IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 007174

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Kaylah Veronica Sarah Woollard
Date of birth:	14 May 1997
Date of death:	15 December 2022
Cause of death:	1(a) Mixed drug consumption (pregabalin, oxycodone, desmethylvenlafaxine, aripiprazole, olanzapine, delta-9-tetrahydrocannabinol) in a woman with WHO Class III obesity and cardiac hypertrophy
Place of death:	Laverton, Victoria, 3028
Keywords:	National Disability Insurance Scheme, NDIS, Supported residential service, prescription medication, overdose, Corella Place, drug trafficking, SDA-enrolled dwelling

INTRODUCTION

1. On 15 December 2022, Kaylah Veronica Sarah Woollard[1] was 25 years old when she was located deceased in her Laverton home in circumstances consistent with a drug overdose.

2. Kaylah was raised by her mother, Natasha Woollard (**Natasha**), in Reservoir. Natasha recalls that Kaylah was bullied during primary and secondary school due to her weight, and that, during her school years, she *'was starting to get depressed'*.

3. During her adolescence, Kaylah began using marijuana and methylamphetamine. Around 19 years of age, she attempted suicide by consuming large quantities of prescription medication. Natasha recalls *'[Kaylah] was in a really dark place and was very sad'*.

4. In 2020, Kaylah commenced a relationship with a man (hereinafter referred to as her **'partner'**) who resided at Corella Place in Ararat, a post-sentence residential facility for serious offenders (involving either serious sexual or violent offences) who are subject to Supervision Orders imposed by the County Court under the *Serious Offenders Act 2018*. The relationship appears to have been conducted via fortnightly visits to Corella Place until restrictions were placed on Kaylah's partner seeing her. It is unclear how the relationship commenced, though Kaylah's mother noted that Kaylah met him '*through other friends*'.

5. In 2020, Kaylah moved to Williamstown, into a residential facility operated by Mind Australia (**Mind**). The same year, Kaylah began attending upon General Practitioner (**GP**), Nicola Chambers (**Dr Chambers**). Dr Chambers noted a medical history of WHO Class III obesity, mechanical back pain, complex post-traumatic stress disorder (**CPTSD**), anxiety and depression.

6. Dr Chambers encountered difficulty controlling Kaylah's back pain in the context of the *'risk of opioid dependency'*. They had discussions regarding obesity and Kaylah's mental health, including to update Kaylah's care plan *'with the aim of targeting weight loss'*. At the time of her death, Kaylah was prescribed several medications, including quetiapine, pregabalin, olanzapine, aripiprazole and desvenlafaxine. Records do not indicate the Kaylah had been prescribed oxycodone.

7. Dr Chambers notes that during the course of their clinical relationship, Kaylah's mental health often fluctuated. In late 2020, Kaylah attempted suicide by ingesting a large quantity of

[1] Referred to throughout my finding as 'Kaylah', unless more formality is required.

quetiapine and by self-harming. She was hospitalised though undertook a repeat attempt the following month by again consuming excess quantities of prescription medication. Kaylah's sister, Chelsea Woollard (**Chelsea**), reported that she attempted suicide *'four to five times'* around this time.

8. From September 2020 onwards, Kaylah's medication (desvenlafaxine, aripiprazole, olanzapine, pregabalin and lisdexamfetamine) was administered via dose administration aids (Webster-paks). On one occasion, quetiapine tablets were supplied to Kaylah outside of the Webster-pak, however, due to her history of attempted overdose, all medications were otherwise provided in the pack by her regular pharmacy.

9. In October 2022, Kaylah re-located to Laverton, at a residential facility also operated by Mind. Mind staff noted that Kaylah sought increased independence, which could be offered at the Laverton location.

10. Mind stated that initially upon her arrival at Laverton, *'Kaylah had been responsible for having her medication stored within her residence',* however, staff identified numerous occasions where *'she missed doses, misused or overdosed on medication'*. Accordingly, staff updated Kaylah's wellbeing and safety plan such that her Webster-paks were stored securely in the facility's main office where *'staff would witness her ingest the medication'*.

11. Kaylah's final consultation with Dr Chambers occurred on 17 November 2022. Kaylah reported she was settling into living at Laverton. Dr Chambers recalls she *'appeared to be improving and reported being optimistic about progress'*.

THE CORONIAL INVESTIGATION

12. Kaylah'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.

13. 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.

