IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 004191

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of: RICHARD MARK ELLIS

Findings of:	AUDREY JAMIESON, Coroner
Delivered on:	30 September 2025
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria 3006
Hearing dates:	30 September 2025
Representation:	None
Counsel assisting the Coroner:	Ms Anna Pejnovic of the Coroners Court of Victoria

I, AUDREY JAMIESON, Coroner, having investigated the death of RICHARD MARK ELLIS

AND having held a Summary Inquest in relation to this death on 30 September 2025

at the Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria 3006

find that the identity of the deceased was RICHARD MARK ELLIS

born on 13 September 1958

and the death occurred on 1 August 2023

at 2 Stanley Street, Mooroopna, Victoria 3629

from:

1a: ASPIRATION EVENT OBSTRUCTION IN A MAN WITH OROPHARYNGEAL DYSPHAGIA AND PARKINSON'S DISEASE.

in the following summary of circumstances:

RICHARD MARK ELLIS was 64 years old when he died the day after a witnessed choking incident. Richard had an intellectual disability, schizophrenia and Parkinson's disease and lived in Supported Disability Accommodation in Shepparton, owned by the Department of Families, Fairness and Housing and with supports provided by disability services provider ConnectGV.

BACKGROUND CIRCUMSTANCES

1. Richard was one of three siblings and grew up on a farm in the Goulburn Valley. He was slow to meet developmental milestones and did not speak in full sentences until the age of five. Richard attended high school until the age of 15 but left due to severe bullying.

2. Richard's mental health appeared to decline following the death of his father in 1983. At this time, he lived alone and was not receiving any support, other than from family.

3. In the 1990s, concerned by Richard's escalating behaviours including theft, his family arranged for him to be assessed by a psychiatrist. He was diagnosed with an intellectual disability and referred to a social worker, who assisted in linking him with ConnectGV.

4. In the early 2000s, Richard moved into supported accommodated in Shepparton. He later moved into a full-time care unit where he received around-the-clock support.

5. Richard was diagnosed with schizophrenia in 2001 and schizoaffective disorder in 2010. His mental health was managed by the Goulburn Valley Area Mental Health & Wellbeing Service.

6. In 2005, Richard was involved in a serious motor vehicle collision. He was found not guilty by reason of mental impairment, and on 19 November 2007 was placed on a non-custodial supervision order under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) that required him to live in the community under the supervision and support of the then Department of Health and Human Services. This remained in place (with annual review) at the time of his death.

7. Richard's health appeared to decline from late-2022 and in early 2023, he was assessed by a geriatrician and diagnosed with hemiparkinsonism. He experienced functional decline with impaired mobility and experienced recurrent falls, resulting in a lengthy hospital admission. On his discharge in March 2023, he had deteriorated considerably and required assistance for most activities of daily living.

8. Richard was again admitted to Goulburn Valley Health (**GVH**) from 2 to 3 May 2023, following an unwitnessed fall at home. He was found to have minimally displaced fractures of the transverse process at T10, T11, L1 & L2 vertebral bodies, which were for conservative management.

9. Richard had impaired swallowing and on 23 June 2023 had a video fluoroscopy swallow study. During the assessment he was observed to aspirate on thin and mildly thickened fluids and did not clear the aspirations fully, so was sent to the GVH Emergency Department (**ED**). On review he did not demonstrate any clinical or radiological signs of aspiration and was discharged home.

10. Richard was admitted to the inpatient psychiatric unit of GVH from 14 to 28 July 2023 for a relapse of his schizoaffective disorder after his antipsychotic was ceased. His medications

were adjusted during the admission and he was discharged with improvements in his tardive dyskinesia[1] and paranoid thoughts.

THE CORONIAL INVESTIGATION

Jurisdiction

11. Richard'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 or unnatural. In addition, Richard's death was reportable as he was a 'person placed in custody or care' within the meaning of the Act, as he was an SDA resident residing in an SDA enrolled dwelling.

12. The death of a person in care is a mandatory report to the Coroner, even if the death appears to have been from natural causes. This category of death is reportable to ensure independent scrutiny of the circumstances leading to the death, given the vulnerability of this cohort.

