STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Noreen Peacock
Hearing dates:	14 - 16 October 2015
Date of findings:	29 October 2015
Place of findings:	State Coroner's Court, Glebe
Findings of:	Magistrate Sharon Freund, Deputy State Coroner
File numbers:	2013/316181
Representation:	Mr. I Bourke SC instructed by Ms. L Turner as Counsel Assisting the Coroner Mr. G James QC for Melissa Peacock Mr. E James instructed by Mr. L James for Jaslyne Haywood and Debra Crozier
Findings:	I find that Noreen Peacock died at Kellyville, New South Wales sometime between 1 April 2013 and 1 August 2013. The direct cause and manner of her death are both to be recorded as undetermined.

REASONS FOR DECISION

INTRODUCTION

1. Noreen Peacock was found deceased in the home she shared with her daughter Melissa Peacock on 18 October 2013. She was 83 years of age and had on all accounts suffered from Alzheimer's and vascular dementia for a number of years, with Melissa, her youngest daughter, her sole carer.

2. The circumstances of Mrs. Peacock's death on first blush would not be unusual however, Mrs. Peacock was found in a mummified state in her bed, by real estate agents conducting an inspection of the property on 18 October 2013. She had clearly been deceased for a long period of time. Melissa Peacock, her sole carer, was missing and was only located after an extensive media reporting of the case. She was eventually located at the Shangri-La hotel 6 days later, on 24 October 2013.

THE FUNCTION OF THE CORONER AND THE PURPOSE OF THIS INQUEST

3. The role of a Coroner as set out in s. 81 of the Coroners Act 2009 ("**the Act**") is to make findings as to:
    a. the identity of the deceased;
    b. the date and place of a person's death;
    c. the physical or medical cause of death; and
    d. the manner of death, in other words, the circumstances surrounding the death.

4. A coroner, pursuant to s.82 of the Act, also has the power to make recommendations, concerning any public health or safety issues arising out of the death in question.

5. As set out by Mr. Bourke SC, Counsel Assisting during his opening there is no issue as to the identity or the place of Mrs. Peacock's death. Accordingly the only issues to be determined in relation to Mrs Peacock's death were:

a. When did she die?
b. What was the cause of her death? and
c. What were the circumstances of her death?

I will deal with each of these issues in turn.

BACKGROUND

6. Noreen Peacock was born on 24 April 1930 in Muswellbrook, NSW. She married Nicol Peacock in 1952 and they had three daughters – Jaslyne, Debra and Melissa. They separated in 1976. By that time, Jaslyne and Debra had, or were about to, finish their secondary schooling and move out of home. They both met their future husbands in 1976 and from that time onwards appear to have forged their own careers and started their own families. Melissa, however, was considerably younger than her sisters. She remained living with her mother and extended family in Muswellbrook until 1981, when she moved to Sydney.

7. In 1995, Mrs. Peacock retired and moved in with Melissa at Neutral Bay. Mrs. Peacock was about 65 years old and Melissa was about 30 years old. From this time, mother and daughter lived together and never had anyone else living with them. It is clear from the evidence before me that they had a very close and dependent relationship.

8. Mrs. Peacock and Melissa moved back to NSW in April 2006. They rented a two-storey, four bedroom home at Kellyville.

9. From about 2007, Melissa worked as a receptionist at various private hospitals operated by Healthscope. She had, since 1996, worked almost exclusively in various administrative and clerical positions at hospitals. By all accounts she was a knowledgeable, dependable and hardworking employee. From 2009 to about mid-2013, Melissa was employed as a casual receptionist at Norwest Private Hospital. She worked weekdays between 2.00pm and 9.00pm and Sundays between 8.00am and 2.00pm. As she had never obtained her driver's licence, she faced a two hour commute for each shift. In total, she would generally be out of the Kellyville home for nine hours each weekday and eight hours on Sunday.

10. For the first few years following the move to Kellyville, Mrs. Peacock appears to have been relatively healthy and active. The evidence indicates that neighbours would often see her gardening and Melissa reported to police that her mother was "normal" and would walk and do the shopping and gardening in those early years.

