IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 007101

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Julie Elizabeth Bruton
Date of birth:	23 October 1965
Date of death:	20 December 2023
Cause of death:	1a: Aspiration pneumonia 1b: Rapidly progressive frontotemporal dementia 2: Malnourishment
Place of death:	Calvary Health Care Bethlehem 476 Kooyong Road Caulfield South Victoria 3162

INTRODUCTION

1. On 20 December 2023, Julie Elizabeth Bruton was 58 years old when she died in hospital. At the time of her death, Julie lived in Supported Disability Accommodation (**SDA**) in Highett, where she received Supported Independent Living **(SIL**) services from Scope (Aust) Limited.

2. Julie required support for all daily living activities, including meal preparation, personal care, mobility and continence management. She communicated by non-verbal cues.

Background

3. Julie had three children with her former husband, Rod. They lived in Bentleigh and Julie worked in the home raising their children, having left her career in graphic design to do so.

4. Julie and Rod separated in 2005, following which Julie found it difficult to enter the workforce. She retrained to be a childcare worker which she initially enjoyed, however struggled to hold down a job, which her daughter Erin reflects was likely due to her changing mental state.

Frontotemporal Dementia diagnosis

5. Julie's children noticed a change in her behaviour in 2018 but put this down to her difficult life circumstances and the fact she had always had somewhat of an 'airy-fairy' demeanour. She began displaying a loss of self-awareness, loss of empathy, increased impulsivity and a lack of inhibition.

6. In March 2022 Julie was diagnosed with frontotemporal dementia (**FTD**). Following the diagnosis, Erin became her guardian and financial administrator and applied for National Disability Insurance Scheme (**NDIS**) funding.

7. Initially Julie received care in her home, which Erin described as 'unacceptable and quite disappointing'. She then moved to respite care in Cranbourne, where her level of care was similarly substandard.

8. In October 2022, Julie was conveyed to Casey Hospital after Erin called an ambulance, 'at her wits end' with the lack of care provided by the respite facility. Julie was unable to recognise anyone and was afraid and mistrusting, attempting to remove medical interventions and leave the hospital.

9. In November 2022, Julie was transferred to the Monash Health Kingston Rehabilitation Centre, where she stayed for the next nine months. During this time, her condition continued to decline, leaving her bedbound.

10. In August 2023, Julie moved to the SDA home in Highett where she received good care. She had several assessments from allied health and medical professionals due to concerns about her declining mobility function, declining oral intake and difficulty swallowing.

11. On 11 October 2023, following an assessment from her General Practitioner and discussion with Erin, Julie was referred to the Monash Health Palliative Care Team. The goals of her care were to ensure she was kept comfortable, and the preference of her family was to avoid invasive treatments. Palliative care nurses regularly visited Julie at her home.

THE CORONIAL INVESTIGATION

12. Julie's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Specifically, Julie was immediately before her death 'a person placed in custody or care', as she was an SDA resident residing in an SDA enrolled dwelling.[1] The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

13. Section 52(2) of the Act prescribes when a coroner must hold an Inquest into a death. This includes where the deceased was, immediately before death, a person placed in custody or care. However, as Julie's death was due to natural causes, I am not required to hold an Inquest.[2]

14. 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.

15. 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

[1] Regulation 7(d) of the *Coroners Regulations 2019.*
[2] Section 52(3A) of the *Coroners Act 2008.*

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

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

17. This finding draws on the totality of the coronial investigation into the death of Julie Elizabeth Bruton 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.[3]

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

Circumstances in which the death occurred

18. On 17 December 2023, Julie's care staff called Triple Zero as they observed her to be in discomfort with shortness of breath and wheezing. She was assessed by paramedics who discussed her case with a Virtual Emergency Department consultant. She was considered to have had an acute respiratory event, possibly aspiration, which was likely a terminal event. She was conveyed to Calvary Health Care Bethlehem for end-of-life care.

19. Julie was provided with supportive care and appeared comfortable, though her condition deteriorated over the following days.

20. Julie died at 6:30pm on 20 December 2023.

Identity of the deceased

21. On 20 December 2023, Julie Elizabeth Bruton, born 23 October 1965, was visually identified by her daughter, Erin Bruton, who completed a Statement of Identification.

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

[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.

Medical cause of death

23. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Julie Bruton on 29 December 2023. Dr Baber considered the Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan, VIFM contact log and E-Medical Deposition Form from Calvary Health Care and provided a written report of her findings dated 15 January 2024.

24. The external examination showed findings in keeping with the clinical history. Dr Baber noted that Julie was a slim adult female with a body mass index[4] of 15.6.

