IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 000157

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Heather Ash

Findings of:	Coroner Leveasque Peterson
Delivered On:	3 March 2025
Delivered At:	Coroners Court of Victoria,
	65 Kavanagh Street, Southbank
Hearing Date:	10 December 2024
Counsel Assisting:	Courtney Davies
Keywords:	In-care; Supported Disability Accommodation (**SDA**)

INTRODUCTION

1. On 10 January 2022, Ms Heather Ash was 68 years old when she passed away at the Benalla Memorial Hospital (**BMH**). At the time of her death, Ms Ash lived at Wattletree Grove, Benalla, in specialist disability accommodation (**SDA**). Ms Ash was a participant in the National Disability Insurance Scheme (**NDIS**).

2. As Ms Ash had no family, she also had a Victorian Civil and Administrative Tribunal (**VCAT**) appointed financial administrator to assist her to manage her money.

3. Ms Ash had a very complex medical history. She had been diagnosed with an intellectual disability at birth, and she had limited communication skills. Ms Ash also suffered from Parkinson's disease and dementia.

4. Ms Ash had been a client of Yooralla in Wattletree Grove, Benalla, for over 35 years. She had formed strong connections with staff and co-residents over that period of time.

THE CORONIAL INVESTIGATION

5. Ms Ash's death was reported to the Coroner as it fell within the definition of a reportable death in the Coroners Act 2008 (**the Act**).

6. Ms Ash was a "person placed in custody or care" pursuant to the definition in section 4 of the Act, as she was "a prescribed person or a person belonging to a prescribed class of person" due to her status as an "SDA resident residing in an SDA enrolled dwelling"[1].

7. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The circumstances are limited to events which are sufficiently proximate and causally related to the death.

8. I requested that a Victoria Police officer be appointed as the Coroner's Investigator for the

[1] Pursuant to Reg 7(1)(d) of the Coroners Regulations 2019, a "prescribed person or a prescribed class of person" includes a person in Victoria who is an "SDA resident residing in an SDA enrolled dwelling", as defined in Reg 5. I have received confirmation from the NDIA that Mr Cameron resided at an address where the residents meet these criteria.

investigation of Ms Ash's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Heather Ash including evidence contained in the coronial brief, and supplementary reports and statements obtained by the Court. 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

10. Ms Ash's General Practitioner (**GP**), Dr Fleur Christopherson, reported that Ms Ash was generally resistant to medical treatment, and she would often become dysregulated during examinations.

11. In late 2019 Ms Ash's health began to deteriorate. She experienced drowsiness, abdominal pain and syncopal episodes. Staff at Yooralla noticed increasing urinary incontinence and Ms Ash became more unsteady on her feet. Her mental health also appeared to decline, with staff reporting episodes when Ms Ash would refuse food and fluids. She began to lose weight, and she was paranoid and at times, aggressive. In 2020, Ms Ash was diagnosed with dementia.

12. From November 2021 there was a significant decline in Ms Ash's health which resulted in 20 hospital transfers for treatment. On each occasion Ms Ash would be treated and discharged back to her SDA home as this was always her strong desire. However, facility director, Mr Malik, noted that these transfers back to the facility often exacerbated Ms Ash's difficult behaviours, as she had the propensity to become distressed when in unfamiliar environments.

[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

13. As observed by her GP, Ms Ash was assessed by numerous medical specialists including a geriatrician, a neurologist and a geriatric psychiatrist. Despite the many clinical investigations, it became increasingly difficult to treat Ms Ash as she would often refuse blood tests and computed tomography (**CT**) scans. All these challenges occurred in a period in late 2021 where Ms Ash was also in consistent functional decline.

14. On 1 January 2022 Ms Ash was admitted to BMH for palliative care. It had become apparent that further investigations of Ms Ash were futile as she had begun to refuse all food and fluid intake. Staff at the SDA facility also felt unable to supervise the syringe driver medication regime required for palliative, end of life care as prescribed by Ms Ash's GP.

15. On admission to BMH, Ms Ash was given morphine and midazolam via a subcutaneous syringe and an end of life pathway was commenced.