MRS. PEACOCK'S MEDICAL CARE FROM 2010

11. Mrs. Peacock saw Dr Tina Chow, geriatrician on two occasions namely, 11 August and 8 September 2010. On both occasions she was accompanied by Melissa.

12. At the first consultation, Melissa reported that her mother had exhibited progressive short-term memory problems for over a year, which worsened acutely from March 2010. She reported that Mrs. Peacock was requiring prompting to shower and dress but once started she was able to complete the tasks relatively independently. She also reported three episodes of wandering (one of which required police to escort Mrs. Peacock home). Melissa reported a one year history of cognitive decline.

13. However, based on her assessment, Dr Chow was of the opinion that it is likely that Mrs. Peacock's symptoms were present for substantially longer. Mrs. Peacock had achieved a Mini Mental State Examination ("**MMSE**") score of 7/30 (normal being 30/30) which appears to have been independently verified later by her general practitioner, Dr Peter Aitken. Dr Chow noted that of her three daughters, Mrs. Peacock could only name Melissa.

14. On the basis of the MMSE score and the reported history, Dr Chow diagnosed Mrs. Peacock with advanced dementia, most likely due to Alzheimer's disease, with a possible component of vascular dementia.

15. Following the initial assessment, Dr Chow organised for Mrs. Peacock to have an MRI brain scan to investigate whether there was a vascular component to her symptoms. She was also intending to check Noreen's fasting lipids as she had borderline high cholesterol on her blood tests. She requested that Melissa organise an ophthalmologist appointment. Dr Chow provided Melissa with information about Orange Blossom Cottage, a day centre for patients suffering from Dementia to assist carers. An Aged Care Assessment Team assessment

referral was also organised for services to assist in the community and if needed, respite and permanent care in an aged care facility to plan ahead for progression of the Dementia process, if the family could not continue to look after Mrs. Peacock.

16. Dr Chow gave evidence that Orange Blossom Cottage could provide day care, generally during business hours, of up to about six hours a week to allow carers respite from their daily responsibilities. She also gave evidence that the ACAT could recommend up to about 16 hours of services a week. Those services might include meal preparation, personal care, housecleaning, and escorted outings and appointments.

17. At the second assessment on 8 September 2010, Melissa reported that her mother had wandered twice. The episodes generally occurred on a Tuesday night (when Melissa was working at Norwest Private Hospital). She said that police were notified on both occasions.

18. By 6 October 2010, Dr Chow had received the results of the investigations planned at the first assessment. The MRI bran scan showed small vessel disease only and fasting lipids revealed a cholesterol level of 5.4mmol/L and triglycerides of 1.1mmol/L. Dr Chow noted that Noreen had commenced monthly injections for a vitamin B12 deficiency. Ophthalmology and ACAT reviews were pending.

19. Following the second assessment, Dr Chow recommended that supervision of Noreen be maximised through adjustment of Melissa's work schedule. She explained during the course of her oral evidence[1] that this might mean that Melissa would not work the night shift on Tuesdays, when Mrs. Peacock tended to wander. She prescribed a low dose of atorvastatin (Lipitor) 10mg to manage Mrs. Peacock's high cholesterol and recommended that the monthly injections for the vitamin B12 deficiency continue. Dr Chow also planned to organise a dementia information session for Melissa to attend.

20. Following Noreen's death, Melissa told police that she attended an information night held at the Norwest Private Hospital. She also said that ACAT contacted

[1] On 15 October 2015

her some time afterwards but she thought that having strangers in the home would *"freak"* her mother out a bit, so she did not proceed with the assessment.

21. The evidence indicates that Melissa did not reduce her work hours as recommended by Dr Chow or seek any other assistance, including the services provided by Orange Blossom Cottage. In short, Melissa did not engage with any of the services to which she had been referred.

22. Mrs. Peacock did not attend a follow up appointment in February 2011 as recommended by Dr Chow. As Dr Chow and Melissa both worked at Norwest Private Hospital, from time to time Dr Chow would enquire after Mrs. Peacock. Dr Chow gave evidence that Melissa informed her that there she was "taking care of it". There was no further consultation with Dr Chow. The last consultation that Mrs. Peacock had with any medical practitioner was on 6 November 2010, when she saw a general practitioner (Dr Azab Taoum) who practised with Dr Aitken.

