IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006300

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Angela Christy Tulloh

Delivered On:	15 April 2024
Delivered At:	Melbourne
Hearing Dates:	15 April 2024
Findings of:	Coroner Simon McGregor
Police Coronial Support Unit	Leading Senior Constable Premala Thevar
Keywords	In care

I, Coroner Simon McGregor, having investigated the death of Angela Christy Tulloh, and having held an inquest in relation to this death on 15 April 2024, make findings as follows.

INTRODUCTION

1. Angela Christy Tulloh was 44 years old when she passed away on 2 November 2022. Angela was a National Disability Insurance Scheme (**NDIS**) participant and a long-term resident of Specialist Disability Accommodation (**SDA**) at 122 Canterbury Street, Brown Hill, Victoria, a residence operated by registered NDIS provider Melba Support Services (**Melba**).[1]

2. Angela was born in Melbourne, Victoria, on 17 March 1978 and was one of eight children.[2] From an early age it was identified that Angela was not meeting developmental milestones and after attending a mainstream primary school until the age of 10 years old, she was transitioned to specialist schools for the remainder of her schooling.[3]

3. Angela had diagnoses of autism spectrum disorder, intellectual disability, borderline personality disorder and depression. Angela had a long history of behavioural difficulties and self-harm which included the ingesting of cleaning products and other poisons, and overdoses of medication. Angela would also consume large amounts of alcohol if she was able to gain access to it and on several occasions these self-harm attempts resulted in Angela being hospitalised.[4] Most of these incidents occurred following Angela leaving her residence unannounced, with the intention of obtaining substances to self-harm with. In the 16 months prior to her death, Angela engaged in dangerous or self-harming behaviours on seven recorded occasions.[5]

THE CORONIAL INVESTIGATION

4. Angela'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

[1] Jacqui McCOWAN statement 6.
[2] Rebecca TULLOH statement 2.
[3] Ibid.
[4] Jacqui McCOWAN statement 11.
[5] Ibid.

unexpected, unnatural or violent or result from accident or injury. Because Angela was an SDA resident residing in an SDA enrolled dwelling at the time of her death, her passing was determined to be 'in care'[6] and, as such, is subject to a mandatory inquest, pursuant to section 52(2) of the Act.

5. 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.

6. 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.

7. At my direction, Victoria Police assigned Senior Constable Steven Tung to be the Coronial Investigator for Angela's death. Senior Constable Tung conducted inquiries and took statements from witnesses including Angela's sister, Rebecca Tulloh, Melba Disability Support staff members and Angela's treating clinician, before compiling and submitting a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Angela Christy Tulloh including evidence contained in the coronial brief. 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.[7]

[6] See Regulation 7(1)(d) of the *Coroners Regulations 2019*.
[7] 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.

9. In considering the issues associated with this finding, I have been mindful of Angela's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

10. Angela was a long-term resident of specialist disability accommodation at 122 Canterbury Street, Brown Hill. The property, which consists of four units on the one block, is managed by Melba Support Services. Angela lived in the main unit with two other female residents, with the three other units on the property being occupied by single residents. Angela had been living at the Canterbury Street property for approximately nine years prior to her death.[8]

11. Residents of the property receive 24-hour support from disability support staff, with up to three staff supporting residents at any one time, including overnight sleepover shifts. In addition to the support provided within the unit, Angela required support to access the community and attend appointments and would be accompanied by a support worker whenever she left the residence.[9]

12. Angela was also supported by her family, who she had a close relationship with, and visited them the weekend before her death. Angela was in good spirits during this visit and did not indicate that anything was concerning her, nor did she express any intent to self-harm.[10]

13. On Monday 31 October 2022 Angela was at home at the Canterbury Street property with Disability Support worker, Paul Collins, also present. Angela was seated in the kitchen area of the unit while Paul was preparing lunch for the residents. Angela appeared to be in a good mood and did not show any signs of being distressed or upset.[11]

[8] Jacqui McCOWAN statement 6.
[9] Ibid 7.
[10] Rebecca TULLOH statement 35.
[11] Paul COLLINS statement 7.

