IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002700

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Ross Robert Richards
Date of birth:	17 June 1947
Date of death:	20 May 2023
Cause of death:	1a: aspiration pneumonia in the setting of parkinson's disease and other medical comorbidities
Place of death:	Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria, 3128
Keywords:	Death in care, disease progression, natural causes

INTRODUCTION

1. On 20 May 2023, Ross Robert Richards was 75 years old when he died in Box Hill Hospital from a lung infection.

2. At the time of his death, Ross lived in supported residential accommodation owing to his high care needs associated with Parkinson's disease and other medical co-morbidities.

3. Ross also had *dysphagia*, problems with swallowing. Assessments by speech pathologists found that Ross was at high risk of aspirating food and fluids into his lungs and recommended for a modified diet to swallow safely. Ross and his family elected to proceed with eating and drinking despite these risks, referred to as eating and drinking with acknowledged risk.

4. Ross had multiple episodes of *aspiration pneumonia*, an infection of the lungs from aspiration of foreign material, presumably food or fluids relating to his dysphagia.

THE CORONIAL INVESTIGATION

5. Ross' death fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as he was a 'person placed in custody or care' within the meaning of the Act, as he was a Specialist Disability Accommodation (**SDA**) resident[1] living in an SDA enrolled dwelling.[2]

6. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

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.

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[1] SDA resident is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Ross' death, is a person who is a National Disability Insurance Scheme participant funded to reside in an SDA enrolled dwelling, or a person who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program). The definition of SDA resident was amended on 1 July 2024 pursuant to the *Disability and Social Services Regulation Amendment Act 2023* to extend to include persons who are residing, or propose to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement.

[2] *Coroners Regulations 2019*, r 7(1)(d).

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. On 4 July 2023, the coroner who initially held carriage of this investigation issued a Form 3 – Finding into Death and Determination to Discontinue Investigation. The determination to discontinue was made pursuant to section 17 of the Act and, relevantly, requires that a death is from natural causes and the person was not a 'person placed in custody or care'.

10. At the time of the determination, it was not appreciated that Ross was a 'person placed in custody or care'. Once known, the investigation resumed, and I took carriage of the investigation upon my appointment to the Court in September 2024.

11. Ross' family were notified that the investigation had resumed. The family had no concerns with the care provided to Ross and were *"completely satisfied"* with Ross' providers.

12. This finding draws on the totality of the coronial investigation into the death of Ross Robert Richards. 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.[3]

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

Circumstances in which the death occurred

13. On 29 April 2023, Ross was admitted to Box Hill Hospital with aspiration pneumonia.

14. The aspiration pneumonia was treated with antibiotics and showed improvement. However, Ross had functionally declined and required additional care and support which was not available at his current supported residential accommodation.

15. Instead, Ross was planned for an admission to a rehabilitation unit with an aim to reduce the requirement for additional supports to a level where he could be safely discharged home.

[3] 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.

16. During admission, Ross was reviewed by a speech pathologist. After discussion about the risks of aspiration with current food and fluid consumption with Ross and his family, it was decided to continue eating and drinking with acknowledged risk.

17. Ross had multiple aspiration events throughout his admission. After further discussions with Ross' family, a decision was made to not investigate further likely aspiration events with blood tests or imaging.

18. Ross remained medically stable until 20 May 2023, where he had multiple aspiration events with significant impact on his vital signs.

19. Ross' family were notified of the deterioration, and Ross was transitioned to palliative management.

20. Ross passed away comfortably later that evening.

Identity of the deceased

21. On 21 May 2023, Ross Robert Richards, born 17 June 1947, was visually identified by a staff member at his accommodation who completed a statement of identification.

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

Medical cause of death

23. On 23 May 2023, Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**) performed an external examination and provided a written report of the findings.

24. The examination showed no significant evidence of trauma or natural disease.

25. There were increased posterior lung markings in keeping with aspiration pneumonia.

26. Dr Francis provided an opinion that the medical cause of death was *1(a) aspiration pneumonia in the setting of parkinson's disease and other medical comorbidities* and that the death was from natural causes.

27. I accept Dr Francis' opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Ross Robert Richards, born 17 June 1947;

    b) the death occurred on 20 May 2023 at Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria, 3128, from *aspiration pneumonia in the setting of Parkinson's disease and other medical comorbidities*.

    c) the death occurred in the circumstances described above.

29. The available evidence does not support a finding that there was any want of clinical management or care on the part of staff at the SDA dwelling, or clinical staff at Box Hill Hospital, that caused or contributed to the death.

30. Having considered all the available evidence, I find that Ross' death was from natural causes as the natural progression of his neurodegenerative disease, and I am satisfied that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into the death and to finalise the investigation in chambers.

I convey my sincere condolences to Ross's family, friends, and carers for their loss, and acknowledge the distress caused by the delay in the investigation.

Pursuant to section 73(1B) of the Act, this finding is to be published on the Court's website in accordance with the rules.

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

Ian Richards, Senior Next of Kin

Signature:

Coroner Dimitra Dubrow

Date: 30 June 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 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.