IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000968

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Therese McCarthy
Deceased:	Wayne Douglas Scott
Date of birth:	27 October 1969
Date of death:	21 February 2021
Cause of death:	1a: High blood alcohol and positional asphyxia in a man with cerebral palsy and acquired brain injury
Place of death:	5 Dianne Court Lalor Victoria
Keywords:	Disability, self-managed NDIS participants, platform providers

INTRODUCTION

1. On 21 February 2021, Wayne Douglas Scott[1] was 51 years old when he was found deceased in his own home in Lalor, Victoria.

2. Wayne resided alone in public housing. He was estranged from his two children and other family members.

3. Wayne had a diagnosis of cerebral palsy, low vision, dysarthria, depression, acquired brain injury, and physical disability. He was a self-managed participant of the National Disability Insurance Scheme (**NDIS**) due to the physical, sensory and communication disability that he experienced following an acquired brain injury, from a drug overdose, more than 20 years ago.

4. Wayne also experienced a long-standing substance use disorder, specifically alcohol and cannabis.[2] He was routinely prescribed diazepam and mirtazapine for depression. His depression and alcohol use increased following the death of his father in 2020.

THE CORONIAL INVESTIGATION

5. Wayne'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 unexpected, unnatural or violent or result from accident or injury.

6. 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.

7. 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.

[1] Referred to throughout this finding as 'Wayne', unless more formality is required.
[2] Statement Joanne Wilson, dated 19 December 2021, Coronial Brief (CB).

8. The investigation into Wayne's death was commenced by Coroner John Olle and I assumed carriage of the matter in August 2025 upon his retirement, to conclude the investigation and make findings.

9. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Wayne's death. The Coronial Investigator conducted inquiries at the Court's request, including taking statements from witnesses – such as friends, support workers, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Wayne Douglas Scott including evidence contained in the coronial brief and additional statements from the care provider and National Disability Insurance Agency. 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.[3]

BACKGROUND

11. Wayne managed his own NDIS plan, funding arrangements and finances,[4] and employed private disability support workers (DSW), primarily through an on-line introductory service, Mable. Mable is a digital platform used to connect people living with a disability to independent support workers.[5] These services are termed NDIS digital platform providers (**Platform Providers**).[6]

12. Wayne used an electric wheelchair as he was unable to walk or self-propel a manual wheelchair. He required assistance with all transfers, self-care tasks, domestic chores and community activities. He employed DSWs for 2 hours each morning and 2 hours each evening. He did not have any other formal or informal supports.

13. A high-school friend, Joanne, kept in daily contact with Wayne. She was originally employed as one of Wayne's DSWs for a short time before she ceased the formal work arrangement in

[3] 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.

[4] At the time of Wayne's death, he had $110,906 of unspent funds in the plan.

[5] Mable facilitate access to, and choice of, independent support workers as a third party. NDIS participants create an employment contract directly with the worker and not via Mable.

[6] Platform providers are online marketplaces or apps that connect participants directly with support workers. These platforms enable a participant to set up profiles, search for workers, and manage bookings and payments.

September 2020. Joanne continued to support him in the capacity of a friend, and she recalled attending many of Wayne's '*accidents*'. She reported that it was not uncommon for her to be at Wayne's house '*4 times within one day*'.[7]

14. Following shoulder surgery in early 2020, Wayne experienced a significant decline in his physical capacity. He lost weight and lost muscle in his legs, leaving him with only minimal strength to attempt to stand.[8] He was unable to use his hands effectively due to a lack of grip strength and needed assistance for nearly all tasks that required the use of fingers, hands and/or fine motor skills. He was unable to feed himself, roll cigarettes, access medication from blister strips, or open bottles. However, he was able to open a beer bottle with his teeth.[9]

15. Wayne experienced frequent falls during transfers, increasing difficulty with bed mobility, and reduced upper and lower limb strength.[10] One of Wayne's regular DSW suggested that he consider 24-hour support, or an emergency call system for overnight, a proposal with which he disagreed.[11] However, he did agree to having his care needs assessed, with the hope of increased funding for additional DSW hours.

