IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006401

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Ms K[1]
Date of birth:	[redacted] 1956
Date of death:	[redacted] 2021
Cause of death:	*Unascertained (Natural Causes)*
Place of death:	[redacted], Victoria
Keywords:	*In care; Natural causes*

[1] *At the direction of Coroner Sarah Gebert, the name of the deceased and her family members have been replaced with pseudonyms to protect their identities. Identifying details have also been redacted.*

INTRODUCTION

1. On [redacted] 2021, [redacted] (**Ms K**) was 65 years old when she was located deceased in bed by her carers. At the time of her passing, Ms K lived in a residential care facility funded under the National Disability Insurance Scheme (**NDIS**) and operated by Aruma Disability Services in [redacted].

2. Ms K was the third child born into her family with an older sister, [redacted], older brother [redacted], and younger brother [redacted]. Her mother suffered from Rubella during her pregnancy which resulted in Ms K suffering numerous intellectual disabilities from a young age. She was later diagnosed with Schizophrenia and depression. Ms K was moved into a full-time care facility at the age of seven and remained in different residential care facilities up until her passing.

3. Ms K would spend time with her family at Christmas and birthdays. She spoke to her sister [redacted] on the phone approximately once a week and would see her roughly once every two months.

THE CORONIAL INVESTIGATION

4. Ms K'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. However, if a person satisfies the definition of a person placed in care immediately before the death, the death is reportable even if it appears to have been from natural causes.[1]

5. While Ms K's death was reported to the Coroner, I note that as funding for disability services shifted from the Department of Families Fairness and Housing to the National Disability Insurance Scheme (**NDIS**), the definition of a person placed in custody or care in section 3(1) of the Act to include "a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health", no longer captured the group of vulnerable people in receipt of disability services as envisaged by the legislation when it passed. This meant that where the deaths of those people were from natural causes and not otherwise reportable, their deaths and the circumstances in which they died – including the quality of their care – were not to be subjected to coronial scrutiny, despite this cohort being as vulnerable as ever.

[1] See the definition of '*reportable death'* in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of *'person placed in custody or care'* in section 3(1) of the Act.

6. More recently, on 11 October 2022, this lacuna in the legislation was rectified when amendments to the *Coroners Regulations 2019* came into effect. Sub-regulation 7(1)(d) provides that a 'person placed in custody or care' now includes "a person in Victoria who is an SDA resident[2] residing in an SDA enrolled dwelling".[3] Ms K would now likely meet the new definition of a person placed in custody or care. For this reason, I intend to treat her death as one occurring in care, and I will publish this finding in accordance with the Rules (in redacted form).

7. 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.

8. 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.

9. Victoria Police assigned Sergeant Michelle Palmer (**Sgt Palmer**) to be the Coroner's Investigator for the investigation of Ms K's death. Sgt Palmer conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, 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 Ms K including evidence contained in the coronial brief. 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.[4]

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[2] 'SDA resident' has the same meaning as in the *Residential Tenancies Act 1997* (Vic) and captures a person who is an SDA recipient (that is, an NDIS participant who is funded to reside in an SDA enrolled dwelling).

[3] 'SDA enrolled dwelling' also has the same meaning as in the *Residential Tenancies Act 1997* and is defined as a: "long-term accommodation for one or more SDA resident and enrolled as an SDA dwelling under the National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016 of the Commonwealth as in force from time to time or under other rules made under the National Disability Insurance Scheme Act 2013 of the Commonwealth."

[4] 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.

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

Circumstances in which the death occurred

11. On [redacted] 2021, Ms K was out in the community participating in a community access program with the assistance of carers during the day. She returned to her residential care facility at approximately 3.00 pm and requested a cup of tea and some biscuits for afternoon tea. Her carers noted that she regurgitated a small amount of the biscuit and experienced some bowel incontinence.

12. She was given a shower and settled in bed afterwards watching television as per her usual routine. At 4.00 pm, Ms K came out of her room for her medication round before returning to her room again afterwards.

13. Ms K declined dinner and requested to be given some fruit and a cup of tea as she reported a poor appetite. She was administered her supper medication at 8.00 pm and at 10.30 pm, staff noted that Ms K was asleep in bed.

14. At 6.00 am the following morning, staff found Ms K with the upper part of her body on the bed and her feet on the floor, unresponsive. Her carers commenced cardiopulmonary resuscitation (**CPR**) and called 000. Ambulance Victoria paramedics arrived shortly after and sadly confirmed that Ms K was deceased.

15. Victoria Police conducted an investigation and determined that there were no suspicious circumstances surrounding the death.

Identity of the deceased

16. On [redacted] 2021, Ms K, born [redacted] 1956, was visually identified by her long-time carer, [redacted].

17. Identity was not in dispute and required no further investigation.

Medical cause of death

18. Forensic Pathologist Dr Michael Burke (**Dr Burke**) from the Victorian Institute of Forensic Medicine conducted an examination on [redacted] 2021 and provided a written report of his findings dated [redacted] 2021.

19. The post-mortem CT scan showed a small amount of fluid in the pelvis, fluid levels in the small bowel and probably diverticular disease. The external examination was otherwise unremarkable.

20. Dr Burke commented that there was no evidence to suggest that the death was due to anything other than natural causes.

21. Dr Burke therefore provided an opinion that the medical cause of death was *unascertained (natural causes)*.

22. I accept Dr Burke's opinion as to medical cause of death.

FINDINGS AND CONCLUSION

23. Pursuant to section 67(1) of the Act I make the following findings:

    a) the identity of the deceased was Ms K, born [redacted] 1956;

    b) the death occurred on [redacted] 2021 at [redacted], Victoria, 3061, from *unascertained (natural causes)*; and

    c) the death occurred in the circumstances described above.

24. Having considered all of the circumstances, I am satisfied that there were no prevention opportunities in this case and that Ms K's death was the result of natural causes.

25. I express my sincere condolences to her family, friends, and carers for their loss, and I acknowledge the sudden and unexpected circumstances in which her death occurred.

26. 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.

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

    [redacted], Senior Next of Kin

    Sergeant Michelle Palmer, Coroner's Investigator

    Kylie Haynes, NDIS Commission

Signature:

Coroner Sarah Gebert

Date : 31 July 2023

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.