14. Under the Act, coroners also have the important function 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.

15. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Kaylah's death. The Coroner's Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

16. Then-Deputy State Coroner Jacqui Hawkins initially held carriage of the investigation until it came under my purview in September 2023 for the purposes of obtaining further material, finalising the matter and handing down findings.

17. This finding draws on the totality of the coronial investigation into the death of Kaylah Veronica Sarah Woollard 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.[2]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

18. On 14 December 2022, Kaylah received a parcel in the post that had been sent from Ararat Post Office from her partner. Contained within were pregabalin and oxycodone tablets which her partner subsequently admitted that he had been *'stockpiling'* at Corella Place. Mind staff were unaware that the parcel had been received.

19. At approximately 5pm on 15 December 2022, a Mind worker spoke with Kaylah. Kaylah reported that her chronic back pain was flaring, but she otherwise *'present[ed] as her normal typical self'* and stated she was going to visit a friend's apartment. The friend later reported that Kaylah visited at approximately 6:45pm and told her she had taken *'16 or 17'* pregabalin tablets.

[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.

20. When Kaylah returned to her accommodation, at 6:55pm, Kaylah approached another Mind worker and asked for her night-time medication. The worker accompanied Kaylah to the staff office and observed her take her prescribed medication.

21. As the worker turned their back to fill out the medication chart, they *'heard a loud noise'* and turned to see Kaylah lying prone on the floor. The worker observed Kaylah was *'gasping'* and with the aid of other staff, turned her onto her back. Staff administered cardiopulmonary resuscitation, until the arrival of emergency services, who declared Kaylah deceased.

22. In the days after Kaylah's death, her partner divulged to his NDIS support worker that he had sent Kaylah a parcel of pregabalin and oxycodone the day before her death, and further that he had sent parcels multiple times in the past. He was investigated by Victoria Police and charged with, amongst other things, drug trafficking. He received a sentence of imprisonment of 9 months.

IDENTITY OF THE DECEASED

23. On 19 December 2022, Kaylah Veronica Sarah Woollard, born 14 May 1997, was visually identified by her mother, Natasha Woollard, who completed a Statement of Identification to this effect.

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

MEDICAL CAUSE OF DEATH

25. Forensic Pathologist Dr Michael Duffy (**Dr Duffy**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 20 December 2022 and provided a written report of his findings dated 31 March 2023.

26. The post-mortem examination revealed an enlarged heart as a complication of World Health Organisation (**WHO**) Class III obesity. An enlarged heart is associated with higher oxygen demands and is more susceptible to ischemia, meaning less cardiac reserve or reduced baseline function to offset any hypoxic (low oxygen) events. In turn, this can cause damage to the heart and disrupt the electrical conductivity leading to lethal arrhythmias and sudden death.

27. Dr Duffy noted Kaylah's BMI of 94.5kg/m^2, stating that WHO Class III obesity increases the risk of hypoventilation syndrome and obstructive sleep apnoea, meaning reduced respiration with build-up of carbon dioxide and less circulating oxygen leading to respiratory failure.

28. Dr Duffy stated that there is an increased risk of sudden death amongst persons with schizophrenia compared to the rest of the population. The mechanism of death in these instances in uncertain but may be due to structural cardiovascular, respiratory and neurological abnormalities. Anti-psychotic medication can also prolong QT intervals and cause lethal arrhythmias.

29. The post-mortem examination did not reveal any evidence of injuries that may have caused or contributed to the death.

30. Toxicological analysis of post-mortem samples identified the presence of the following compounds:

Pregabalin	~ 25 mg/L
Amphetamine	~ 0.06 mg/L
Oxycodone	~ 0.04 mg/L
Desmethylvenlafaxine	~ 0.4 mg/L
Aripiprazole	~ 0.2 mg/L
Olanzapine	~ 0.1 mg/L
Delta-9-tetrahydrocannabinol	~ 3 ng/mL

31. As discussed, the presence of significant natural disease caused a predisposition to sudden cardiac death, but in the context of multiple drugs detected upon toxicological analysis, this may have contributed to the death.

32. That only the metabolite of methylamphetamine, amphetamine, was detected indicates it was not used immediately prior to death, but at some time preceding. The long-term use of stimulant substances can cause hypertension, early cardiovascular atherosclerotic disease and tachyarrhythmias which can increase the risk of lethal arrhythmias and sudden death.

33. Oxycodone is a semi-synthetic opiate related to morphine which can cause central nervous depression and respiratory depression in acute overdoses. The level of oxycodone detected upon toxicological analysis alone would not have been sufficient to cause the death.