16. In November 2020, an Occupational Therapist (**OT**) assessment identified several issues in relation to Wayne's safety and independence at home, including:

    a) Frequent falls;

    b) Lack of suitable assistive technology and medical equipment;

    c) Existing equipment requires replacement and/or repair;

    d) Insufficient support worker hours;

    e) Inability to eat without assistance;[12]

    f) Lack of therapy programs; and

    g) Lack of funding to purchase incontinence products.

17. Of note, the OT assessment also identified significant occupational health and safety risks with manual handling tasks of transferring Wayne from one position to another. A

[7] Statement Joanne Wilson, dated 19 December 2021, CB.
[8] Statement Joanne Wilson, dated 19 December 2021, CB.
[9] Statement Joanne Wilson, dated 19 December 2021, CB.
[10] Occupational Therapy Report, dated November 2020, CB.
[11] Supplementary statement of Desiree April, 20 September 2025.
[12] Wayne was not eating lunch due to lack of support worker hours during the day.

recommendation was made that Wayne receive physical assistance from two DSWs for transfers in and out of his wheelchair.

18. On 23 November 2020, a NDIS change of circumstances form was submitted to request funding for further assessment, equipment and increased support worker hours. On 7 December 2020 (within the required 21-day timeframe), NDIS declined the request due to a lack of supporting evidence. On 31 December 2020, the change of circumstances form was resubmitted with the required additional evidence.

19. On 8 January 2021, Wayne was informed that his NDIS plan would be revised. On 10 February 2021, initial discussions commenced in relation to his additional needs for support.

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

Circumstances in which the death occurred

20. On 20 February 2021, Desiree (a DSW) observed Wayne to be '*depressed and emotional*'. She recalls that he told her that he was '*missing his father*', who had passed away the previous year. She noticed Wayne had drunk a few beers and smoked cannabis.[13]

21. Wayne agreed to Desiree's invitation to have dinner at her home. He brought beer to Desiree's home, and he continued to drink there. During the course of the evening, Wayne requested that Desiree shave his head, which she did.[14]

22. After dinner, Desiree transported Wayne back to his home. She, and her husband, assisted Wayne into bed and parked the wheelchair close to the bed, in the usual place. Wayne requested another cannabis joint and took his medication. Before Desiree left, Wayne thanked her and her family '*for a great night'* and that he would '*see [her] in the morning*'.

23. On 21 February 2021, at 9:30 am, Desiree arrived at Wayne's home for her support work duties. She was unable to gain entry via the front door as '*the door was jammed and could not be opened*'. She knocked on the window and called out Wayne's name but received no response. Desiree tried the back door which was also not working. Desiree called Joanne, who coincidentally arrived at Wayne's house. Earlier that morning, Joanne attempted to contact

[13] Statement of Desiree April, 19 December 2021, CB.
[14] Statement of Desiree April, 19 December 2021, CB.

Wayne via Facebook Messenger and received no response. She was concerned for his safety and had intended to check on him.

24. Upon Joanne's arrival, both she and Desiree continued to call out and knock without success. Joanne and Desiree gained access to Wayne's bedroom via a window.

25. Joanne observed Wayne lying on the floor, wedged between his wheelchair and the bed. She checked for a pulse and upon touching Wayne's wrist, she noted that he was cold and grey in colour. She called Triple Zero at 10:09pm and reported that she believed that Wayne was '*past resuscitation*'.

26. Ambulance Victoria paramedics arrived and verified that Wayne was deceased at 10:39am.

27. At 10:41am, Victoria Police arrived at the scene. Police observed Wayne to be lying on his knees on the floor next to his bed and bedside table. It appeared to police, that Wayne had fallen and struck his head on the bedside table drawer knob. The drawer knob was located on the floor, presumably having been dislodged. Police did not identify any evidence that another person was involved in Wayne's death.