16. Ms Ash died peacefully at BMH on 10 January 2022.

Medical cause of death

17. On 19 January 2022, Dr Brian Beer of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination and provided a report of his findings dated 11 May 2022.

18. The autopsy confirmed ischaemic liver changes and terminal bronchopneumonia.

19. Dr Beer provided an opinion that the medical cause of death was 1 a) *Terminal palliation in the setting of ischaemic liver and bronchopneumonia*.

20. I accept Dr Beer's opinion as to the cause of death.

CPU REVIEW AND FURTHER INVESTIGATIONS

21. In addition to the brief of evidence I received, I directed the Coroners Prevention Unit (**CPU**)[3], to provide an independent review of the care, treatment and management received by Ms Ash. In particular, I wanted to examine why many of the medical investigations

[3] 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

recommended by Ms Ash's treating GP could not be implemented due to Ms Ash not having a family member or a guardian to make decisions on her behalf.

22. The CPU considered all the medical evidence and noted the complex nature of Ms Ash's presentation. They noted that following the deterioration in Ms Ash's health in 2019, Dr Christopherson became increasingly concerned that there may have been a neurological component to Ms Ash's urinary incontinence, poor mobility and food refusal. Dr Christopherson therefore took steps to obtain neurological reviews for Ms Ash. She also suggested magnetic resonance imaging (**MRI**) under sedation to confirm if Ms Ash had normal pressure hydrocephalus, an abnormal buildup of cerebrospinal fluid in the ventricles of the brain and ordinarily is characterised by progressive cognitive impairment and dementia.

23. The CPU concluded that the medical care and management of Ms Ash was reasonable and appropriate, however there were challenges in facilitating Ms Ash's medical care in the absence of a medical decision maker that warranted further examination.

24. The CPU report observed that Dr Christopherson had received conflicting advice from specialist clinicians about the likely impact of a shunt on Ms Ash's quality of life. Dr Christopherson therefore considered that an independent person ought to be appointed to make medical decisions on Ms Ash's behalf.

25. In collaboration with Mr Noel Finch, a social worker from BMH, an application was made to VCAT on 19 February 2021 for a medical guardian to be appointed for Ms Ash.

26. On 16 April 2021, VCAT dismissed the application to appoint a medical guardian for Ms Ash.

27. A further application was made on 7 December 2021, however, this application was not determined at the time and Ms Ash passed away before the hearing.

28. Following receipt of this information the Court sought a statement from the Office of the Public Advocate (**OPA**), as it had represented Ms Ash at the VCAT hearing.

29. OPA reported that at the time of the application:

    a. there was no need for a decision to be made about Ms Ash's accommodation or

medical treatment given that she had been discharged back into the care of Yooralla on 9 March 2021 and evidence had been produced at the hearing that her condition was improving;

b. there was no specific medical decision that needed to be made; and

c. there were less restrictive pathways for medical treatment decision making.

30. Whilst I am concerned about the difficulties associated with trying to have a medical decision maker appointed for Ms Ash, I accept the evidence of the OPA and note that the scope of my coronial investigation is limited. I can only examine matters that are sufficiently proximate to and causative of, or contributory to the death, and in my view this issue falls outside of my remit.

CONCLUSION

31. Having investigated the death of Ms Ash and having held a summary inquest on 10 December 2024, I make the following findings pursuant to section 67(1) of the Act:

    a. the identity of the deceased is Ms Heather Ash born 20 February 1953;

    b. the death occurred on 10 January 2022 at Benalla Memorial Hospital from terminal palliation in the setting of ischaemic liver and bronchopneumonia; and

    c. the death occurred in the circumstances described above.

I convey my sincere condolences to Ms Ash's family for their loss.

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:

Joyce Hall, Senior Next of Kin

Senior Constable Richard Erskine, Coroner's Investigator

Yooralla

Benalla Health

National Disability Insurance Scheme Quality and Safeguards Commission

State Trustees Ltd

Signature:

Coroner Leveasque Peterson

Date: 10 September 2025

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 inquest. 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.