25. The post mortem CT scan showed cerebral atrophy, dependent lung markings and a slightly fatty liver.

26. Dr Baber provided an opinion that the medical cause of death was 1(a) ASPIRATION PNEUMONIA, 1(b) RAPIDLY PROGRESSIVE FRONTOTEMPORAL DEMENTIA, 2 MALNOURISHMENT.

COMMENTS

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

1. Erin provided a measured, though poignant statement to the Court depicting Julie's trajectory following her FTD diagnosis. She describes Julie as having 'slipped through the cracks of the health care system' and depicts a provision of care that appears to range from substandard to potential neglect.

2. Though not proximate to Julie's death, Erin's reflections on the care provided to her mother following her diagnosis of FTD bear repeating – they are an indictment on the delivery of care to people with a disability from the perspective of a caring family member.

3. Despite her family's best efforts, they were repeatedly told that due to Julie's age she would be ineligible to be placed into an aged care facility, that would likely have been more equipped to deal with Julie's needs. Instead, the support workers who cared for her in her home were noted by Erin to lack both confidence and the necessary knowledge to care for someone with

[4] The Body Mass Index (BMI) is an index of weight-for-height that is commonly used to classify underweight, overweight and obese adults. BMI is defined as the weight in kilograms divided by the square of the height in metres (kg/m2). According to the World Health Organisation, the normal range for BMI in adults is 18.5 to 24.99 kg/m2.

high care needs. She observed them often sitting using their phones rather than interact with and care for Julie, and as a result her hygiene and quality of life deteriorated greatly.

4. When Julie was moved to respite care in Cranbourne, she was left isolated, unable to even watch television. Her personal hygiene was ignored leading to a further decline in health, and according to Erin she had been left to sit in her own urine and faeces.

5. Erin also described great difficulty 'proving' Julie's illness to the NDIS to obtain necessary funding. Due to Julie's cognitive decline, it was difficult for her to cooperate with assessments from clinicians and therapists. In a particularly difficult catch-22, Julie's family relied on daily care diary entries as proof of her illness to get her the necessary care, but the support workers she had often failed to complete these.

6. Erin noted that she felt as if she would sit for hours with Julie's allied health care teams, and while she was grateful for their help and understood the difficulties surrounding making healthcare decisions, she felt that funding should have been put into those who worked directly with Julie, who were 'understaffed, undertrained and undervalued'. She sadly reflected:

   We did not receive the type of care and funding required and sadly mum's likely last conscious memories were not spent of her getting to go out on trips to have coffee at her favourite café, or to visit her parent's graves like she had always.

7. Julie's experience, and that of her family, is tragically not uncommon. Victorian Coroners, and I would suspect our interstate counterparts, regularly investigate instances of substandard care in the disability sector.

8. Though the substandard care provided to Julie was not proximate to her death, and I have not identified any pertinent recommendations, I intend to distribute this finding to the NDIS Quality and Safeguards Commission and relevant ministers in the hope that Julie's story encourages their ongoing work in improving conditions for some of our most vulnerable.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Julie Elizabeth Bruton, born 23 October 1965;

   b) the death occurred on 20 December 2023 at Calvary Health Care Bethlehem, 476 Kooyong Road, Caulfield South Victoria 3162,

c) I accept and adopt the medical cause of death ascribed by Dr Yeliena Baber and I find that Julie Elizabeth Bruton, has died from aspiration pneumonia in association with rapidly progressive frontotemporal dementia, contributed by, but not caused by, malnourishment;

2. AND, I have determined that the application of section 52(3A) of the Act is appropriate in the circumstances as I accept that Julie Elizabeth Bruton's death was due to natural causes and I find there is no relationship or causal connection between her death and her status as a person placed in custody or care immediately before his death.

3. AND FURTHER, I find that the care provided to Julie Elizabeth Bruton by Scope (Aust) Pty Ltd and Calvary Health Care was reasonable and appropriate.

I convey my sincere condolences to Julie'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:

Erin Bruton, Senior Next of Kin

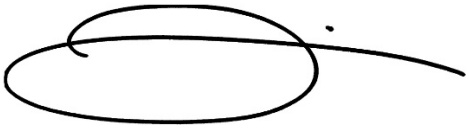
Scope (Aust) Ltd

The Hon Mark Butler MP, Minister for Health and Ageing, Minister for Disability and the National Disability Insurance Scheme

Senator the Hon Jenny McAllister, Minister for the National Disability Insurance Scheme

Senior Constable Robin Skinner, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 2 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.