13. Section 52(2)(b) of the Act requires that I must hold an Inquest into the death of a person placed in custody or care, unless that death is due to natural causes.

14. Having considered the available evidence, I determined that this matter would be appropriately finalised by way of a Summary Inquest and Form 37 *Finding into Death with Inquest*. Interested parties were informed of my determination by way of a formal notice for a Summary Inquest to be held on 30 September 2025.

Purpose of a coronial investigation

15. The purpose of a coronial investigation of a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[2]

[1] Tardive dyskinesia refers to the involuntary nature of muscular movements or the difficulty in performing voluntary muscular movement. Tardive means a condition has the tendency to appear late. Symptoms of tardive dyskinesia can develop and persist long after use of the medication causing the disorder has been discontinued and can be both distressing to the person and interfere with their ability to function.
[2] Section 67(1), of the Act.

16. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The circumstances in which death occurred refer to the context or background and surrounding circumstances but are confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[3]

17. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the prevention role.[4]

18. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[5] These powers are effectively the vehicles by which the Coroner's prevention role can be advanced.[6]

19. The Coroners Court of Victoria is an inquisitorial jurisdiction.[7] Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[8]

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[3] This is the effect of the authorities – see for example, *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[4] The "prevention" role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as "implicit".

[5] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations, respectively.

[6] See also sections 73(1) and 72(5), which requires publication of coronial findings, comments and recommendations and responses respectively; sections 72(3) and 72(4), which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[7] Section 89(4) of the Act.

[8] Section 69(1) of the Act. However, a Coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1) of the Act.

Sources of evidence

20. This Finding is based on the totality of the material produced by the coronial investigation into the death of Richard Mark Ellis. That is, the Court File and Coronial Brief of evidence compiled by Senior Constable Bridie Bremner-Graham.

21. The Brief will remain on the Court File, together with the Inquest transcript.[9] In writing this Finding, I do not purport to summarise all the material and evidence but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

Standard of proof

22. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*[10]. These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

    - the nature and consequence of the facts to be proved;
    - the seriousness of any allegations made;
    - the inherent unlikelihood of the occurrence alleged;
    - the gravity of the consequences flowing from an adverse finding; and
    - if the allegation involves conduct of a criminal nature, weight must be given to

[9] From the commencement of the Act, that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

[10] *Briginshaw v Briginshaw (1938)* 60 C.L.R. 336 esp. at 362-363: *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters, "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…".*

- the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

IMMEDIATE CIRCUMSTANCES OF DEATH

23. At around 3:30pm on 31 July 2023, Richard choked while eating quiche at home. Triple Zero was called and on the arrival of paramedics he was observed to not be in respiratory distress and had coughed up some food, but still felt like something was stuck in his throat.

24. Richard was conveyed by ambulance to the GVH ED, arriving at 4:30pm. Due to ramping, he was assessed in the ambulance. On assessment his vital signs were normal, his chest was clear, and he appeared settled. He was discharged at 6:54pm.

25. At around 8:48pm that evening, support worker Jamal Sharif called Triple Zero as *"Richard didn't look right, he was still gasping, and he was very weak".* According to Mr Sharif, the two attending paramedics disagreed on whether Richard should be taken to hospital, with one stating *"we're going to be waiting for a long time, hospital is busy."*

26. Paramedics called GVH and spoke to a doctor who reportedly noted that Richard had missed his regular medication dose while in ED, and that may have caused his behaviour at the time.[11]

27. At 10:30pm, Mr Sharif spoke to house supervisor Linda Glover and advised that Richard had been assessed by paramedics but not taken to hospital. He explained that Richard *"didn't seem right, he was still weak and still wheezing badly".* Ms Glover advised Mr Sharif to place a duress mat underneath Richard so that he would hear if he moved during his sleepover shift.

28. Mr Sharif heard the mat alert a few times during the night. On each occasion he checked on Richard who said he was okay.

29. At around 1:35am on 1 August 2023, Mr Sharif was alerted by the mat that Richard had moved. He attended and found him laying with his legs off the couch, gasping for air. Mr

[11] GV Health does not have any independent record of this conversation.

Sharif immediately called Triple Zero and commenced CPR on the instruction of the call taker.