WHEN DID MRS. PEACOCK DIE?

23. The evidence of Dr Szentmariay, Forensic Pathologist, who gave evidence on the first day of the inquest[2] was that in his opinion, Mrs. Peacock's death had occurred about 3 to 6 months before her body was discovered.

24. Mrs. Peacock's body was discovered on 18 October 2013. Six months takes the date back to April 2013, while three months takes the date back to July 2013.

25. Evidence was also sought from Associate Professor Wallman, Forensic Entomologist in the hope that his expertise may provide a refinement of the time of death of Mrs. Peacock. Associate Professor Wallman concluded in his report dated 8 October 2015 that: *"the available insect evidence in this case can likely only account for a minimum death time of a period in the range of 1-2 months."*[3]

26. On 24 October 2013, Melissa Peacock participated in an ERISP with police[4]. Melissa Peacock in this interview provided an approximate date for her mother's death, namely, July 2013. By the end of the ERISP, Melissa stated that it *"would*

[2] 14 October 2015;
[3] Exhibit 1, Volume 3, Tab 84 at page 4;
[4] Exhibit 1, Volume 1, Tab 15;

have been the last Sunday in July"[5], however at other points in the ERISP, she was less precise, for example she also stated:

a. "a Sunday *towards the end of July"*[6];
b. "*It was July. Definitely July"*[7]; and
c. "that it was after she found Noreen on *the Sunday* that she changed her shifts"[8].

27. There is some other corroborating independent evidence which provides some support to Melissa's claim that it was "*the last Sunday in July*" that is, Sunday 28 July 2013, that she found her mother deceased.

28. It was the evidence of Ms Jodi Bradshaw that:

"*On either Monday the 29th or Tuesday 30th of July 2013 Melissa arrived for work at 2pm. She was obviously distressed and she was visibly shaking and looked like she had been crying. She came into my office and said "I need to resign", I said "why". She said "I am really struggling to get over the shingles and Mum is really, really unwell and I can't leave her." I said "I don't want you to resign, I am happy for you to have some time off or keep one shift a week if you want it. If you want the Sunday's I am happy for you to keep the Sunday because its is penalty rates as well". She said "are you sure, is that okay to do?" I said, " I am happy to do it, because I value your work here, we really don't want to lose you and you may want to come back full time in the future when you decide what you are going to do with your mum." ....She agreed to work on Sundays from 8am till 2pm....*"[9]

29. I note however, that the shift roster for Norwest Private Hospital[10] shows that Melissa still worked four days that week, but that her shifts changed to roughly two or three per week from August 2013 onwards.

30. Moreover, the banking records[11] show that on 1 and 2 August 2013 Melissa commenced staying at hotels in the Sydney CBD.

31. The date on which Melissa discovered her mother had passed away would be, I assume, a very traumatic and therefore memorable event for Melissa, and I

[5] Ibid at Q 993 at page 82;
[6] Ibid at Q 628 at page 186;
[7] Ibid at Q 871 at page 205;
[8] Ibid at Q 906 at page 208;
[9] Exhibit 1, Volume 1, Tab 18 at paragraph 17;
[10] Exhibit 1, Volume 2, Tab 67, at page 439;
[11] Exhibit 1, Volume 2, Tab 50A at page 381;

accept that some weight needs to be given to her account, that her mother died *"on the last Sunday in July 2013"*. The date is also not inconsistent with the evidence of Dr Szentmariay.

32. However, I accept the submission of Mr. Bourke SC that there are at least three difficulties in relying upon Melissa's account namely:
    a. the dates proffered in her ERISP is often vague and not entirely consistent, in that at times she simply says it "*would have been July*"[12];
    b. on her own admissions, she was during the relevant time drinking very substantial quantities of alcohol, which may have affected the reliability of her recall of events around this time; and
    c. Finally, Melissa has conceded during the course of her ERISP that she *"made up"* stories, which included a boyfriend[13] , a former husband and children[14] , and that she had made up stories *"all my life"* [15]. This tendency to fantasise with stories to others is something that was confirmed by Melissa's sisters.

