IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 5724

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**JUSTIN DANCE**
Date of birth:	**18 May 1971**
Date of death:	**13 November 2018**
Cause of death:	**Complications of chronic lymphocytic leukaemia in a man with intellectual disability**
Place of death:	**Melba Support Services, Mooroolbark House, 23 Larbert Avenue, Mooroolbark Victoria 3138**

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Justin Dance was 47-years old and resided at the disability support service, Melba Support Services' residence located at 23 Larbert Avenue, Mooroolbark (Mooroolbark House) at the time of his death.

2. On 13 November 2018, after a decline in his health, Mr Dance passed away with support workers by his bedside.

3. Mr Dance's death was treated as reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) (the Act) because he was a person who immediately before death was a person placed in care. Section 3 of the Act states that a person placed in care includes a person who is under the control, care or custody of the Department of Health and Human Services (DHHS).

4. Despite Mr Dance's disability services provider not being run by DHHS, I nonetheless determined his situation to be analogous to a person in care as defined by the Act, such that the investigation into his death was conducted in the same manner as if he had been under the control, care or custody of the DHHS. He was a vulnerable person dependant on his carers.

INVESTIGATIONS

Forensic pathology investigation

5. Dr Gregory Young, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination upon the body of Mr Dance, reviewed a post mortem computed tomography (CT) scan, notes from Melba Support Services and referred to the Victoria Police Report of Death, Form 83.

6. Medical statements detail a medical history of epilepsy, Lennox-Gastraux syndrome, intellectual disability and chronic lymphocytic leukaemia.

7. Dr Young stated that the external examination showed no unexpected signs of trauma and that the post mortem CT scan showed no significant pathology.

8. Dr Young ascribed the cause of death to complications of chronic lymphocytic leukaemia in a man with intellectual disability.

Police investigation

9. Upon attending the Mooroolbark residence after Mr Dance's death, Victoria Police observed Mr Dance in bed with his legs elevated and with a small pillow under his chin. Staff advised that Mr Dance suffered from chronic lymphocytic leukaemia and required constant care due to him being non-verbal, non-mobile and also suffering from an intellectual disability. They further advised that they had been at his bedside as he passed away and that his death was expected.

10. Senior Constable (SC) Marcus Weber was the nominated Coroner's Investigator.[1] At my direction, SC Weber investigated the circumstances surrounding Mr Dance's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by family, disability support workers, treating clinicians and investigating officers.

11. During the investigation, police learned that Mr Dance's mother, Joan Masefield became aware that her son required medical intervention at around the age of three. After various tests, it was found that Mr Dance was suffering seizures. By the time Mr Dance was five, his seizures had increased to approximately 20 a day.

12. Ms Masefield persisted in seeking out treatments for her son. She dedicated her life to caring for him, so as to avoid placing him in an institution.

13. Throughout the years, Mr Dance attended a "special needs" school, where he boarded Monday to Friday. This arrangement continued for approximately seven years, until his care requirements resulted in Ms Masefield caring for him full time at home.

14. Throughout his teenage years, Mr Dance developed problems with his legs and lost the ability to swallow. Mr Dance underwent a successful trial treatment to redirect his saliva glands. Mr Dance's seizures continued. Ms Masefield did her best to keep her son

[1] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

mobile however, by the time he was 18-years-old, despite best efforts he was wheelchair bound.

15. Additional care requirements resulted in Mr Dance being placed into a care home however, the frequency of his seizures saw him return back home into the care of his mother. Mr Dance remained at home with Mr Masefield until the age of 24, with periods of respite afforded by Melba Support Services.

16. Melba Support Services offered Mr Dance a fulltime residency when they built a residence in Mount Evelyn. At the age of 27, he moved into Mooroolbark House. Mr Dance eventually lost his ability to speak and due to his immobility, his legs were in danger of amputation. This was avoided by ensuring his legs were elevated.

17. In 2012 at the age of 38, Mr Dance was diagnosed with chronic lymphocytic leukaemia. Mr Dance's family decided to place an emphasis on the quality of his life as opposed to the quantity and favoured conservative treatments. His 2018 Advanced Care Plan detailed further conservative measures, including a "not for hospital admission" and "not for resuscitation" status.

18. In October of 2018, he acquired pneumonia and fell ill. He was not expected to survive however, against the odds he lived through the night. Following this episode, Mr Dance was placed in palliative care.

19. In the period leading to his death, Mr Dance's health deteriorated significantly. He was extremely lethargic and struggling with fluid, food and medication intake. In addition, Mr Dance was also losing weight and his seizures were increasing in severity and frequency. His medication was adjusted accordingly.

20. In the days leading up to his death, family, friends and staff attended to say their "goodbyes".

21. Melba Support Services' progress notes detail that on 13 November 2018, Mr Dance's breathing had become "gasping and shorter". These notes further detail that he "was surrounded by many staff and peacefully passed away at 2.53pm."

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. Having determined to investigate the death of Justin Dance as if he was a person placed in care as defined in the Act, section 52(3A) of the Act provides, *inter alia*, that a Coroner is not required to hold an Inquest into the death of a person who was in custody or care immediately before their death, if the Coroner considers that their death was due to natural causes. Mr Dance's death falls under the auspices of this section of the Coronial legislation and, consequently, I have determined that it was appropriate to finalise my Investigation by way of a Form 38 *Finding into a Death with Circumstances.* Such a Finding must be published, pursuant to section 73(1B) of the Act.

FINDINGS

1. I find that Justin Dance, born 18 May 1971, died on 13 November 2018 at Melba Support Services, Mooroolbark House, 23 Larbert Avenue, Mooroolbark Victoria 3138.

2. I accept and adopt the cause of death ascribed by Dr Gregory Young and I find that the cause of Justin Dance's death was complications of chronic lymphocytic leukaemia in a man with intellectual disability.

3. And I further find that there is no causal relationship between the cause of Justin Dance's death and the fact that I determined that he was a person placed in care.

Pursuant to section 73(1A) of the *Coroners Act 2008* (Vic), I order that this Finding be published on the internet.

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

Joan Masefield

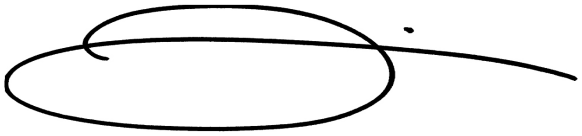
Michael Dance

Maggie Whitmore, Disability Services Commissioner

Shane Beaumont, Department of Health and Human Services

Senior Constable Marcus Weber

Signature:



AUDREY JAMIESON

CORONER

Date**: 28 April 2020**