30. Paramedics arrived and took over CPR. Mr Sharif called Richard's sister Vicki who advised that Richard had a do not resuscitate order in place. Paramedics ceased CPR, and Richard was declared deceased shortly after.

INVESTIGATION PRECEDING THE INQUEST

Identification

31. On 1 August 2023, Richard Mark Ellis, born 13 September 1958, was visually identified by support worker Linda Glover, who completed a Statement of Identification.

32. The identity of Richard Mark Ellis is not in dispute and requires no further investigation.

Medical cause of death

33. On 4 August 2023, Forensic Pathologist, Adjunct Associate Professor Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on the body of Richard Ellis. A/Prof Parsons considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, medical notes from GV Health, Ambulance Victoria notes and Wyndham House Clinic pathology results and provided a written report of her findings dated 16 November 2023.

34. The autopsy identified polarisable foreign material deep in the lungs, but none in the trachea or larger airways. A/Prof Parsons commented that it is possible this material was from the choking episode on the afternoon when he was transferred to hospital. There was some focal bronchopneumonia associated with this.

35. There was significant swelling of the pharynx, with unclear aetiology. It is possible that the oedema and swelling was a consequence of focal trauma from his earlier choking episode or may be the cause of it.

36. Myocardial fibrosis, mild to moderate coronary artery disease and Lewy bodies in the substantia nigra were also identified.

Toxicology

37. Toxicological analysis of post-mortem samples revealed the presence of amisulpride[12], olanzapine[13], zuclopenthixol[14], metformin[15], baclofen[16], lorazepam[17] and benztropine[18].

Forensic pathology opinion

38. A/Prof Parsons provided an opinion that the medical cause of death was 1 (a) Aspiration event obstruction in a man with oropharyngeal dysphagia and Parkinson's disease.

CORONERS PREVENTION UNIT REVIEW

39. I requested the Coroners Prevention Unit (**CPU**) review the care provided to Richard and in particular the following:

    a. The appropriateness of the decision to discharge Richard from Goulburn Valley Health (**GVH**) on the evening of 31 July 2023;

    b. Whether the medications prescribed to Richard could have contributed to his worsening dysphagia; and

    c. The appropriateness of Richard's management at his residence by Connect GV proximate to his death.

[12] Amisulpride is an antipsychotic medication used in the treatment of acute and chronic schizophrenia in which positive symptoms and/or negative symptoms are prominent, including patients characterised by prominent negative symptoms.
[13] Olanzapine is a second-generation antipsychotic indicated in the treatment of schizophrenia and related disorders, and bipolar disorder.
[14] Zuclopenthixol is a long-acting antipsychotic injection used for treatment of psychotic illnesses and prevention of future episodes.
[15] Metformin is an oral antidiabetic drug in the biguanide class. It is the first-line drug of choice for the treatment of type 2 diabetes, in particular, in overweight and obese people and those with normal kidney function.
[16] Baclofen is a muscle relaxant used to treat spasticity and muscle pain.
[17] Lorazepam is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety or anxiety associated with depressive symptoms and alcohol withdrawal.
[18] Benztropine is used to treat the symptoms of parkinsonism including tremor, slow movement and stiffness.

Discharge from GVH on 31 July 2023

40. The CPU sought a statement from GVH as to Richard's management in ED and the rationale for his discharge. Dr Sheldon Hall, Acting Clinical Director of Emergency Medicine, provided a comprehensive statement.

41. Dr Hall advised that the decision to discharge Richard was made on the following bases:

    a. Richard did not appear to be in any respiratory distress according to Admitting Officer Dr Adam Bystrzycki's assessment.

    b. Richard had tolerated thickened fluids without issues whilst in ED.

    c. There was no evidence of aspiration pneumonitis upon assessment and no role for antibiotics in the clinical picture.

    d. Dr Bystrzycki made a plan for Richard to return if he became febrile or had shortness of breath and to follow up with the GP in one week.

42. Dr Hall further advised that Richard's death was subject to a desktop review and assessed against the Incident Severity Ratings fixed under the Adverse Patient Safety Event Policy published by Safer Care Victoria as well as the criteria for Sentinel Events. He stated:

> *The review panel concluded that the treatment and management provided to Mr Ellis was reasonable having regard to the documented examination performed by Dr Bystrzycki and it was reasonable for a decision to be made to discharge Mr Ellis in the circumstances. The review panel noted that the medical record documented that there was no indication for pathology or imaging based on the clinical findings … nor was there any role for antibiotics.*

Did Richard's medication contribute to his worsening dysphagia?

