New South Wales

CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of SMS
Hearing date:	10 August 2026
Date of Findings:	10 August 2026
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Judge Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, unascertained cause of death
File number:	2021/290711
Representation:	Ms M Katawazi, Solicitor Assisting (Department of Communities and Justice Legal)
Findings:	SMS died on 11 October 2021 at Nepean Hospital, Kingswood NSW 2747. Despite post-mortem examination and investigations, the cause of SMS's death cannot be ascertained. The post-mortem examination and investigations did not identify any evidence to suggest that any non-natural factor contributed to SMS's death. SMS therefore died of unascertained natural causes.

1. What happened?

1.1 On the afternoon of 9 October 2021, SMS, a 14-year-old high school student, was at home with her family. She told her father that she was feeling dizzy and unwell and had a headache. SMS's father told her to have a shower, have something to eat and get some fresh air. Later that afternoon, SMS appeared to be her usual self.

1.2 At around 10:00pm, SMS went to her bedroom and watched a movie with her cousin over Zoom until around 5:00am the next morning.

1.3 At around 10:45am on 10 October 2021, SMS's mother went to her bedroom and found SMS lying face down in her bed. SMS was unresponsive and not breathing.

1.4 Emergency services were contacted and resuscitation efforts were commenced. Paramedics arrived on scene a short time later and continued the resuscitation efforts. Return of spontaneous circulation was achieved and SMS was taken to hospital where she was admitted to the intensive care unit.

1.5 Investigations revealed that SMS had suffered irreversible neurological injury. Following discussions with her family, a decision was made to withdraw advanced life support. At 8:46am on 11 October 2021, SMS was tragically pronounced deceased.

2. Why was an inquest held?

2.1 Pursuant to the *Coroners Act 2009* (**the Act**), a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and the cause and the manner of that person's death.

2.2 Certain deaths are reportable to a Coroner. Some examples of reportable deaths are where the cause of a person's death is not due to natural causes, or where the cause or manner of a person's death may not immediately be known. In SMS's case, the cause of her death could not be identified, even following a post-mortem examination and an extensive coronial investigation.

2.3 The Act provides that an inquest is required to be held where the cause and manner of a person's death has not been, using the language of the Act, "*sufficiently disclosed*". As the coronial investigation did not sufficiently disclose the cause of SMS's death, an inquest was required to be held.

2.4 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the coronial jurisdiction and inquest process into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will wish to attempt to cope with the consequences of such a traumatic event in private. The sense of loss experienced by family members does not diminish significantly over time. Therefore, it should be

acknowledged that both the coronial process and an inquest by their very nature unfortunately compel a family to re-live distressing memories and to do so in a public forum.

3. SMS's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. It is hoped that what is set out briefly below acknowledges SMS's life in a meaningful way.

3.2 SMS was born in October 2006 to CM and JS. She had an older and a younger sibling.

3.3 SMS's family lived in [redacted] and she attended [redacted] in [redacted]. SMS loved playing all sports, particularly football, and she enjoyed watching movies. SMS's family describe her as having a bubbly and outgoing personality.

3.4 There can be no doubt that SMS's family, loved ones and friends have been profoundly affected by the suddenness of SMS's death at such a young age. Her life, her aspirations, her dreams have all been tragically cut short. The grief and loss that those closest to SMS have experienced cannot be described in mere words. But the memories and love they all have for SMS remain undiminished.

4. Factual summary

4.1 SMS had no known significant medical conditions. She was considered to be fit and healthy although on occasion was noted to be slightly out of breath when running. She had not been prescribed any regular medication.

4.2 In around August 2021, SMS reportedly "*blacked out*" and needed to be collected from school. After returning home, SMS appeared well with no further issues reported. SMS's mother attributed the incident to SMS being either overdressed on a warm day or simply wanting to leave school and return home.

4.3 On 24 September 2021, SMS attended a chemist in [redacted] and was given her first dose of the Moderna COVID-19 vaccine. Apart from SMS having a sore arm afterwards there were no complications with the vaccination.

4.4 At around 4:00pm on 9 October 2021, SMS was at home and called out to her father for help, reporting that she was feeling unwell and dizzy and had a headache. SMS's father told her to have a shower and something to eat and get some fresh air as it was a warm day. In the previous week or two, SMS had been relaxing inside at home and not going outside, apart from an occasional short walk. Later in the evening, SMS appeared to be her usual self.

4.5 At around 10:00pm, SMS went to her bedroom and watched a movie over Zoom with her cousin until around 5:00am. SMS's cousin observed that SMS appeared to be her usual, happy self and nothing amiss was noted.

4.6 At around 10:45am on the 10 October 2021, SMS's mother went into SMS's room to wake her. She found SMS lying in bed, with her head face down on her pillow. SMS was unresponsive, not breathing with her lips cyanosed and reddish coloured froth coming from her mouth.

