents' statements. I note that the contemporaneous clinical notes maintained at the medical centre generally appear to be careful and detailed and there is no reason for me not to accept they represent an accurate description of Catherin's attendances whereas, Mr and Mrs Rozario appear to have perhaps conflated events in their recollections, such as, for example, the reason for referring Catherin to the RCH.

48. The medical centre's records contain a single reference to an EpiPen, being that of 20 July 2014, when Mrs D'Rozario told Dr Feng that Catherin had been seen by "*immunology*" and advised an EpiPen was not necessary. Dr Feng's note suggests an impression that Catherin's condition was not related to "*true anaphylaxis*". There is also no evidence that Catherin was referred to RCH for assessment of her allergies in or about 2017. This is not in any way to derogate from Mr or Mrs D'Rozario's recollections, however, they are less likely for many reasons (such as stress and grief for example) to be accurate than those recorded contemporaneously by Catherin's medical practitioners.

49. There was no reason for the medical practitioners Catherin attended to have specific concerns about her allergies which were not raised in any of the numerous consultations which followed. Nor was there any evidence that her asthma was increasing in severity.

50. There is no evidence that Catherin had ever previously suffered an anaphylactic reaction nor an allergic reaction of anything approaching the severity of the catastrophic reaction she suffered on 23 August 2019. Her mother's evidence is that, if by chance Catherin ate something to which she was allergic, she would feel unwell and that vomiting would cause her to feel better.

51. So even had carrying an EpiPen been suggested to her she (and perhaps her parents) may reasonably have considered it to be unnecessary.

52. I asked the Coroners Prevention Unit[15] (**CPU**) to identify how many deaths involving anaphylaxis from food allergies have occurred in the last five years. The CPU advised me that, for the period 1 January 2015 to 31 August 2020, they identified nine deaths (including

[15] The role of the CPU is to assist coroners investigating deaths, particularly deaths which occur in a healthcare setting. It is staffed by healthcare professional, including practising physicians and nurses, who are independent of the health professionals and institutions under consideration.

Catherin's) related to anaphylaxis from a food allergy. Of the nine deaths, four were of young persons aged nineteen years or younger.

53. Whilst not intended as a criticism of the practitioners at Kings Park Medical Centre, I consider there was a potential missed prevention opportunity in July 2014 when Dr Feng was made aware of Catherin's food allergies. Although Catherin had not presented for treatment of allergies at that (or indeed at any other) time and, he was apparently reassured by Mrs D'Rozario that Catherin had been assessed by an (unidentified) immunology clinic and did not require an EpiPen, it may have been prudent to have recommended referring Catherin for review of her allergies, either directly to a specialist immunologist or back to the RCH to assess the status of her allergies. Accordingly, I make the recommendations below inviting the Royal Australian College of General Practitioners, the Royal Australian College of Physicians and the Australian Society of Clinical Immunology and Allergy and Allergy and Anaphylaxis Australia to remind general practitioners of the dangers of food allergies and not to hesitate to refer patients for assessment.

54. In addition, I have recommended that the Department of Education and Department of Health consider formulating an education campaign designed to alert parents, teachers and students of the dangers of allergies and anaphylaxis and encourage them to seek medical advice.

Dragon Pot Restaurant

55. It is at least very likely that the allergic reaction that Catherin suffered resulted from what she ate at the Dragon Pot Restaurant. As noted above, Mr Kuo, Director of Dragon Hot Pot restaurant provided a detailed statement and supporting documentation to the CI. In his statement, Mr Kuo explained that his company runs six Dragon Pot restaurants; 4 in Melbourne CBD, one in Glen Waverley and another in Box Hill. Mr Kuo provided details about the training required to be undertaken by staff regarding food handling and advised me that the training includes dealing with customers with allergies.

56. In relation to signage he told me that, as at 23 August 2019, large food allergy notices were displayed as follows: at the restaurant entrance; next to the area where customers collect bowls and tongs; the top right corner of each display fridge, another at the cashier and one at the sauce counter. The signs advise customers that the food served/cooked in the restaurant may contain allergens (such as nuts and/or fish) and that cross contamination with milk, eggs, wheat, soybeans, peanuts, tree nuts fish and shellfish cannot be avoided. The notices advise customers to ask staff about ingredients of specific dishes.

