IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2022 001246

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	John Hardy Stow
Date of birth:	28 January 1949
Date of death:	5 March 2022
Cause of death:	1(a) Aspiration pneumonia Contributing factors Cerebral palsy
Place of death:	St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria
Key words:	In care, disability, aspiration pneumonia, palliative care

INTRODUCTION

1. On 5 March 2022, John Hardy Stow was 73 years old when he passed away in hospital. At the time, Mr Stow lived in a disability support service in Kew.

2. Mr Stow's medical history included cerebral palsy, intellectual disability, epilepsy, gastro-oesophageal reflux, Barrett's oesophagus, depression, recurrent falls, pressure ulcers, osteoporosis, and recurrent urinary tract infections. Mr Stow was at high risk of aspiration and had a history of aspiration pneumonia. He also had a history of self-harming behaviours such as banging his head against hard objects.

3. After Mr Stow's father and mother passed away in the 1970s and 1980s respectively, he moved to a disability support service where he could receive 24-hour care and support from disability support staff. He resided in several facilities before finally settling at 8 Collins Street, Kew, which is managed by Home@Scope. Mr Stow received support with his daily activities and medical needs.

4. Mr Stow's cousin, Erin Cassell, was also a constant support. She visited him regularly, taking him on outings, and liaised with his carers regarding his care. Ms Cassell was also Mr Stow's financial administrator, appointed by the Victorian Civil and Administrative Tribunal.

5. According to Ms Cassell, Mr Stow's general health and mobility significantly deteriorated in the 10 years preceding his death. He developed dysphagia, which meant he needed a modified diet and assistance at mealtimes. He also eventually became wheelchair-bound and was deemed to be at high risk of falls.

6. Ms Cassell expressed the opinion that Mr Stow received exceptional care in the later stages of his life, which allowed him to take part in activities and maintain his hobbies.

THE CORONIAL INVESTIGATION

7. Mr Stow'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 death, the death is reportable even if it appears to have been from natural causes.[1]

[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 of the Act.

8. While Mr Stow's death was reported to the Coroner, I note with concern that, as funding for disability services shifted from the Department of Families, Fairness and Housing (**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 adequately 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 – would not be subjected to coronial scrutiny.[2] [3] [4]

9. 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.

10. 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.

11. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Stow'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.

12. This finding draws on the totality of the coronial investigation into Mr Stow's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only

[2] 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".* Mr Stow would now likely meet the new definition of person placed in custody or care.

[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."*

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]

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

Identity of the deceased

13. On 5 March 2022, John Hardy Stow, born 28 January 1949, was visually identified by cousin, Erin Cassell, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

15. Forensic Pathologist, Dr Hans de Boer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 7 March 2022 and provided a written report of his findings dated 9 March 2022.

16. The post-mortem examination was consistent with the reported history.

17. Dr de Boer provided an opinion that the medical cause of death was *"1(a) Aspiration pneumonia"* and including *2 Cerebral Palsy* as a contributing factor.

18. I accept Dr de Boer's opinion.

Circumstances in which the death occurred

19. In the months preceding his death, Mr Stow had multiple presentations and admissions to St Vincent's Hospital. His health was generally deteriorating with COVID-19 infections, falls, urinary tract infections, and injuries caused by self-harm. Due to a recent escalation in Mr Stow's behavioural issues, which had caused him to self-harm, he was prescribed escitalopram (an antidepressant) and quetiapine (an antipsychotic) and referred to a private psychiatrist for assessment and treatment.

[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.

20. On the evening of 1 March 2022, Mr Stow was unwell with vomiting. He was taken by ambulance to St Vincent's Hospital where he was admitted for suspected aspiration pneumonia and treated with intravenous antibiotics.

21. The next day, further investigations revealed Mr Stow had a small bowel obstruction. Such a condition would typically require surgery, but Mr Stow was assessed to be a high anaesthetic and peri-operative risk.

22. In consultation with Ms Cassell, it was decided that Mr Stow would not undergo surgery. Mr Stow was subsequently transitioned to palliative care and passed away peacefully on 5 March 2022.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was John Hardy Stow, born 28 January 1949;

    (b) the death occurred on 5 March 2022 at St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria;

    (c) the cause of Mr Stow's death was aspiration pneumonia with cerebral palsy as a contributing factor; and,

    (d) the death occurred in the circumstances described above.

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

Erin Cassell, senior next of kin

St Vincent's Hospital

Home@Scope

National Disability Insurance Scheme Quality and Safeguards Commission

Constable Cameron Sist, Victoria Police, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date: 20 December 2022

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.