4.7 SMS's mother called out to SMS's father and resuscitation efforts were commenced immediately. SMS's mother also notified a neighbour and asked them to contact emergency services.

4.8 At 11:01am, paramedics arrived on scene and noted that SMS was unresponsive, not breathing and had nil cardiac output. Her heart rhythm was noted to be in asystole. Resuscitation efforts were initiated and adrenaline was administered with two direct current shocks administered. Return of spontaneous circulation was achieved and SMS was placed on a ventilator. However, it was noted that her pupils were fixed and dilated.

4.9 SMS was taken to Nepean Hospital by ambulance and arrived at the emergency department at 11:50am. She was noted to be in profound respiratory acidosis. SMS was intubated and arrangements were made for further investigations, including a CT scan of the brain and input from the cardiology team.

4.10 SMS was transferred to the intensive care unit and a CT scan of her brain showed global cerebral ischaemia and generalised loss of grey-white matter. Following input from the neurosurgery team, it was considered that no neurosurgical interventions were likely to improve SMS's condition. Following discussions with SMS's family, a decision was made to provide supportive care and it was explained that SMS's prognosis was poor.

4.11 Later that evening, it was explained to SMS's parents that she had likely sustained brain death. It was decided that supportive care would continue but no further resuscitation efforts would be commenced.

4.12 On the morning of 11 October 2021, following further discussions between SMS's parents and the treating team, a decision was made to withdraw advanced life support. SMS was extubated and tragically declared life extinct at 8:46am.

5. The post-mortem examination

5.1 A post-mortem examination was performed by Dr Alexandra Kullen, forensic pathology trainee, supervised by Dr Elsie Burger, forensic pathologist, on 14 October 2021 at Forensic Medicine Sydney. The significant findings from the examination can be summarised as follows:

(a) features in keeping with hypoxic-ischaemic encephalopathy with mild inflammation, neuronal loss and gliosis (cellular change following damage to the central nervous system) in the medial temporal lobe, suggestive of viral or autoimmune encephalopathy;

(b) acute pneumonia and features associated with mild asthma;

(c) increased fat within the right ventricle but no fibrosis;

(d) features in the myocardium in keeping with global hypoperfusion (reduced blood flow);

(e) human herpes virus 6 (**HHV 6**) DNA was detected in heart and lung tissue but no microscopic evidence of viral infection was seen in these tissues;

(f) no evidence of viral infection or pathogens from virology testing; and

(g) toxicological analysis of antemortem blood did not detect any common medications or other substances.

5.2 Neuropathology examination was performed by Professor Michael Buckland, neuropathologist, at Royal Prince Alfred Hospital. Professor Buckland noted the features from the postmortem examination suggestive of a viral or autoimmune encephalitis (acute inflammation of the brain tissue). He expressed the opinion that in the absence of identifiable viral infection, these features may represent a mild autoimmune/limbic (connected structures deep within the brain) encephalitis. Professor Buckland also noted that these changes (and their underlying cause) may have caused a seizure event at or around the time of SMS's death.

5.3 Dr Kullen and Dr Burger noted the following factors to consider:

(a) Autoimmune encephalitis typically presents with prodromal (early signs or symptoms) headache, fever or viral-like process, followed by progression to symptoms similar to that of viral encephalitis. Both conditions can give rise to seizures of which there are typically no demonstrable features at post-mortem examination.

(b) Whilst the post-mortem examination did not identify any abnormality within the heart, some conditions are the result of defects in ion channels caused by genetic factors (known as channelopathies) which cannot be demonstrated from post-mortem examination. These channelopathies can result in sudden fatal cardiac dysrhythmias. Given SMS's young age and the absence of any significant morphological findings, Dr Kullen and Dr Burger noted that sudden cardiac death should be considered in SMS's case.

(c) While there was evidence of acute pneumonia, the features were more in keeping with ventilator and/or aspiration-associated pneumonia rather than a viral pneumonia.

(d) The features of asthma changes seen in the lungs were not severe and there were no clinical features of asthma when SMS was in hospital.

(e) Based on the gross and histological examination, there is no indication that SMS's vaccination on 24 September 2021 played any role in her death.

5.4 In the post-mortem examination report dated 9 December 2021, Dr Kullen and Dr Burger opined that the cause of SMS's death could not be ascertained.

6. Further investigation as to cause of death

6.1 On 14 October 2021, SMS's death was reported as an adverse event following immunisation.

6.2 On 17 November 2021, SMS's death was considered by the Health Protection NSW COVID-19 Vaccine Safety Expert Panel (**Panel**). At this time, the post-mortem examination report had not been completed. The Panel noted the following:

(a) whilst SMS had a history of very mild asthma as a young child, there was no wheeze that would be expected with asthma and no obstructive airway disease;

(b) SMS had no history of drug use or smoking and very rarely drank alcohol;

(c) SMS had no family history of cardiac deaths; and

(d) whilst SMS reportedly fainted in August 2021, the circumstances surrounding this event were unclear.