57. Again, as at 23 August 2019, staff at the cashier's desk would ask the customer if he/she had any allergies. If the response was affirmative, they would be reminded that the food served may contain nuts and seafood. The customer is asked to read the allergy notice at the counter and is asked to tell staff if they feel unwell.

58. Mr Kuo also advised me that since Catherin's death, some changes have been made to the restaurants' procedures including:

(i) Staff allocated to the front entrance during opening hours to ask allergy questions

(ii) Additional allergy signage and warnings about potential contamination with nuts and seafood across the store.

(iii) Retraining of staff in relation to allergies to ensure that all of the allergy questions are asked.

(iv) A staff guide to the allergy questions placed at the counter to prompt staff to ask the right questions and respond appropriately to customers' responses. Mr Kuo stated that the restaurants currently do not have a specific procedure for dealing with anaphylaxis. Some staff members are trained in First Aid and all staff know to call 000 in the case of an emergency.

59. Mr Kuo concluded:

> *"We have taken this incident very seriously. Straight after the incident we were very cautious and told staff not to serve anyone with allergies, but we had a lot* [sic] *complaints from people who we refused to serve whose allergies weren't severe. We have six restaurants across Melbourne and in the three years we have been open this is our first incident in relation to food allergies. Our restaurants averaged about 250 customers per day per restaurant."*

60. Asian style cuisine generally is likely to include common food allergens such as peanuts, tree nuts, sesame, soy, fish and seafood and a Chinese restaurant is not perhaps the wisest choice for a person with known food allergies. I am satisfied that at the time of Catherin's visit to the Dragon Pot Restaurant in August 2019, the restaurant displayed clear signage warning customers that the food served may contain common allergens such as sesame. The management of the Dragon Pot Restaurants has increased the signage and vigilance since Catherin's death. Accordingly, there would be no purpose served by making recommendations to the Department of Health about safe service of spicy foods in restaurants.

61. I am satisfied on the basis of the evidence available that no further investigation into Catherin's death is required.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I recommend:

(1) That, in order to reduce the risk of harm associated with food allergies and anaphylaxis that the Royal Australian College of General Practitioners, the Royal College of Physicians and in consultation with the Australian Society of Clinical Immunology and Allergy work collaboratively towards educating their members and fellows of the dangers and that they consider referring all patients (especially children and young persons) who present with food allergies to a specialist immunologist or immunology clinic such as that at the Royal Children's Hospital for assessment and management of such allergies.

(2) That the Australian Society of Clinical Immunology and Allergy, the Victoria Department of Education and the Victorian Department of Health consult widely and work collaboratively towards establishing an educational program directed to parents, teacher and students of school and universities alerting them to the potentially fatal consequences of food allergies and anaphylaxis.

I direct that a copy of this Finding be provided to those bodies noted above for the purpose of considering my recommendations.

FINDINGS AND CONCLUSION

62. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

(a) The identity of the deceased was Catherin D'Rozario born on 19 July 2002;

(b) Ms D'Rozario's death occurred;

i. On 25 August 2019 at Sunshine Hospital, St Albans, Victoria;

ii. from complications of acute asthma in the setting of an allergic response; and

iii. in the circumstances described in paragraphs 18-29 above.

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

(a) Mr Mathew D'Rozario and Mrs Stella D'Rozario, senior next of kin.

(b) Ms Samantha Burries, Sparke Helmore Lawyers;

(c) Ms Meaghan Bruns, DonateLife, Victoria

(d) Dr Matthew Miles, CEO, The Royal Australian College of General Practitioners (Victoria)

(e) Mr Peter McIntyre, CEO, The Royal Australian College of Physicians,

(f) Ms Jill Smith, CEO, The Australian Society of Clinical Immunology and Allergy

(g) Mr Martin Foley, Minister for Health, The Victorian Department of Health;

(h) Mr James Merlino, Minister for Education, The Victorian Department of Education; and

(i) First Constable Rhiannon Downs, Coroner's Investigator, Victoria Police.

Signature:

DARREN J BRACKEN

CORONER

Date: 31 December 2020