43. Richard was on several medications prior to his last inpatient mental health admission in July 2023. Richard's sister Lisa Garland, in her statement as part of the Coronial Brief, noted that she had spoken to a doctor in the week before Richard's death and told them they needed

to watch him if they changed his medication, because his history indicated he had a *"strong reaction"* each time this was done.

44. Professor Ravi Bhat, Divisional Clinical Director of the Goulburn Valley Area Mental Health & Wellbeing Service provided a statement regarding the changes to Richard's medication at his last inpatient admission, among other matters.

45. Prof Bhat advised that Richard was noted to have tardive dyskinesia during his admission, and so tetrabenazine was prescribed following discussion with Richard's treating psychiatrist in the community. It appeared that Richard had both medication-induced tardive dyskinesia and Parkinson's disease, so the risk benefit of its use was discussed, but given the severity of his tardive dyskinesia it was decided to continue trialling tetrabenazine. The tardive dyskinesia appeared to improve during the admission after commencing the medication.

46. Richard had been prescribed zuclopenthixol, which as a first-generation antipsychotic has a greater propensity to cause or worsen tardive dyskinesia. As such, the decision was made to trial him on a second-generation antipsychotic. Quetiapine was initially trialled, but this was changed to amisulpride as it was less likely than quetiapine to worsen Richard's glycaemic control.

47. Richard was taking levodopa-benserazide, which can induce dyskinesia in patients with Parkinson's disease with an estimated incidence of 10% per year. However, Richard was noted to have tardive dyskinesia at a previous admission on 18 January 2023, before he was commenced on levodopa-benserazide.

48. Prof Bhat concluded:

> *In the balance, it is much more likely that the dyskinesia was an adverse effect of long-term first-generation antipsychotic medication than being levodopa induced. Therefore, the plan to trial tetrabenazine appears to be a considered one. Importantly, Mr Ellis reported a lessening of the abnormal movements during his review with the treating psychiatrist on 25 July 2023. Furthermore, the AIMS score from the assessment on 24 July 2023 shows no abnormal movements of the tongue and minimal movements of the*

jaw, both of relevance with regards to dysphagia. Together these suggest that the tardive dyskinesia that Mr Ellis was experiencing improved with tertrabenazine.

Richard's management by ConnectGV

49. The CPU sought a statement from Jacinta Russell, CEO of ConnectGV, to facilitate a review of Richard's management at his residence proximate to his death. Ms Russell provided a comprehensive overview of ConnectGV's involvement in his care.

50. Richard commenced living at the Stanley Street residence in November 2014. The residence was owned by the Department of Families, Fairness and Housing (**DFFH**) with supported living services provided by ConnectGV. DFFH Justice had overall responsibility for his health and wellbeing, due to the supervision order in place.

51. Ms Russell described Richard's mental and physical decline from late 2022 onwards and the steps taken by ConnectGV to meet his increased needs, that included obtaining reports from an occupational therapist, physiotherapist and speech therapist and implementing all recommendations. ConnectGV had placed him on a Level 5 minced moist diet as recommended by the speech therapist, though acknowledged he often found the diet unpalatable. However, they appeared to respond in a client-centred way by substituting disliked food with foods he did like (e.g., ice cream) and locking away foods that were not approved on the diet. Additionally, a sensor mat was used at night to wake sleepover staff so they could monitor any food that he was able to access.

52. ConnectGV staff took part in multiple care team meetings during Richard's hospitalisation in early 2023 and their disability support workers provided outreach support to assist his rehabilitation and enable him to return to Stanley Street instead of an aged care facility. This took place after the Stanley Street residence had been assessed by an occupational therapist as suitable for his care needs.

53. Since Richard's death, ConnectGV have implemented weekly meal audits of people receiving Level 5 or 6 modified diets that will assist in ensuring the meals align with the International Dysphagia Diet Standardisation.