Identity of the deceased

28. On 21 February 2021, Wayne Douglas Scott, born 27/10/1969, was visually identified by his friend, Joanne Wilson.

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

Medical cause of death

30. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 24 February 2021 and provided a written report of her findings dated 22 July 2021.

31. The post-mortem examination revealed a small amount of scalp bruising and abrasions to the head and nose. There were no acute injuries or natural diseases capable of causing death.

32. Toxicological analysis of post-mortem samples identified the presence of alcohol (0.18 g/100 mL), mirtazapine and diazepam (and metabolites). There was also evidence of recent cannabis use.

33. Dr Baber noted that a blood alcohol concentration in excess of 0.15 g/100 mL can cause considerable depression of the central nervous system (**CNS**) that can affect cognition and behaviour.

34. Dr Baber also made comment that other drugs capable of depressing the CNS (in this case, the benzodiazepine, Diazepam) will increase the effects of alcohol when consumed in combination. The combined effects of these substances include depression of the respiratory drive. Thus, the amount of alcohol and diazepam, present in Wayne's blood samples, were capable of causing respiratory depression.[15]

35. I accept Dr Baber's opinion that the medical cause of death was '*1(a) High blood alcohol and positional asphyxia in a man with cerebral palsy and acquired brain injury'*.

FURTHER INVESTIGATIONS

36. As part of the Court's investigation into Wayne's death, the matter was referred to the Coroner's Prevention Unit (**CPU**) for a review of the NDIS support arrangements, the care provided by Mable and the adequacy of any internal investigations, or recommendations made, by the National Disability Insurance Agency (**NDIA**).[16]

37. The CPU provided the me with a detailed report, dated 30 June 2026 and I accept their opinions on the adequacy of NDIS support and the role of Mable as outlined below.

38. The CPU noted that following Wayne's functional decline after undergoing shoulder surgery in March 2020, the NDIS plan no longer adequately supported his changed circumstances. This was correctly identified by his DSW at the time, but they were prevented from directly approaching the NDIS Local Area Coordinator (**LAC**) for additional support as Wayne '*did not want carers involved in any organising or liaising with NDIS*'.[17]

39. Marble were not aware of the content of Wayne's NDIS support plan as; they were not a registered NDIS provider at that time. This meant that Wayne determined whether or not shared his plan with Mable, DSW or other health providers.

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[15] A serious condition where breathing is too slow or shallow, causing dangerous buildups of carbon dioxide and low blood oxygen.

[16] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

[17] Supplementary statement of Desiree April, 20 September 2025.

40. Of note, Mable DSWs were required to adhere to the Mable Code of Conduct. Disability Support Workers lodged six incident reports, between 12 September 2018 and 21 February 2021. One report was related to a fall, whereby Wayne fell from his wheelchair and became stuck between the dresser and a wall.[18] Wayne was not seriously injured and requested that the incident not be recorded, as it did not occur 'during' a DSW shift.[19]

41. Additionally, Mable recorded a few incidents indicating that Wayne had consumed alcohol, however there were no specific concerns identified or flagged in the incident reporting system. On 4 December 2020, Wayne was found asleep on the floor but refused medical treatment.[20] Further to this incident, on 31 December 2020, Wayne has observed to be '*in a bad condition*', '*drunk*' and with a house that was '*really dirty*'.[21]

National Disability Insurance Scheme investigation

42. The CPU noted that the NDIS was unaware of Wayne's functional decline until they received the initial change of circumstances form submitted on 23 November 2020. The NDIS responded within the mandated 21 days indicating additional information was required. Once the request form was resubmitted, the NDIS informed Wayne of the successful outcome within eight days, which was well within the required 21 day timeframe.[22]

43. The CPU concluded that at the time of Wayne's death, the NDIS were in the process of developing a more appropriate support plan that would address his physical needs and occupational health and safety issues related to his carers. I agree with this conclusion.