33. For the reasons set out in the preceding paragraph I give little weight to Melissa's evidence, except to the extent that it is corroborated by independent evidence. While the evidence of Ms Bradshaw might provide some corroboration, it is not sufficiently specific in my view to justify a finding that Noreen's death occurred on 28 July 2013, or even just "July 2013". This could have been simply the date or time that Melissa had come to terms that her mother had in fact died.

34. The only person to have seen Mrs Peacock alive in 2013, other than Melissa, was her neighbor, Shailish Singh. His evidence was that he had not seen Mrs Peacock "for at least six months, it could be more"[16]. Having regard to Mr Singh's imprecise estimate, and Melissa's change in working hours and stays in hotels from early August 2013, I prefer a range of 1 April to 1 August 2013 as the approximate date of Mrs Peacock's death. This period of time is also consistent with the expert evidence.

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[12] ERISP Exhibit 1, Volume 1, Tab 15, Q 993 at page 215;
[13] Ibid, Q 963 at page 212;
[14] Ibid, Q 970 at page 213;
[15] Ibid, Q 965 at page 213;
[16] Exhibit 1, Volume 1, Tab 23 at paragraph 6;

35. Accordingly, I find that Mrs. Peacock died sometime between 1 April and 1 August 2013.

WHAT WAS THE CAUSE OF MRS. PEACOCKS DEATH?

36. The Post Mortem Report dated 18 August 201[17] could not conclude or determine a direct cause of death for Mrs. Peacock. Dr Szentmariay gave oral evidence on the second day of the inquest, and expanded upon the matters he had taken into account. As he explained, his ability to determine a precise cause of death was limited significantly by the state of decomposition of Mrs. Peacock's body.

37. Dr Szentmariay made a number of important negative findings, including:
    a. firstly, the absence of any indication of aspiration and pneumonia. It was the evidence of Dr Szentmariay that he found this surprising in a person with dementia, who might have difficulty swallowing;
    b. secondly, the absence of pressure ulcers. Although Dr Szentamariay explained that the lack of pressure ulcers does not mean that Mrs. Peacock was not bed bound, he gave oral evidence that on the balance of probabilities Mrs. Peacock "was not completely bed bound"; and
    c. That he saw no evidence of disfigurement of the bone, which would be the consequence of Paget's disease, and excluded that as a contributing cause of death.

38. Dr Szentmariay also noted the *"unusual"* finding of a fracture to the thyroid cartilage. The fracture was on one side only. He did not detect any haemorrhage, but gave evidence that it is difficult to detect a haemorrhage in the months after a death due to the breakdown of blood. He explained in evidence that the thyroid cartilage is part of the Adam's Apple and it can fracture even if only a relatively small force is applied.

39. Considerable investigations were undertaken in an attempt to establish if the fracture occurred before or after death. The forensic police officers and the government contractors who handled the Mrs. Peacock's body prior to Dr Szentmariay provided statements or gave evidence to the effect that they

[17] Exhibit 1, Volume 1, Tab 7;

were careful when handling the body. Dr Szentmariay gave evidence that it is possible the fracture can occur at autopsy and he could not say whether the fracture was caused before or after death

40. The most likely cause of death, in Dr Szentmariay's opinion, was hypothermia. As he found *"multiple mucosal spots (Wischnewsky ulcers)"*[18] in his examination of the stomach and also observed "*Red discolouration, both knees, anterior aspect*"[19]. This evidence on autopsy coupled with:
    a. the approximate date of death given by Melissa during her ERISP was during the coldest months of the year;
    b. that Mrs. Peacock was found naked; and
    c. that Melissa in her ERISP said that she did not think that she had the heating, namely reverse cycle air-conditioning, turned on in the house around the time that her mother died[20].

41. A finding as to the cause of death is a serious one. It requires the application of the *Briginshaw*[21] principle, namely that I be comfortably satisfied by reasonably compelling evidence. When pressed in oral evidence, by Counsel Assisting, Dr Szentmariay said that although he thought hypothermia was the likely cause of death, he was not prepared to say that on the balance of probabilities, Noreen's death was due to hypothermia. Accordingly, although I am satisfied that hypothermia is the likely cause of Noreen's death, the evidence is not in my view sufficient that I be comfortably satisfied on the balance of probabilities. As a result the direct cause of Mrs. Peacock's death will be recorded as undetermined.