34. Dr Duffy could not be certain that the combination of substances was sufficient to have caused the death however, nor could they be excluded from contributing to the death, particularly, the anti-psychotic medications increases the risk of QT prolongation. He stated that the circumstances were not consistent with death due to central nervous depression.

35. Dr Duffy provided an opinion that the medical cause of death was 1(a) *mixed drug consumption (pregabalin, oxycodone, desmethylvenlafaxine, aripiprazole, olanzapine, delta-9-tetrahydrocannabinol) in a woman with WHO class III obesity and cardiac hypertrophy.*

36. I accept Dr Duffy's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Kaylah Veronica Sarah Woollard, born 14 May 1997;

    b) the death occurred on 15 December 2022 at Unit 2, Room 4, 40 Woods Street, Laverton, Victoria, 3028, from *mixed drug consumption (pregabalin, oxycodone, desmethylvenlafaxine, aripiprazole, olanzapine, delta-9-tetrahydrocannabinol) in a woman with WHO Class III obesity and cardiac hypertrophy*; and

    c) the death occurred in the circumstances described above.

38. I have considered all of the circumstances, including that Kaylah Veronica Sarah Woollard had a documented history of mental ill health and of multiple suicide attempts, including by overdosing on prescription medication. Given this history, it is distinctly possible that Kaylah Veronica Sarah Woollard ingested multiple drugs on 15 December 2022 with the intention of ending her own life. In this connection, I note that she had reported to her friend that she had consumed 16-17 pregabalin tablets just before her death, along with the prescribed medications from her Webster-pak.

39. However, I note the evidence provided by General Practitioner, Dr Nicola Chambers, such that Kaylah Veronica Sarah Woollard was in a position of relative stability and settling into her new accommodation in the time proximate to her death. There was no 'suicide note' or other indicator that Kaylah Veronica Sarah Woollard intended to end her own life on this occasion, nor that she had deteriorated significantly in her mental health in the lead-up to death.

40. In this regard, I consider there is insufficient evidence to find, on the balance of probabilities, that Kaylah Veronica Sarah Woollard consumed the substances present upon post-mortem toxicological testing with an explicit intention to take her life. While the ingestion of oxycodone and multiple additional pregabalin tablets on top of her Webster-pakked medications suggests a degree of recklessness or indifference to the outcome, Kaylah Veronica Sarah Woollard may have been unaware of the potential impact of the ingestion of these drugs in the context of her body habitus and natural disease.

41. In this connection, noting that all other drugs found on post-mortem toxicological testing were prescribed to her, other than oxycodone, and were Webster-pakked, and noting the evidence that Kaylah Veronica Sarah Woollard consumed 16-17 pregabalin tablets in the hours preceding her death, and that her prescribed pregabalin was otherwise Webster-pakked, I consider that it is open to me to find, on the balance of probabilities, that, just before her death, Kaylah ingested the drugs she had received via the post the previous day from her partner who was residing at Corella Place. Their contribution to her death cannot be ruled out.

42. However, in circumstances in which she had significant natural disease and the cause of her death was ascribed by the forensic pathologist as mixed drug **consumption**, rather than **toxicity**, the role of the additional pregabalin and oxycodone in her death should not be overstated. Dr Duffy opined that the history of Kaylah Veronica Sarah Woollard collapsing suddenly suggests a sudden cardiac event due to her enlarged heart because of her WHO Class III obesity. Dr Duffy noted that he was not convinced that the drugs were sufficient to cause death but could not exclude their contribution, particularly the multiple anti-psychotic medications which increase the risk of prolonged QT (arrhythmia). Dr Duffy opined that the circumstances of death do not correspond with a central nervous depressant death.

43. This brings into sharp relief the need to better understand the clinical rationale of the prescribing regime for Kaylah Veronica Sarah Woollard, especially given she was prescribed three antipsychotics with potential weight-gain-inducing effects, and what consideration was given to the metabolic risks this posed in light of her steadily increasing BMI. In this connection, I note that Kaylah was 251kg upon death, with a BMI of 94.5 kg/m^2.

44. It is clear from the statement and records from her GP that attempts were made to discuss Kaylah Veronica Sarah Woollard's weight with her and to engage her with various treatment options, including a referral to an endocrinologist, though her engagement with this was limited.