14. At approximately 12:25 pm, Paul left the kitchen to take a call from one of the other support workers who was out taking another resident to an appointment. While on the phone, Paul heard Angela leave the unit. Paul ended his phone call and went looking for Angela, searching the unit and the rest of the property before discovering she had left the address.[12]

15. Paul notified his supervisors and Melba staff began searching the local area for Angela by car, checking locations she had previously been found. Angela was then reported as a missing person to the Ballarat Police Station.[13]

16. Over the next two days an extensive search operation was coordinated by Victoria Police. The search operation involved uniform members, the Mounted Branch, K9 unit, Search and Rescue Unit, Police special solo motorcycles, aerial patrols by the Police Air Wing and the Drone Unit and ground searches by the State Emergency Service.[14]

17. On Tuesday 1 November 2022, a young girl who lived nearby noticed a person lying on the ground at the rear of the Shell Service Station building located at 350 Humffray Street North, Brown Hill. The child thought the person was sleeping or had passed out, but this sighting was not reported to police at the time.[15] The Shell Service station on Humffray Street is located approximately one kilometre from Angela's SDA unit.

18. On Wednesday 2 November 2022, at approximately 4:30 pm the same child re-attended the service station with two of her friends. On seeing the person lying on the ground in the same position as the previous day, the children notified the staff at the service station.[16]

19. Service station staff inspected the rear of the building and located Angela lying hunched over on the ground in a narrow space between the rear of the building and a tall Colourbond fence. The staff members called '000' and Police and Ambulance Victoria attended a short

[12] Paul COLLINS statement 8.
[13] Ibid 9.
[14] PEEC Incident Activity Log, Exhibit 4 to Coronial Brief, 71-84.
[15] Senior Constable Steven TUNG statement 3.
[16] Angel JOY statement 5.

time later and Angela was pronounced deceased. A 1L bottle of methylated spirits was located on the ground next to Angela with approximately 500mL missing.[17]

20. A check of the Shell Service Station's CCTV footage shows that Angela entered the store at approximately 12:30 pm on Monday 31 October 2022. After entering the store Angela removed a 1L bottle of methylated spirits from the shelf and placed it in her top, before leaving the store and walking to the rear of the building to the area between the building and the fence. She remained there until she was located at approximately 4:30 pm on 2 November 2022.[18] The area that Angela was located in is not covered by CCTV footage and is not easily visible from the main thoroughfares around the service station.[19]

21. According to the Bureau of Meteorology website, the maximum temperature for the Ballarat weather station (the closest weather station) on 31 October 2022 was 15.9 degrees Celsius and the minimum temperature was 9.8 degrees Celsius. The maximum temperature on 1 November 2022 was 10.6 degrees Celsius and the minimum temperature was 4.4 degrees Celsius.[20]

Identity of the deceased

22. On 2 November 2022, Angela Christy Tulloh, born 17 March 1978, was Visually identified by her sister, Rebecca Tulloh.

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

Medical cause of death

24. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine conducted an autopsy on 9 November 2022 and provided a written report of her findings dated 26 May 2023.

[17] Senior Constable Steven TUNG statement 6.
[18] Senior Constable Steven TUNG statement 6.
[19] Scene photographs, Exhibit 1 to Coronial Brief, 43.
[20] Autopsy Report (Medical Examination Report), Exhibit 13 to Coronial Brief, 121.

25. Toxicological analysis of post-mortem samples showed Angela had a blood alcohol level of 0.19g/100mL and a vitreous humour level of 0.20 g/100mL at the time of testing.[21]

26. Dr Francis provided an opinion that the medical cause of death was 1 (a) hypothermia in the setting of methylated spirits ingestion.

27. I accept Dr Francis's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Angela Christy Tulloh, born 17 March 1978;

    b) the death occurred on 2 November 2022 at 350 Humffray Street North, Brown Hill, Victoria, 3350, from hypothermia in the setting of methylated spirits ingestion; and

    c) the death occurred in the circumstances described above.

29. Having considered all of the evidence, I am satisfied that the care provided to Angela by Melba Support Services was reasonable and appropriate in all the circumstances.

Pursuant to section 73(1) 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:

Andrew Tulloh, Senior Next of Kin

Margaret Tulloh, Senior Next of Kin

Penny Harris, Melba Support Services

Dr Raveendran Nair Lalitha, Grampians Area Mental Health Service

[21] Autopsy Report (Medical Examination Report), Exhibit 13 to Coronial Brief, 121.

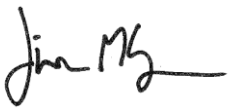
Dr Linda Danvers, Ballarat Health Services

National Disability Insurance Scheme Quality and Safeguards Commission

Regan Richards, National Disability Insurance Agency

Senior Constable Steven Tung, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date: 15 April 2024

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 inquest. 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.