WHAT WAS THE MANNER OF MRS. PEACOCK'S DEATH?

42. The term "manner" of death is not defined in the Act. However it seems generally to be accepted that the statutory duty of a Coroner to determine "manner of death", if that is possible on the evidence, requires consideration of the question

[18] Ibid at page 17;
[19] Ibid at page 19;
[20] Exhibit 1, Volume 1, Tab 15, Q708 at page 192;
[21] *Briginshaw v Briginshaw* [1938] HCA 34; (1938) 60 CLR 336

of how the death came about, namely a consideration of the circumstances that led to it.

43. Determining the 'manner' in which Noreen Peacock died requires an examination of more than just the physical events that ultimately led to her death.

44. It is not possible to ascertain exactly what happened in the final days, weeks and months of Mrs. Peacock's life. The only person who is aware of those circumstances is Melissa Peacock and for the reasons set out earlier in these findings I have found her evidence inherently unreliable. However, there are a number of known facts which as submitted by Counsel Assisting, suggest that her death may have been caused, or accelerated by, her isolation. The most significant of the known and uncontested facts are:-

a. that Mrs. Peacock had a number of medical conditions, namely Paget's disease, hyperparathyroidism, high cholesterol, vitamin deficiency, and, most importantly, dementia, that required medical monitoring. The evidence indicates that she received no monitoring from 6 November 2010, when she last saw a general practitioner (Dr Azab Taoum, practiced with her usual general practitioner, Dr James Aitken);
b. contrary to medical advice, Mrs. Peacock was not seen by a doctor after 6 November 2010, approximately 2 ½ years before her death;
c. Mrs. Peacock was being locked, alone, inside her two storey house for many up to nine hours, and up to six days per week.
d. Mrs. Peacock was further isolated by the fact that she had no access to a telephone, as the landline was cancelled by 1 April 2013, and perhaps would not have been able to use one even if she had such access due to the advanced state of her dementia;
e. her extremely low body weight at the time of her death. At Post Mortem, Mrs. Peacock was recorded to have a body weight of 31kg and a height of 1.63m. I accept that she was always a slim woman however, even after factoring an additional 15% weight for water loss post mortem, her weight at the time of her death would not have been more than 37 kg which made her seriously underweight and would have been of "extreme concern" to treating medical practitioners if they had known about it;

f. Mrs. Peacock's carer was affected by a serious alcohol-dependency problem, and also suffered depression, and in mid-2013, suffered from shingles, a seriously debilitating illness, such that the quality of the care she gave to Mrs. Peacock (if she was then still alive) may have been seriously compromised; and

g. there was no-one in the outside world, including her other daughters, or any external services, keeping watch over Mrs. Peacock or the care she was being given.

45. Media reports of this inquest have focused on the more sensational aspects of the belated discovery of Noreen's death, the circumstances surrounding Melissa's alcohol abuse, and her being charged with the offences of fraud and of failing to report the death. Viewed in this overly simplistic way, the death of Mrs. Peacock might appear to be a simple story of neglect of an elderly and helpless woman, by one person, Melissa Peacock. However, this is far too simplistic, and ignores a far more complex familial and factual background.

46. It is clear that Mrs. Peacock and Melissa lived a very isolated existence, and that after the onset of Noreen's dementia, they became even more insulated from the outside world. The evidence from Melissa's sisters is that Mrs. Peacock and Melissa were very close, and it is obvious from all of the evidence that Melissa was very dedicated to her mother, probably in quite a "dependent" way. There is evidence to support the conclusion that for many years, Melissa performed a remarkably good job of looking after her mother, with no assistance from anyone else.

47. It was submitted by Mr. James QC that neither Melissa, or her sisters, Jaslyne and Debra, should be subject to adverse criticism. He submitted that they were clearly estranged at the time of their mothers passing and it would be unfair to "*require or impose upon estranged relatives a new social dynamic and moral burden*". Moreover he stated that "*adverse criticism of those whose domestic circumstances with those who have been excluded or those who have detached as a result of an unrealised mental illness problem*" would be unfair.