44. The NDIS Quality and Safeguarding Commission were notified of Wayne's death but did not undertake an investigation.

45. Further, the NDIA advised the Court that despite the Platform Providers offering an innovative and flexible way for NDIS participants to access NDIS services and supports, multiple independent reviews and inquiries have identified more regulatory oversight of Platform Providers is needed to improve service quality and safeguards for participants.

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[18] Event recorded as having occurred on 23 January 2019.
[19] Statement of Anthony Charara, dated 28 November 2025, Annexure 2, Copy of Incidents.
[20] Statement of Anthony Charara, dated 28 November 2025, Annexure 1, Copy of Shift Notes.
[21] Statement of Anthony Charara, dated 28 November 2025, Annexure 1, Copy of Shift Notes.
[22] NDIS Guide to changing your plan. Available at https://www.ndis.gov.au/participants/changing-your-plan/types-plan-changes/guide-changing-your-plan.

46. Since November 2024, the NDIS Commission has actively engaged with providers, workers and participants regarding registration of Platform Providers services resulting in an increased regulation regime.[23]

FINDINGS

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

    1. the identity of the deceased was Wayne Douglas Scott, born 27 October 1969;

    2. Wayne's death occurred on 21 February 2021 at 5 Dianne Court Lalor Victoria from 1a: High blood alcohol and positional asphyxia in a man with cerebral palsy and acquired brain injury; and

    3. his death occurred in the circumstances described above.

COMMENT

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

48. Wayne's death highlights the vulnerability of many people with a disability receiving NDIS-funded services delivered by independent providers accessed via digital platforms. At the time, Mable was a conduit between the individual participant and the DSW. Therefore, Mable was not required to be a registered NDIS-provider. While Mable had in place some processes to identify risk, they were unaware of Wayne's functional decline due to the third party nature of their involvement with self-managed NDIS participants.

49. Multiple independent reviews have identified the risks posed by digital platforms such as Mable. In response, as of 1 July 2026, the NDIS will require all digital platform providers to register with the NDIS Quality and Safeguards Commission.[24] This will mean that digital platforms will be required to:

    a) undergo certification audits;

    b) comply with the NDIS Code of Conduct;

    c) comply with NDIS Practice Standards Core Modules;

[23] Mandatory registration | NDIS Quality and Safeguards Commission.
[24] https://www.ndiscommission.gov.au/rules-and-standards/quality-practice/platform-providers.

d) comply with state/territory laws

e) have effective systems for managing complaints and incidents;

f) adhere to behaviour support requirements including reporting the use of regulated restrictive practices to the NDIS Commission; and

g) ensure workers in key roles have NDIS Worker Screening clearances.

This is likely to go some way towards reducing the risks for participants, such as Wayne, who obtain NDIS services though digital platforms.

50. The available evidence does not support a finding that there was any want of clinical management, or care on the part of the disability service provider, that caused or contributed to his death. Wayne's death highlights the challenges of self-managed NDIS participants who do not consent to health information sharing between service providers.

CONCLUSION

51. Having considered all the available evidence, I find that Wayne's death was the unintended consequence of the effects of the combination of alcohol and prescription medication that resulted in a fall from his bed. Due to Wayne's physical limitations, he was unable to reposition himself from the awkward way in which he landed, which led to positional asphyxia that also contributed to his death.

52. I find that no further investigation is required and 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 Wayne's death in chambers.

I convey my sincere condolences to Wayne's family, friends and carers for their loss.

DIRECTIONS

Pursuant to section 73(1A) 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:

Austin Scott, Senior Next of Kin

National Disability Insurance Agency

Acting Sergeant Ashwani Minhas, Victoria Police, Coronial Investigator

Signature:

Coroner Therese McCarthy

Date: 24 July 2026

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.