IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 000459

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Matthew Richard Thomas Biggin
Date of birth:	30 October 1985
Date of death:	23 January 2022
Cause of death:	1(a) T-LYMPHOBLASTIC LEUKAEMIA/LYMPHOMA (T-ALL)
Place of death:	Wantirna Health, 251 Mountain Highway, Wantirna, Victoria, 3152
Keywords:	In care, lymphoblastic leukemia, intellectual disability, palliative care

INTRODUCTION

1. On 23 January 2022, Matthew Richard Thomas Biggin was 36 years old when he died in the palliative care inpatient unit of Wantirna Health. At the time, Mr Biggin resided in a disability support service in Nunawading. Mr Biggin is survived by his mother, Mrs Jill Biggin and brother, Mr Stephen Biggin.

2. Mr Biggin's medical history included developmental delay and severe intellectual disability. He had limited verbal communication and required support with daily living. Mr Biggin's mother was his primary carer for many years.

3. During April 2014, Mr Biggin moved into a full-time care facility in Nunawading owned by the Department of Families, Fairness and Housing (**DFFH**). Community organisation Alkira provides support in specialised housing for people with intellectual disabilities and were contracted to provide care at the Nunawading residence where Mr Biggin resided. Mr Biggin also received support from the National Disability Insurance Scheme (**NDIS**).

THE CORONIAL INVESTIGATION

4. Mr Biggin'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 Mr Biggin's death was reported to the Coroner, I note that as funding for disability services shifted from the DFFH to the 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 was passed. Where the deaths of those people are from natural causes and not otherwise reportable, then, although this cohort is as vulnerable as ever, their deaths and the circumstances in which they died – including the quality of their care – were not be subjected to coronial scrutiny.

[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 residing in an SDA enrolled dwelling."*[2] [3] Mr Biggin would now likely meet the new definition of person placed in custody or care.

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 an officer to be the Coroner's Investigator for the investigation of Mr Biggin's death. The Coroner's Investigator 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 Mr Biggin 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]

[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

Identity of the deceased

11. On 23 January 2022, Matthew Richard Thomas Biggin, born 30 October 1985, was visually identified by his brother, Stephen Biggin, who signed a Statement of Identification to that effect.

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

Medical cause of death

13. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine conducted an external examination on 25 January 2022 and provided a written report of his findings dated 15 February 2022.

14. The post-mortem examination was consistent with the reported history. Toxicological analysis was not recommended.

15. Dr Bedford provided an opinion that the medical cause of death was due to natural causes, namely *1(a) T-Lymphoblastic Leukaemia/Lymphoma (T-all).*

16. I accept Dr Bedford's opinion.

Circumstances in which the death occurred

17. On 22 August 2021, Alkira staff observed that Mr Biggin was not feeling well. He appeared tired, had a cough, and indicated pain around his throat and neck. Despite initially indicating that he wanted to see a doctor, Mr Biggin did not allow the locum doctor to complete a full assessment of him upon arrival. The locum doctor advised staff that Mr Biggin had a low-grade temperature but did not note any further concerns. Mr Biggin appeared to be in better health and spirits over the course of the next week.

18. On 1 September 2021, Mr Biggin commenced coughing again and a telehealth appointment was booked with his local general practitioner, Dr Peter Sanad. Mr Biggin was prescribed a short-term course of antibiotics, but his coughing did not improve. He also started to feel out of breath.

19. A follow up appointment was made with Dr Sanad on 9 September 2021. Dr Sanad recommended that a chest x-ray be performed which subsequently revealed a pleural effusion (fluid on the lungs). Mr Biggin was referred to Box Hill Hospital for further investigation.

20. Following further testing, Mr Biggin was diagnosed with acute lymphoblastic leukaemia, a severe cancer of the white blood cells. He remained in hospital for a period of time before being discharged back to his Nunawading residence. As his health continued to deteriorate over the coming weeks, Mr Biggin attended hospital several more times and was subsequently considered for palliative care admission. This was due to the severity of his intellectual disability and physical needs which precluded the capacity to tolerate chemotherapy.

21. On 11 October 2021, Mr Biggin was admitted to the inpatient palliative care unit at Wantirna Health. He was treated with oral medications to make him comfortable. Staff from Alkira Nunawading attended the hospital for several hours per day to provide support and social interaction for Mr Biggin. Mr Biggin's family also visited him frequently.

22. On 23 January 2022, Mr Biggin lost his battle with lymphoblastic leukaemia and died at 8.40pm.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Matthew Richard Thomas Biggin, born 30 October 1985;

    b) the death occurred on 23 January 2022 at Wantirna Health, 251 Mountain Highway, Wantirna, Victoria 3152;

    c) the cause of death was T-Lymphoblastic Leukaemia/Lymphoma (T-All) and;

    d) the death occurred in the circumstances described above.

24. I convey my sincere condolences to Mr Biggin'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:

Jill Biggin, Senior Next of Kin

Senior Constable Rachael Carr, Coroner's Investigator

Dr Yvette Kozielski, Eastern Health

Alkira Support Services

Department of Fairness, Families and Housing

National Disability Insurance Scheme/National Disability Insurance Agency

Signature:

Coroner Paresa Antoniadis Spanos

Date: 27 March 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.