48. I do not agree. In so concluding I have also carefully considered the submission of Mr E. James for Jaslyne and Debra that I would be mindful of the evidence of

John Watkins, the CEO of Alzheimer's Australia (NSW) that Alzheimer's disease is a disease that terrifies second only to cancer. I am cognisant of the fact that it was probably a sad and terrifying experience for all of Mrs. Peacock's daughters to witness their mother's decline and memory loss. I am also cognisant of the fact that, as explained by Mr Watkins, families will often do the best they can to deal with the difficult situation of caring for a loved one with dementia.

49. Nonetheless, responsibility for the isolation of Mrs. Peacock must rest primarily with Melissa. It is in my view totally unacceptable that Mrs. Peacock was deprived of medical attention from November 2010. Quite apart from the ongoing medical attention that one would expect to be required by an elderly person with advanced dementia, on Melissa's own account, at least in the weeks prior to Mrs. Peacock's death she was experiencing vomiting and diarrhea. It is also unacceptable that Mrs. Peacock was being left alone, in a locked two storey house, for up to nine hours per day, six days a week, for many months while Melissa went to work. The risks involved in leaving an elderly person unsupervised for this length of time are obvious. The risks were greatly magnified in this case, by reason of Mrs. Peacock's advanced dementia.

50. Of course, it is also necessary, when considering Melissa's actions, to take into account the fact that she was probably also suffering the effects of a long-standing serious depression. I accept the submission of Mr James QC that Melissa was successful, in large part, from concealing her mental illness from her colleagues.

51. However, the extent to which Melissa was able to conceal her mental illness from her sisters is less clear. It was the evidence of both Jaslyne and Debra that they were aware that their younger sister was known to have a history of depression and that she was in the habit of "telling stories". Neither of them were told of Melissa's fictitious boyfriend, "Brad". It is clear that neither of them were aware of Melissa's alcoholism, but it is unclear when Melissa started drinking in earnest.

52. Melissa's sisters were, at least, aware that Melissa had a history of depression and that she would "tell stories". They also knew, at least as at May 2012, that their mother suffered from advanced dementia. Debra gave evidence that she understood that dementia and Alzheimer's disease was progressive, incurable

and usually involved a loss of capacity to care for oneself. The older sisters did not discuss a plan nor did they make further inquiries as to how Melissa was coping. They simply did not want to know.

53. Debra often repeated, in evidence, that she did not make active enquiries regarding her mother's or Melissa's welfare because she believed that Melissa would have called her if something happened to their mother. It is patently obvious that this did not occur. Jaslyne gave evidence that she did worry about her mother and occasionally thought about driving to visit her. However, she did not know what she could do.

54. Although the isolation of Mrs. Peacock occurred as a direct result of Melissa's conduct, it must be said that Jaslyne and Debra share some of that responsibility. Caring for an ageing parent should be a joint responsibility. While the primary responsibility may in many cases, fall upon or be taken up by one family member that does not absolve other family members, in my view, from their moral duty to provide whatever assistance and support they can. I have no doubt that it must have been very painful for Jaslyne and Debra when their mother failed to recognise them in May 2012. However, that should not have resulted in there being no further contact with their mother. To the contrary, Mrs. Peacock's deteriorating mental state was a reason to increase their attempts to remain connected with their mother, to monitor her health, and to provide whatever assistance they could to her and their sister at least from an emotional support perspective.

55. It is quite extraordinary that both Jaslyne and Debra thought it acceptable when they were told, in May 2012, that Noreen was being left unsupervised in a locked house for hours on end. It is surprising, to say the least, that neither of them appear to have questioned Melissa as to how many hours Mrs. Peacock was spending alone in the locked house. And it is even more surprising that after May 2012, they took no practical steps to check on their mother's or their sister's well-being. In practical terms, Jaslyne and Debra were the only people in the outside world who were in a position to insist upon obtaining access to their mother, so as to monitor her welfare. While doing so would not have been easy, given Melissa's evasive nature, and would have been emotionally painful, this does not

excuse the failure by Mrs. Peacock's two eldest daughters to remain involved in her life.

