IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004839

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Stephen Hills
Date of birth:	19 December 1957
Date of death:	13 April 2023
Cause of death:	1a: Intracranial mass - glioblastoma multiforme
Place of death:	Ballarat Base Hospital 1 Drummond Street North Ballarat Central Victoria 3350
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 13 April 2023, Stephen Hills (known as Peter to his family and friends) was 65 years old when he died at the Ballarat Base Hospital following a seizure.

2. At the time of his death, Mr Hills was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] at 61 Kilkenny Drive, Alfredton, provided by the then-Department of Health and Human Services.

3. Mr Hills had come a long way since moving into his Alfredton home and his family believed he was very happy there. He enjoyed attending day programs four days a week and getting out into the community, and had a love of bikes, cars, aeroplanes and all things with motors.

THE CORONIAL INVESTIGATION

4. Mr Hills' death fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as he was a 'person placed in custody or care' within the meaning of the Act, as a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling immediately prior to his death. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

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.

[1] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Mr Hills' death, is a permanent dwelling that provides long-term accommodation for one or more SDA residents, that is enrolled as an SDA dwelling under relevant NDIS (Specialist Disability Accommodation) Rules in force at the relevant time. An SDA resident means a person who is an NDIS participant funded to reside in an SDA enrolled dwelling, or who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program). The definition of SDA resident was amended on 1 July 2024 pursuant to the *Disability and Social Services Regulation Amendment Act 2023* to extend to include persons who are residing, or propose to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement.

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. This finding draws on the totality of the coronial investigation into the death of Stephen Hills, including information from the National Disability Insurance Agency (**NDIA**) and the NDIS Quality and Safeguards Commission, as well as a Medical Certificate Cause of Death (**MCCD**) completed by a medical practitioner at Ballarat Base Hospital. 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.[2]

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

Circumstances in which the death occurred

8. On 11 April 2023, Mr Hills was observed by a disability support worker to be experiencing seizure-like symptoms and become unresponsive. The support worker immediately called 000 and paramedics arrived a short time later. On initial assessment, clinicians suspected Mr Hills had suffered a minor stroke and he was conveyed by ambulance to the Ballarat Base Hospital Emergency Department.

9. At hospital, Mr Hills was diagnosed with a late-stage brain tumour and placed on ventilation support.

10. Over the following days, Mr Hills' health continued to decline, and on 13 April 2023 he passed away at 9:00 pm.

Identity of the deceased

11. On 13 April 2023, Stephen Hills, born 19 December 1957, was identified by Medical Practitioner Dr Nicole Hunter via review of medical records and detailed knowledge of the circumstances surrounding his death.

[2] 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.

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

Medical cause of death

13. On 13 April 2023, Medical Practitioner Dr Nicole Hunter reviewed Mr Hills' complete medical history and, having regard to her own detailed knowledge of the circumstances surrounding his death, completed a MCCD. Dr Hunter provided an opinion that the medical cause of death was an intracranial mass, namely glioblastoma multiforme.

14. On 18 August 2024, a Medical Liaison Nurse at the Victorian Institute of Forensic Medicine reviewed the MCCD at my direction and confirmed that the cause of death was due to natural causes.

15. I accept Dr Hunter's opinion and am satisfied that Mr Hills' death was due to natural causes.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Stephen Hills, born 19 December 1957;

    b) the death occurred on 13 April 2023 at Ballarat Base Hospital, 1 Drummond Street North, Ballarat Central, Victoria 3350, from 1(a) intracranial mass - glioblastoma multiforme.

    c) the death occurred in the circumstances described above.

17. The available evidence does not support a finding that there was any want of clinical management or care on the part of the SIL provider, or clinical staff at Ballarat Base Hospital, that caused or contributed to Mr Hills' death.

18. Having considered all the available evidence, I find that Mr Hills' death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation of Mr Hills' death in chambers.

I convey my sincere condolences to Mr Hills' family, friends and carers for their loss, and acknowledge the distress caused by the delay in the reporting and investigation of his death.

Pursuant to section 73(1B) 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:

Paul Hills, Senior Next of Kin

Anne Lovell, Family

Sovereign Lives Victoria

Ballarat Health Services

Signature:

Date: 8 November 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 investigation. 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.