45. Further, despite encouragement from Kaylah's GP to attend in person, the consultations with her doctor were often via telehealth. The conditions for ongoing metabolic monitoring were thus not ideal, though greater communication from her GP to her psychiatrist on this issue – including developing a plan to monitor and address the potential weight gain impacts associated with her multiple anti-psychotics, and for periodic medication reviews – may have optimised this. I consider that Kaylah Veronica Sarah Woollard's lack of engagement in other weight management strategies emphasised the need for her GP to determine whether her medications had a role in her weight gain.

46. The care provided to Kaylah Veronica Sarah Woollard by her treating clinicians otherwise appeared reasonable and appropriate in light of the complex physical and mental health issues she presented with. Her GP in particular demonstrated a great deal of care towards her and assisted her in a variety of actions to support her in her life, including assisting in an application for a Disability Support Pension.

47. I have also considered the actions of Mind Australia staff, in particular to Kaylah Veronica Sarah Woollard's wellbeing and safety plan which required staff to store and administer her medication. The evidence before me demonstrates that Mind Australia staff were not aware that Kaylah was surreptitiously receiving medication in the post and had taken steps to supervise her medication ingestion to minimise the risk of overdose. I consider that the care provided by Mind Australia was reasonable and appropriate in the circumstances.

48. In the circumstances, apart from the need for further strategies to assess the impact of her medications on her weight, I consider there are no further prevention opportunities to canvass in relation to the death of Kaylah Veronica Sarah Woollard.

49. However, the circumstances of her death – and the drugs that had a potential role therein – give rise to pertinent comments connected with the death that I now turn to.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Drugs trafficked from Corella Place

50. Given the nature of Kaylah's death, it would be remiss of me to not acknowledge that she received Schedule 4 and Schedule 8 drugs, specifically pregabalin and oxycodone, via the post, and that these parcels originated from within a facility operated by the Department of

Justice and Community Safety. It is of concern that Kaylah's partner, while under the management and supervision of the Commissioner of Corrections Victoria,[3] was able to stockpile and send via Australia Post Schedule 4 and 8 drugs to Kaylah, and that he had a known history of stockpiling and misusing medications, for which he had been disciplined while in Corella Place, including in the months preceding Kaylah's death.

51. The issue of medication stockpiling and misuse has historically been a problem that has posed significant risks to Corella Place residents, as is evident in the Finding into the Death of Gregory Sedgman;[4] the present case demonstrates the potential risks posed to members of the broader community through such actions.

52. Prior to finalising this Finding, I sought the input of Corrections Victoria on these concerns, and in October 2025, it provided the Court with a response which addressed, amongst other things, the changes implemented particularly with regard to Corella Place residents' access to medication and the facility's approach to the issue of stockpiling.

53. Corrections Victoria informed me that in May 2023, an active review of the Practice Guidelines in effect at Corella Place was commenced. As a result of the review, in October 2024, changes to Practice Guidelines and relevant Local Operating Procedures were implemented. Further changes to Local Operating Procedures occurred in May 2025.

54. In October 2024, the Local Operating Procedure entitled *'Resident Medication'* was amended and the template for issuing a Lawful Instruction was updated.

55. A Lawful Instruction can be made by the Corella Place Officer in Charge pursuant to sections 183(1)(a) and (b) of the *Serious Offenders Act 2018* (Vic). It is apparent from the legislation that the threshold to provide a Lawful Instruction is relatively low and only requires that the *'reasonable instruction'* be necessary to ensure, amongst other things, the (a) good order of the facility or (b) safety and welfare of offenders, staff or visitors.[5]

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[3] The issue of whether residents of Corella Place facilities are 'in custody' for the purposes of the *Coroners Act 2008* has been addressed by Coroner Jamieson in the Finding Into Death with Inquest, delivered on 15 April 2026 and accessible via the Court's website at: https://www.coronerscourt.vic.gov.au/sites/default/files/2026-04/COR%202020%20002744%20-%20Form%2037%20-%20Finding%20into%20Death%20with%20Inquest_Deidentified_0.pdf (**LX Finding**).

[4] Finding Into Death with Inquest of Gregory Sedgman. Delivered by then-Deputy State Coroner Jacqui Hawkins on 9 September 2022 and accessible at: https://www.coronerscourt.vic.gov.au/sites/default/files/Form%2037%20Sedgman%20Inquest%20finding_COR%202018%204920.pdf

[5] *Serious Offenders Act 2018* (Vic) section 183(1). Other conditions are that the instruction is necessary to ensure (c) compliance with conditions of the supervision order (including interim supervision order) or (d) compliance with directions given by the Authority to the offender in accordance with the supervision order or interim supervision order.