56. There were many facts known to Jaslyne and Debra that should have acted as warning signs, and led to them taking a greater role in monitoring their mother and providing at least emotional support to Melissa. Among these were Mrs. Peacock's increasing dementia, Melissa's history of depression and story-telling, and the fact that their mother was being left alone in a locked house for large periods of time.

CONCLUSION

57. Whether the failures by Jaslyne and Debra to remain connected to their mother's life contributed to the death of Mrs. Peacock cannot and will never be known. Nor is it possible to determine with any certainty, as a result of her failing to report her mother's death in a timely manner, that it was any particular failing by Melissa which led to Mrs. Peacock's death.

58. What seems likely however, is that Mrs. Peacock's death was contributed to, or accelerated by, the inability of Melissa to meet the demands that her mother's care must have involved, especially during 2013. This conclusion can be drawn, based on a combination of circumstances, but including Mrs. Peacock's extremely low weight at the time of death[22], and the fact that Melissa, her sole carer, had a significant depressive illness and alcohol problem, and was absent from the home for many hours each week.

59. This was an extraordinarily sad case.

60. Noreen Peacock died being cared for by the person who no doubt loved her the most, her youngest daughter Melissa. However, at some point in time, Melissa became unable to cope with the responsibility of being the sole provider and carer of a frail, elderly mother who was suffering from the advanced stages of dementia. Melissa did not reach out for help. Her sisters did not extend assistance despite awareness of their mother's deteriorating condition. This in my

[22] At Post Mortem body weight was 31kg. It was the oral evidence of Dr Szentmariay that approximately 10% of the body weight would have been lost as a result of the Post Mortem changes to the body.

view further isolated Melissa and their mother from the outside world. Accordingly, Melissa was left to flounder and the consequences were extreme.

FINDINGS

61. Accordingly, I now turn to the findings I am required to make pursuant to s. 81 of the Act.

I find that Noreen Peacock died at Kellyville, New South Wales sometime between 1 April 2013 and 1 August 2013. The direct cause and manner of her death are both to be recorded as undetermined.

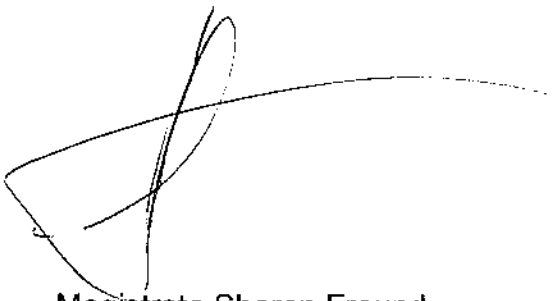
RECOMMENDATIONS

62. I had the benefit of evidence from Dr Chow and from Mr Watkins to the effect that there are services available in NSW to sufferers of dementia and their carers. The evidence shows however, that those services are limited, somewhat scattered, and not necessarily easy to access. Furthermore, even with the maximum level of support (21 hours per week according to Mr Watkins, and 22 hours per week according to Dr Chow, if the maximum hours were provided as a consequence of an ACAT assessment and by Orange Blossom Cottage) this would not have been anywhere near the number of hours of supervision that Mrs. Peacock required for the period that she was left alone in the house while Melissa worked Norwest Private Hospital.

63. This is not however, an inquest which directly raises the question of the availability of resources to help carers of persons with advanced dementia. Melissa never asked for help. And even if help had been available 24 hours a day, 7 days a week, free of charge, it is clear that Melissa would not have accepted it. This is made plain in her police interview where she said that her mother would have been *"freaked out"* by strangers in the house. It is also made plain by the very private and anti-social behaviours that Melissa demonstrated to her co-workers and neighbours. She simply did not want others intruding into the lives of herself and her mother.

64. Pursuant to s. 82 of the Act, Coroners may make recommendations connected with a death. However, for the reasons set out in these findings, I decline to make recommendations.

I close this inquest.



Magistrate Sharon Freund
Deputy State Coroner
29 October 2015