IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 003486

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Benjamin Suggate
Date of birth:	6 April 1983
Date of death:	27 June 2023
Cause of death:	1(a) Complications of Influenza A infection in a man with cerebral palsy and congenital malformation of the brain (palliated)
Place of death:	University Hospital Geelong, Bellarine Street Geelong, Victoria
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Key words:	In care, SDA resident, Influenza A, cerebral palsy

INTRODUCTION

1. On 27 June 2023, Benjamin Suggate was 40 years old when he passed away in hospital. At the time, Mr Suggate lived in SCOPE Specialist Disability Accommodation in Highton.

2. Mr Suggate's medical history included cerebral palsy, congenital malformation of the brain, hydrocephalus, intellectual disability, epilepsy, quadriplegia, and osteoporosis. He had high support needs, including requiring full assistance with meals and required a wheelchair to mobilise. Mr Suggate was non-verbal and communicated with facial expression and gestures.

3. According to his mother, Mr Suggate was a happy and contented child but his development was severely delayed. He enjoyed a full life and enjoyed his school years and various activities with his friends.

4. From the age of 18 years until his passing, Mr Suggate attended SCOPE Manifold five days per week. In about 2017, Mr Suggate moved to a supported residential care facility in Highton where he enjoyed the company of fellow residents and staff.

5. Mr Suggate also enjoyed spending time with his extended family. Mr Suggate's parents visited him on Saturdays and Sundays each week and took him on outings weekly. He also had a particularly close relationship with his maternal grandparents who visited regularly.

6. Mr Suggate loved loud music, going for walks and drives, watching motorcycles, and roasts.

THE CORONIAL INVESTIGATION

7. Mr Suggate'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. Generally, 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. Regulation 7(1)(d) of the Coroners Regulations 2019 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".* '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). '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*

8. 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.

9. 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.

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

11. This finding draws on the totality of the coronial investigation into Mr Suggate's death, 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]

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

Identity of the deceased

12. On 29 June 2023, Benjamin Suggate, born 6 April 1983, was visually identified by his father, Alastair Suggate, who signed a formal Statement of Identification to this effect.

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

force from time to time or under other rules made under the National Disability Insurance Scheme Act 2013 of the Commonwealth."

[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.

Medical cause of death

14. Forensic Pathologist, Dr Chong Zhou, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 30 June 2023 and provided a written report of her findings dated 4 July 2023.

15. The post-mortem examination did not show any significant injuries that may have caused or contributed to death. Dr Zhou explained that the mechanism of death was likely due to respiratory failure secondary to a significant lower respiratory tract infection due to Influenza A which was complicated by a parapneumonic effusion. She noted Mr Suggate was at increased risk of developing respiratory tract infections due to his history of cerebral palsy and congenital malformation of the brain, resulting in quadriplegia.

16. Dr Zhou provided an opinion that the medical cause of death was *"1(a) Complications of Influenza A infection in a man with cerebral palsy and congenital malformation of the brain (palliated)"*. Dr Zhou expressed the opinion that Mr Suggate's death was from natural causes.

17. I accept Dr Zhou's opinion.

Circumstances in which the death occurred

18. In April 2023, Mr Suggate tested positive for COVID-19. Whilst he did not appear particularly unwell, he never really returned to his pre-infection health baseline. Mr Suggate developed an ongoing cough and appeared quiet and withdrawn.

19. Mr Suggate received the flu vaccine on 12 May 2023.

20. On 23 June 2023, another resident tested positive to Influenza A. Mr Suggate was subsequently tested and returned a negative result. However, he appeared tired with reduced appetite.

21. In the early hours of the next morning, 24 June 2023, Mr Suggate was transported to University Hospital Geelong with difficulty breathing and a high temperature.

22. A chest x-ray showed white-out of the left lung. A CT chest showed a large left parapneumonic effusion. Based on his presentations, examination and investigations, Mr Suggate was diagnosed with Influenza A. He was treated with antiviral medication and antibiotics. A discussion was held with his family and the intensive care unit (**ICU**) team, and he was deemed not for ICU level of care. A left intercostal catheter was inserted by

interventional radiology with drainage of exudative pleural fluid. One dose of intra-pleural enzyme was administered given the persistent pleural effusion. Mr Suggate was observed to have ongoing clinical deterioration despite this treatment, and a decision was made to transition him to palliative care.

23. Mr Suggate subsequently passed away on the afternoon of 27 June 2023 supported by his beloved parents.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Benjamin Suggate, born 6 April 1983;

    (b) the death occurred on 27 June 2023 at University Hospital Geelong, Bellarine Street Geelong, Victoria;

    (c) the cause of Mr Suggate's death was complications of Influenza A infection in a man with cerebral palsy and congenital malformation of the brain (palliated); and

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

25. The available evidence does not support a finding that there was any want of clinical management or care on the part of the staff of SCOPE or Barwon Health that caused or contributed to Mr Suggate's death.

I convey my sincere condolences to Mr Suggate'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:

Alastair and Judith Suggate, senior next of kin

Barwon Health

Senior Constable Lucas Atchison, Victoria Police, Coroner's Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 08 April 2024

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.