6.3 The Panel considered that SMS's case was unlikely to involve myocarditis but there was the possibility of involvement from an inherited arrhythmia syndrome. It was decided to await the final post-mortem examination report and blood testing.

6.4 On 14 October 2022, the Panel reconvened, this time with the benefit of the post-mortem examination report and neuropathology findings. It was also noted that SMS's family had undergone genetic testing for possible channelopathies which returned a negative result. However, Dr Burger noted that this did not exclude the possibility that SMS had experienced a *de novo* issue.

6.5 The Panel noted the following:

(a) There was no elevated troponin or C-reactive protein which would be expected if there had been a vaccine related side-effect. It was also noted that the time course was not consistent with vaccine-related myocarditis and that it would be unusual for this to present suddenly 14 days following vaccination.

(b) HHV 6 is ubiquitous in childhood, can persist in detectable quantities and is therefore difficult to interpret. Negative virology testing makes it less likely to be the cause of any encephalitis.

(c) The presumptive autoimmune cause of encephalitis may have resulted from failure to test for, or capture, another viral cause. Whilst an autoimmune antibody panel might assist in making a positive diagnosis, it was noted that this is was not possible from post-mortem tissue samples.

(d) A seizure is a possible presentation consistent with autoimmune encephalitis which could lead to a cardiac event. The neuronal loss and gliosis seen from the post-mortem examination was in a location (hippocampal region) which is noted to be very strongly associated with seizures.

(e) Whilst it was noted that acute sudden death without any prior symptoms would be a very unusual presentation of autoimmune encephalitis, a sudden event does not preclude it as a diagnosis.

(f) Whilst the detection of a relevant antibody is usually required to confirm a diagnosis of autoimmune encephalitis, it can occur in the absence of detectable antibodies.

6.6 The Panel ultimately concluded that there was no myocarditis and that there was some supporting evidence of a possible sequence of encephalitis leading to seizure and hypoxia with a secondary cardiac event considered plausible.

7. What was the cause and manner of SMS's death?

7.1 The post-mortem examination and the conclusions reached by the Panel exclude any non-natural contribution to SMS's death. Toxicological analysis did not detect any drug or substance which contributed to death, and the post-mortem examination did not identify any findings indicating that vaccination played a role in SMS's death. Furthermore, the Panel found no evidence of myocarditis and noted that there was no evidence of elevated troponin or C-reactive protein indicative of any vaccine related side-effect. Finally, the Panel noted that the time course between SMS's vaccination and death was inconsistent with any vaccine -related adverse outcome.

7.2 The above evidence therefore establishes that SMS died of natural causes. However, the post-mortem examination and investigations performed have not been able to identify the precise cause of SMS's death. Two possibilities have been raised.

7.3 First, the possibility of encephalitis leading to seizure. However, the post-mortem examination did not identify any evidence of viral infection and it has not been possible to confirm a diagnosis from antibody testing. Further, a post-mortem examination is unable to demonstrate evidence of a seizure causative of death.

7.4 Second, the possibility of sudden cardiac death. Although genetic testing was negative for possible channelopathies, it is noted that a genetic change may appear for the first time. Further, a sudden cardiac death resulting from an arrhythmia also cannot be demonstrated from post-mortem examination.

7.5 The available evidence has not been able to rule in or rule out either of these possibilities so that a precise cause of SMS's death can be ascertained. Therefore, SMS's death is best described as being due to unascertained natural causes.

8. Findings pursuant to section 81(1) of the Act

8.1 I acknowledge and express my gratitude to Ms Mena Katawazi, Solicitor Assisting, who has provided excellent assistance throughout the course of the coronial investigation and at the inquest itself. I am particularly grateful to Ms Katawazi for the sensitivity and compassion that has been extended to SMS's family.

8.2 I also thank Senior Constable Dylan Gray, the New South Wales Police Force Officer-in-Charge, for his role in the investigation and compiling the initial brief of evidence.

8.3 The findings that I make under section 81(1) of the Act are:

Identity
The person who died was SMS.

Date of death
SMS died on 11 October 2021.

Place of death
SMS died at Nepean Hospital, Kingswood NSW 2747.

Cause of death
Despite post-mortem examination and investigations, the cause of SMS's death cannot be ascertained.

Manner of death
The post-mortem examination and investigations did not identify any evidence to suggest that any non-natural factor contributed to SMS's death. SMS therefore died of unascertained natural causes.

9. Epilogue

9.1 On behalf of the Coroners Court of New South Wales and the Assisting Team, I offer my deepest sympathies, and most sincere and respectful condolences, to SMS's parents, siblings, and family, and her loved ones and friends for their most tragic loss.

9.2 I close this inquest.

Judge Derek Lee
Deputy State Coroner
10 August 2026
Coroner's Court of New South Wales