



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2024 004844**

**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:	Rolf Liebenow
Date of birth:	22 November 1953
Date of death:	10 November 2022
Cause of death:	1(a) Chronic Lymphocytic Leukaemia
Place of death:	Wantirna Health Palliative Care Unit, Eastern Health, 251 Mountain Hwy, Wantirna VIC 3152
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

## INTRODUCTION

1. On 10 November 2022, Rolf Liebenow (**Mr Liebenow**) was 68 years old when he died at Wantirna Health Palliative Care Unit, Eastern Health from chronic lymphocytic leukaemia.
2. At the time of his death, Mr Liebenow was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling<sup>1</sup> provided by Monkami. Mr Liebenow had been using Monkami services since he was fifteen (15) years old, so they were highly experienced in respect of care and support provision for him.
3. Mr Liebenow at the time of his passing had no immediate family living in Victoria and only extended family across the border in South Australia, however he had had no contact with them for many years. State Trustees held guardianship in respect of Mr Liebenow's financial arrangements. Mr Liebenow attended a day program four days each week through Monkami and greatly enjoyed building objects, Lego and other fine motor skills.

## THE CORONIAL INVESTIGATION

4. Mr Liebenow's 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

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<sup>1</sup> SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Mr Liebenow's 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.

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. This finding draws on the totality of the coronial investigation into the death of Rolf Liebenow, 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 Wantirna Health Palliative Care Unit, Eastern Health. 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.<sup>2</sup>

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

### **Circumstances in which the death occurred**

8. Four years prior to his passing, Mr Liebenow was diagnosed with chronic lymphocytic leukaemia, a progressive terminal condition. He also had long standing issues in respect of his gastrointestinal system for which he was hospitalised for every six to eight weeks.
9. In November 2022 Mr Liebenow's condition deteriorated and he was initially admitted to Box Hill Hospital before being transferred to Wantirna Health Palliative Care Unit where he passed away on 10 November 2022.

### **Identity of the deceased**

10. On 10 November 2022, Rolf Liebenow, born 22 November 1953, was identified by Medical Practitioner Dr Russell Pearce via medical records review and visual identification.
11. Identity is not in dispute and requires no further investigation.

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<sup>2</sup> 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.

## **Medical cause of death**

12. On 10 November 2022, Medical Practitioner Dr Russell Pearce reviewed Mr Liebenow's complete medical history, conducted an examination on the body and completed a MCCD. Dr Pearce provided an opinion that the medical cause of death was chronic lymphocytic leukaemia.
13. On 18 August 2024, a Medical Liaison Nurse (**MLN**) 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.
14. I accept Dr Pearce's opinion and am satisfied that the death was due to natural causes.


## **FINDINGS AND CONCLUSION**

15. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
  - a) the identity of the deceased was Rolf Liebenow, born 22 November 1953;
  - b) the death occurred on 10 November 2022 at Wantirna Health Palliative Care Unit, Eastern Health, Wantirna in Victoria from chronic lymphocytic leukaemia;
  - c) the death occurred in the circumstances described above.
16. 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 Wantirna Health Palliative Care Unit, Eastern Health that caused or contributed to Mr Liebenow's death.
17. Having considered all the available evidence, I find that Mr Liebenow's 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 Liebenow's death in chambers.
18. I convey my sincere condolences to Mr Liebenow's family, friends and carers for their loss, and acknowledge the distress caused by the delay in the reporting and investigation of Mr Liebenow's death.
19. 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.

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

- a) State Trustees
- b) Monkami
- c) Wantirna Health Palliative Care Unit, Eastern Health

Signature:



Date : 5 December 2024

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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.

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