56. Corrections Victoria explained that when a Lawful Instruction is issued Corella Place residents are *'required to provide their medication to staff to be secured and stored at all times within the administration building at the residential facility'*.

57. Under a Lawful Instruction, Corella Place residents can access only their prescribed daily dose of medication - as opposed to multiple days' doses - and the medication is dispensed in a Webster-pak or roll by the pharmacy and provided to Corella Place staff.[6] Corella Place staff provide the resident with access to one days' worth of medication. Corrections Victoria noted that Corella Place does not directly employ any persons licensed to dispense medication under the *Drugs Poisons and Controlled Substances Act 1981*.[7]

58. The changes also require that residents (subject to a Lawful Instruction) are permitted to hold only their prescribed daily dose of medication in their unit. Lawful Instructions require review every six months in respect of residents' *'medication access and use'*.

59. It is apparent that Corrections Victoria, in response to the well-known issue of medication stockpiling at Corella Place, has implemented changes to its operations to attempt to mitigate this activity, which I consider to be positive. However, in my view, it appears that the risk of stockpiling medication (and its potentially very serious consequences) still remains. The response from Corrections Victoria indicates that the above changes apply only when a Lawful Instruction has been issued to a resident. It does not appear that these medication-control measures apply to *all* Corella Place residents, though Corrections Victoria has noted that it needs to consider residents' human rights in any medication restrictions imposed.

60. In this connection, I am reminded of the Finding into the Death of LX (a pseudonym) handed down on 15 April 2026 by my colleague, Coroner Audrey Jamieson.[8] LX was a resident of Corella Place who died in May 2020 due to mixed drug toxicity. At inquest, Her Honour heard evidence from various witnesses including former and current Corella Place residents and Corella Place staff.

61. Coroner Jamieson observed in her finding that *'there was clear and consistent evidence that the trading, exchange and stockpiling of prescription medication was a significant issue at*

[6] This can also be implemented relating to non-prescribed medication if there are *'specific concerns relating to a non-prescribed medication for the particular resident'*.

[7] I note that Lawful Instructions in this regard do not apply to certain medications: inhalers, topical medications, medication for diabetes, heart complaints and *'other known lifesaving critical medications'*.

[8] LX Finding.

Corella Place – that it was commonplace and widely known to be occurring'.[9] That medication was being stockpiled was known by the Corella Place General Manager and other staff.

62. With regard to Lawful Instructions, her Honour heard evidence that one resident had stored seven boxes of methadone tablets in his unit – up to 140 tablets. At the time of the stockpiling, the resident was not subject to a Lawful Instruction and therefore, not required to surrender his medication.[10]

63. Coroner Jamieson's Finding into the death of LX is a thorough and comprehensive analysis of the issue of prescription medication stockpiling, trading and misuse at Corella Place. Her Honour handed down 16 recommendations directed to the Secretary to the Department of Justice and Community Safety. The first three such recommendations have relevance in Kaylah's case, as they relate to medication safety at Corella Place.[11]

64. I endorse these recommendations made by Coroner Jamieson in the Finding into the death of LX. While they pertain to improving safety for residents on post-sentence supervision orders, Kaylah's tragic case demonstrates that the public health and safety benefits may extend even beyond the walls of Corella Place. At the time of writing, the Court has not yet received a response to Her Honour's recommendations. Any response received will be published to the Court's website.

65. In making such comment, I acknowledge that Kaylah may have been able to in any event access non-prescribed medications in the community, should she have desired to do so, and that her partner was prosecuted and sentenced in relation to drug trafficking following admissions made in relation to the incident. I also note that her partner had been banned from

[9] Ibid at p 41.
[10] Above n 7 at p 42.
[11] The recommendations are as follows:
Recommendation One: With the aim of promoting public health and safety and preventing like deaths, I recommend that Corella Place institute a policy whereby residents are required to disclose if they are prescribed any Schedule 8 medications (including methadone) and all Schedule 8 medications should be centrally controlled and administered at Corella Place, subject to limited exceptions overseen by the Multi-Disciplinary Assessment Team.
Recommendation Two: With the aim of promoting public health and safety and preventing like deaths, I recommend that serious consideration be given as to whether controls are placed in relation to pregabalin so that it is centrally controlled and administered at Corella Place, given its potential for abuse, its dangerousness in combination with other medications and its prevalence in trading and exchange.
Recommendation Three: With the aim of promoting public health and safety and preventing like deaths within the correctional facility of Corella Place, I recommend the Department of Justice and Community Safety review the medication management policies at Corella Place with a view to giving consideration to adopting a system of dispensing medication that replicates the system or systems in place in other correctional facilities known as prisons.

seeing Kaylah in the months leading up to her death by Corrections Victoria. Further, while the coronial investigation revealed concerns in relation to the ability of a Corella Place resident to stockpile and send Schedule 4 and 8 drugs to a member of the community through the post, there is no evidence to suggest anything other than that the drugs were ingested willingly by Kaylah, in circumstances where the consumption of a number of other drugs was implicated in the cause of death, along with natural disease, and where there was a long history on her part of overdose.