54. Ms Russell provided copies of the following ConnectGV procedures that were current at the time of Richard's death: On Call, Deteriorating Health and Meals Management. The CPU cross referenced those policies with Ms Russell's statement and the file notes provided by the disability support workers for time proximal to his death, and noted that the policies were followed.

55. During the afternoon and evening of 31 July 2023 and early morning of 1 August 2023, the disability support workers caring for Richard made repeated efforts to check on his condition and seek medical assistance, calling an ambulance on three occasions. The CPU considered that there were no concerns identified with the quality of care.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. Overall, the CPU advised me, and I accept, that Richard had refractory and progressive mental health, behavioural and medical issues and was on a deteriorating trajectory that led to his death.

2. The care and management of Richard by ConnectGV, GVH and Ambulance Victoria appear to have been reasonable and appropriate in the circumstances, and I have not identified any relevant prevention opportunities.

3. I note that Richard's sister Lisa Garland, in her statement as part of the Coronial Brief, expressed concern with the care provided to Richard, stating *"I am still very angry about how Richard was treated by the system … I am angry that medical professionals didn't listen to us as his family who knew him best"*.

4. I have been unable to substantiate the concerns raised by Ms Garland and note that even if substantiated, the concerns likely had no connection to Richard's death given his rapidly deteriorating health due to natural causes.

5. However, substandard care for people with disabilities, in both the disability sector and the health system is sadly not uncommon and has been the subject of several coronial

investigations. The issue was highlighted in a comment made in the Final Report (2023) of the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (**the Royal Commission**) that:

> *People with cognitive disability are subject to systemic neglect in the Australian health system… health services are not designed for people with disability… health workers do not have sufficient disability knowledge and skills" such that "too often, people with disability have received poor care, the wrong care or no care*.[19]

6. Again, I stress that my coronial investigation has not identified any concerns regarding the care provided to Richard. However, I highlight the issue as it is not uncommon, and I certainly hope the recommendations arising from the Royal Commission go some way to improving the lives of Australians living with a disability.

FINDINGS AND CONCLUSION

Having applied the applicable standard to the available evidence, I make the following Findings pursuant to section 67 of the *Coroners Act 2008* (Vic):

1. I find that Richard Mark Ellis, born 13 September 1958, died on 1 August 2023 at 2 Stanley Street, Mooroopna, Victoria, 3629.

2. I accept and adopt the medical cause of death ascribed by Associate Professor Sarah Parsons, and I find that Richard Mark Ellis, a man with oropharyngeal dysphagia and Parkinson's disease, died from an aspiration event.

3. I find that Richard had refractory and progressive mental health, behavioural and medical issues and in the weeks and months before his death was on a deteriorating trajectory.

[19] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (September 2023), *Final Report, Volume 6, Enabling autonomy and access*, p. 321. https://disability.royalcommission.gov.au/publications/final-report-volume-6-enabling-autonomy-and-access.

4. AND, I find that the care provided to Richard Mark Ellis by Goulburn Valley Health, including the decision to discharge him home from the Emergency Department on 31 July 2023, to have been reasonable and appropriate in the circumstances.

5. AND, I find that the care provided to Richard Mark Ellis by ConnectGV proximate to his death was reasonable and appropriate.

6. AND, I also find that there was no causal relationship between Richard Mark Ellis' death from an aspiration event and his status as 'a person placed in custody or care' immediately before his death.

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

PUBLICATION OF FINDING

To enable compliance with section 73(1) of the *Coroners Act 2008 (Vic)*, I direct that the Findings will be published on the internet.

DISTRIBUTION OF FINDING

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

Vicki Gorman, Senior Next of Kin

Goulburn Valley Health

Ambulance Victoria

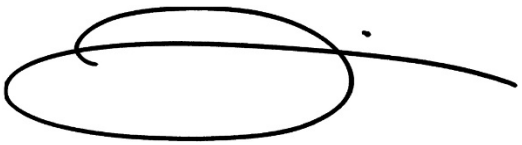
ConnectGV

Department of Families, Fairness and Housing

NDIS Quality and Safeguards Commission

Senior Constable Bridie Sutton

Signature:



AUDREY JAMIESON
CORONER

Date: 30 September 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 inquest. 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.