IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003291

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Robert John Dosser
Date of birth:	3 October 1953
Date of death:	19 June 2023
Cause of death:	1a: ASPIRATION PNEUMONITIS
Place of death:	Footscray Hospital, 160 Gordon Street, Footscray, Victoria, 3011
Keywords:	In care, disability, Specialist Disability Accommodation, SDA, natural causes

INTRODUCTION

1. On 19 June 2023, Robert John Dosser[1] was 69 years old when he died in hospital. At the time of his death, Robert lived in Altona North, Victoria.

2. Robert was raised in the Gippsland region with his older sister, Susan Best (**Susan**). At 5 years of age, he demonstrated delayed development in his communication skills, and he was placed into the care of the Kew Cottages. The then-Department of Health and Human Services managed Robert's care, and he was transferred between various disability residential facilities until he settled at Altona North in 2013.

3. At the time of his death, Robert was a participant in the National Disability Insurance Scheme (**NDIS**). He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling, provided by Home@Scope.

4. Robert had diagnoses of an intellectual disability, chronic aspiration and dysphagia, frontal temporal dementia, bipolar disorder and osteoarthritis. He had a limited vocabulary and used a wheelchair to get around. Scope staff aided Robert with all daily tasks.

5. Robert enjoyed community-based activities organised by the staff including going to the zoo, visiting Ocean Grove, bowling and catching trains. Susan visited Robert, sometimes accompanied by their mother.

6. Susan was Robert's power of attorney and was actively involved in his care. In 2018, Susan organised an advanced care directive.

7. In early 2023, Robert was happy and healthy, engaging with staff and his two fellow residents. However, following this period, Susan observed his swallowing ability had declined, and his diet was limited to thickened fluids.

THE CORONIAL INVESTIGATION

8. Robert's 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 a person in Victoria who was an *'SDA resident residing in an SDA enrolled dwelling'* immediately prior to his death. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort, and is reflected in the

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

definition of a *'person placed in custody or care'* in section 3(1) of the Act, read in conjunction with Regulation 7 of the *Coroners Regulations 2019*.

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. There is a requirement under section 52(2)(b) of the Act to hold an Inquest into the death of a person who was in custody or care immediately prior to passing, though pursuant to section 52(3A) of the Act, the coroner is not required to hold an Inquest if the coroner considers the death was due to natural causes. I exercise my discretion under this provision not to hold an Inquest in the present case on the basis that Robert's passing was due to natural causes and there are no further issues I have identified that require the hearing of *viva voce* evidence.

12. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Robert's death. The Coronial 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.

13. Then-Coroner Katherine Lorenz initially held carriage of the investigation into Robert's death until it came under my purview in July 2023 for the purposes of making findings.

14. This finding draws on the totality of the coronial investigation into the death of Robert John Dosser 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]

[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

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

15. On 13 June 2023, at 3:35pm, Scope staff heard Robert coughing and discovered he was vomiting. They comforted him and organised an appointment with his general medical practitioner (**GP**) for the following day.

16. However, Robert continued coughing and vomiting and so at 3:53pm, staff contacted emergency services. Ambulance Victoria arrived and transported Robert to Footscray Hospital. At the Emergency Department, Robert presented with agitation, vomiting, drowsiness, increasing shortness of breath and required oxygen therapy. A chest x-ray demonstrated bilateral opacification suggestive of aspiration pneumonia.

17. On the basis of Robert's advanced care directive, which prioritised comfort care only, clinicians administered conservative treatment and Robert was given oral antibiotics for his chest infection.

18. Robert's condition continued to deteriorate. On 19 June 2023 at 9:58am, Robert was declared deceased.

IDENTITY OF THE DECEASED

19. On 19 June 2023, Robert John Dosser, born 3 October 1953, was visually identified by disability care worker, Sandra Hill, who completed a formal Statement of Identification to this effect.

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

MEDICAL CAUSE OF DEATH

21. Forensic Pathologist Dr Brian Beer (**Dr Beer**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on the body of Robert Dosser on 21 June 2023. Dr Beer considered the e-Medical Deposition Form completed by Western Health, the Victoria Police Report of Death for the Coroner (**Form 83**) and post-mortem computed tomography (**CT**) scan and provided a written report of his findings dated 27 June 2023.

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

22. The post-mortem CT demonstrated bilateral lower lobe pneumonic process compatible with aspiration pneumonia. Mild coronary artery calcification was also identified.

23. Dr Beer provided an opinion that the death occurred due to natural causes and that the medical cause of death was 1(a) *aspiration pneumonitis*.

24. I accept Dr Beer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Robert John Dosser, born 3 October 1953;

    b) the death occurred on 19 June 2023 at Footscray Hospital, 160 Gordon Street, Footscray, Victoria, 3011, from 1(a) *aspiration pneumonitis*; and

    c) the death occurred in the circumstances described above.

26. Having considered all of the circumstances, I am satisfied that Robert John Dosser's death occurred due to natural causes, in the setting of multiple health conditions.

27. I find that the treatment and care provided by staff at Footscray Hospital and Home@Scope was appropriate.

28. The factual matrix of Robert John Dosser's death does not support a conclusion that him being 'in care' at the time of his death – according to the Act – had a causal relationship with his death. In such circumstances, I have not identified any opportunities for prevention.

I convey my sincere condolences to Robert's family for their loss.

ORDERS AND DIRECTIONS

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:

Susan Best, Senior Next of Kin

Home@Scope

Western Health

First Constable Sarah Beagley, Coronial Investigator

Signature:

Ingrid Giles

Coroner

Date: 20 August 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.