IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 0728

FINDING INTO DEATH WITHOUT INQUEST

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

I, JACQUI HAWKINS, Coroner having investigated the death of Steele Tyson Moller

without holding an inquest:
find that the identity of the deceased was Steele Tyson Moller
born on 10 June 1995
and the death occurred on 11 February 2017
at Ballarat Base Hospital, 1 Drummond Street North, Ballarat, Victoria, 3350
from:

1 (a) ASPIRATION PNEUMONIA
CONTRIBUTING FACTORS – CEREBRAL PALSY

1. Steele Moller was 21 years old at the time of his death. His known past medical history included cerebral palsy, epilepsy, fundoplication and recurrent aspiration pneumonia and urinary tract infections. He was a resident at a Department of Health and Human Services residential facility in Stawell.

2. Steele's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Coroners Act).

3. At the time of his death, Steele was 'in care' pursuant to section 3 of the Coroners Act. A coroner must hold an inquest if the deceased was, immediately before death, a person placed in care, in accordance with section 52(2)(b) of the Coroners Act. Pursuant to section 52(3A) of the

Coroners Act, I am not required to hold an inquest in these circumstances, if I consider that the death was due to 'natural causes'.

4. In accordance with section 52(3B) of the Coroners Act, a death may be considered to be due to 'natural causes' if the coroner has received a report from a medical investigator, in accordance with the rules, that includes an opinion that the death was due to 'natural causes'. I have received such a report in this case. Therefore, I make my findings with respect to the circumstances and exercise my discretion not to hold a public hearing through an inquest.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame, or determine criminal or civil liability[1].

6. In writing this Finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

Identity

7. Steele Moller was visually identified by his mother, Nicole Moller on 13 February 2017. Identity was not in issue and required no further investigation.

Medical cause of death

8. On 14 February 2017, Dr Paul Bedford, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed a medical examination on the body of Steele Moller and reviewed the Form 83 Victoria Police Report of Death, Steele's medical records and the medical deposition completed at Ballarat Base Hospital.

9. Dr Bedford provided an opinion that the medical cause of death was 1(a) ASPIRATION PNEUMONIA CONTRIBUTING FACTORS – CEREBRAL PALSY and that on the basis of the information available at the time of completing his report, he was of the opinion that the death was due to natural causes.

[1] In the coronial jurisdiction facts must be established on the balance of probabilities 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.

Circumstances in which the death occurred

10. On 5 February 2017, Steele was transported to Stawell Hospital with vomiting and fevers on a background of aspiration pneumonia. On 6 February 2017, he was transferred to Ballarat Base Hospital for ongoing care and management. He was commenced on intravenous antibiotics, however his condition did not improve. Following discussions with Steele's mother, the decision was made to focus on comfort measures and palliative care was instituted. Steele passed away on 11 February 2017, with his mother and father by his side.

Findings

11. Having considered the evidence I am satisfied that no further investigation is required.

12. Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

13. I find that:

    a. the identity of the deceased was Steele Tyson Moller born 10 June 1995; and

    b. Steele Moller died on 11 February 2017 from 1(a) 1 (a) *aspiration pneumonia contributing factors – cerebral palsy*;

    c. in the circumstances described above.

14. I wish to express my sincere condolences to Steele's family. I acknowledge the grief and devastation that you have endured as a result of your loss.

15. Pursuant to section 74(1B) of the Coroners Act, this finding must be published on the internet.

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

The family of Steele Moller;
Information recipients; and
Coroner's Investigator, Victoria Police

Signature:

JACQUI HAWKINS
Coroner
Date: 31 May 2017