66. However, I consider it to be a concern, and a matter of public health and safety worthy of comment, that a vulnerable member of our community who was an NDIS recipient with an intellectual disability living in supported accommodation was provided Schedule 4 and 8 drugs by a resident of a Corrections-operated facility, and subsequently died.

SDA-enrolled dwelling and oversight by the National Disability Insurance Agency

67. I note the difficulty encountered during the course of my investigation with respect to clarifying Kaylah's status as an individual potentially residing in a Specialist Disability Accommodation (**SDA**) dwelling, for the purposes of determining whether she was a person 'in care' under Regulations 7 and 8 of the *Coroners Regulations 2019*. At the time of her death, Kaylah was registered with the National Disability Insurance Agency (**NDIA**) as residing at her former Williamstown address (listed with the NDIA as an SDA-enrolled dwelling), despite that she commenced residing in Laverton in 2022 (which was not listed with the NDIA as an SDA-enrolled dwelling). SDA-enrolled dwellings are generally reserved for individuals with extreme functional impairment or very high support needs, as opposed to those with more independence.

68. After an extended period of investigation, it was revealed that Kaylah was <u>not</u> in fact an SDA resident residing in an SDA-enrolled dwelling at the time of her death, and was thus not 'in care' under the *Coroners Act 2008*, and an inquest into her death was not required. However, her NDIS Participant Plan noted that she was <u>eligible</u> for SDA.

69. I consider it to be of concern that the NDIA did not maintain oversight regarding the residential address of a participant receiving its funding, particularly insofar as it relates to the level of care provided at various locations. I was similarly concerned to learn that as a recipient of the NDIS, Kaylah herself was required to report a change of address rather than Mind Australia or the NDIA supporting her through a role of proactive oversight. Ultimately, these concerns were not causal nor contributory to the death, though they were nonetheless an issue

of concern encountered during my investigation and which created a delay in determining Kaylah's status under the *Coroners Act 2008*, including whether an inquest into her death was mandatory and whether she was receiving the correct level of care she was funded for under her NDIS package.

70. Prior to finalising this Finding, I provided a copy of these comments to the NDIA for its consideration and any submissions.

71. In its response, the NDIA confirmed that while Kaylah was residing at a listed SDA-enrolled dwelling while at Williamstown, SDA funding has never been claimed in any of Kaylah's NDIS plans (despite her eligibility).

72. The NDIA also stated that participants of the NDIS can notify the NDIA of any changes to their personal details, including their residential address, and acknowledged the issues that this process had caused in terms of its oversight of where Kaylah was living. It explained that if a participant has services provided under the Support Coordination Budget (Support Coordination/Psychosocial Recovery Coach) and this provider has consent to act for the participant, there would be an expectation that the provider would report to the NDIA any change of residence when they become aware.

73. However, in Kaylah's case, she alone had the authority to report a change of address, which did not occur prior to her moving properties, and the NDIA acknowledged it had no records of or oversight of the address Kaylah was residing at as at the time of her death. It remains of concern to me that the NDIA's oversight of disability-related accommodation arrangements for vulnerable members of our community, who are in receipt of NDIS benefits and who are eligible for specialist disability accommodation, has the potential for such gaps. I have elected to notify my finding to the NDIA to ensure that any future enhancements to information-sharing arrangements can be informed by Kaylah's circumstances.

I convey my sincere condolences to Kaylah's family for their loss and note with sadness the recollections of her mother that in the lead-up to her death, Kaylah '*had a really hard time navigating life, it just wasn't right*'.

ORDERS AND DIRECTIONS

Pursuant to section 73(1A) of the Act, I direct 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:

Ms Natasha Woollard, Senior Next of Kin

Dr Nicola Chambers, c/- The Clinic Footscray

Mind Australia

National Disability and Insurance Agency

Corrections Victoria

Senior Constable Travis Wright, Coroner's Investigator

Signature:

Coroner Ingrid Giles

Date: 23 June 2026

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.