IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 000827

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Mr C
Date of birth:	[redacted] 1965
Date of death:	12 February 2022
Cause of death:	*Complications of clostridium difficile and malnutrition in the setting of cerebral palsy*
Place of death:	South West Healthcare 25 Ryot Street, Warrnambool, Victoria

INTRODUCTION

1. Mr C[1] was a 56 years old man born with an Acquired Brain Injury (**ABI**) and cerebral palsy, who passed away on 12 February 2022. At the time of his passing, Mr C lived in residential supported care in Warrnambool. He is survived by his sister and guardian, Mrs H.

2. Mr C had been residing in care since he was 10 years old and moved to Curtin Court Warrnambool in 2015, where he remained until his passing. He required a wheelchair for mobility and had limited speech.

3. Mrs H described Ms C as a *bright, happy and easy going* person who was *an active member of the disability community in Warrnambool.* Mr C had a passion for music and enjoyed attending music festivals in Tamworth, Queenscliff, Mildura and Port Fairy, and going to live concerts locally.

THE CORONIAL INVESTIGATION

4. Mr C'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.[2]

5. While Mr C's death was reported to the Coroner, I note that as funding for disability services shifted from the DFFH 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 was 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 be subjected to coronial scrutiny despite this cohort being as vulnerable as ever.

[1] Referred to herein as 'Mr C' unless more formality is required.
[2] 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."*[3] [4] Mr C would now likely meet the new definition of person placed in custody or care. For this reason, I intend to treat his death as one occurring in care, and I will publish this finding in accordance with the rules.

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 First Constable Josh McMahon (**FC McMahon**) to be the Coroner's Investigator for the investigation of Mr C's death. FC McMahon 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 C 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.[5]

---

[3] '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).

[4] '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."*

[5] 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.

BACKGROUND

11. Mrs H explained that, although Mr C had limited speech, he was able to communicate through sounds and movements to express his likes and dislikes. Mr C *knew exactly what was being said to him* and *understood what was happening around him*. Although he required a wheelchair for mobility, he was reportedly able to shuffle himself along for short distances within the home.

12. Mr C lived with intellectual and physical disabilities. His medical and health conditions included epilepsy, cataracts in both eyes, hearing impairment, pressure wounds, prepatellar bursitis,[6] mild dysphagia[7] and more recently, depression. The passing of his father in 2017 and mother in 2021 reportedly had a profound effect on him, and significantly impacted his mental and physical health.

13. In June 2021, Mr C's dietician noted that he had lost a significant amount of weight. He continued to be treated for weight loss management up until the time of his passing.

14. On 21 March 2021, care staff were assisting Mr C to dress when he slumped over sideways in his shower chair. Ambulance Victoria paramedics attended; however, Mr C had recovered by the time they arrived and appeared well.

15. On 1 December 2021, Mr C was admitted to Southwest Healthcare Warrnambool for suspected diarrhoea with an unknown cause. A bowel impaction was identified and treated, and Mr C returned to his residence. Mrs H reports that Mr C was not the same following this discharge as he was declining fluids and his favourite foods.

16. On 28 December 2021, Mr C tested positive to COVID-19 with symptoms of lethargy and a cough. He was managed at home with paracetamol.

17. On 10 January 2022, following a three-week history of diarrhoea and hypokalemia, Mr C was admitted to Southwest Healthcare. He was found to be positive for a bacterial infection in the large intestine and was treated with oral vancomycin before being discharged on 18 January 2022.

[6] An inflammation of the bursa in the front of the kneecap which occurs when the bursa becomes irritated and produces too much fluid, which causes it to swell and put pressure on the adjacent parts of the knee.
[7] Difficulties swallowing liquids or solids.

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

Circumstances in which the death occurred

18. On 20 January 2022, Mr C received his COVID-19 booster vaccination during the day. In the evening, he had low food and fluid intake and refused his medication. Mr C's regular GP attended his residence and advised staff that he was to rest for the night.

19. Later that evening, Mr C displayed additional signs of deterioration. His carers contacted the doctor on call who recommended he be taken to hospital.

20. Mr C was transported by ambulance to Southwest Healthcare where he was admitted as an inpatient on 21 January 2022. An abdominal x-ray showed moderate faecal loading and his stomach was found to be significantly distended with air. Blood tests showed an elevated C-reactive protein.

21. On 23 January 2022, treating clinicians noted that Mr C had been refusing food and fluids, and was not showing any signs of clinical improvement. He was deemed not to be a suitable candidate for escalation of care or nasogastric feeds. A decision was made, in consultation with Mrs H, to continue his treatment with intravenous fluids and antibiotics that day, with a plan to transition to palliative care if he did not show any signs of improvement by the following day.

22. Sadly, the following day after no improvements were observed, a decision was made to progress Mr C to palliative management. On 26 January 2022, comfortable end-of-life care was commenced, and Mr C passed away in hospital on 12 February 2022.

Identity of the deceased

23. On 12 February 2022, Mr C, born [redacted] 1965, was visually identified by his carer, [redacted].

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

Medical cause of death

25. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine conducted an examination on 14 February 2022 and provided a written report of her findings dated 16 February 2022.

26. The post-mortem examination showed findings in keeping with the clinical history. Examination of a post-mortem CT scan showed cerebral atrophy, a right lower lobe pneumatocele, and fatty liver.

27. Toxicological analysis of post-mortem samples identified treating medications in keeping with the clinical history and did not identify the presence of other common drugs or poisons.

28. Dr Baber provided an opinion that the medical cause of death was *complications of clostridium difficile and malnutrition in the setting of cerebral palsy*. Dr Baber listed *epilepsy* and *depression* as contributing factors in her report. She also considered that the death was due to *natural causes.*

29. I accept Dr Baber's opinion as to medical cause of death.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr C, born [redacted] 1965;

    b) the death occurred on 12 February 2022 at South West Healthcare 25 Ryot Street, Warrnambool, Victoria, from *Complications of clostridium difficile and malnutrition in the setting of cerebral palsy*; and

    c) the death occurred in the circumstances described above.

31. I convey my sincere condolences to Mr C's friends and family for their loss. I acknowledge Mr C's care team and treating clinicians, who Mrs H described as having shown him *total respect* as a person, in life and in passing.

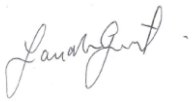
32. Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

    Mrs H, Senior Next of Kin

    First Constable Josh McMahon, Coroner's Investigator

Signature:



Coroner Sarah Gebert

Date : 02 May 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.