



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 000906

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner Ingrid Giles
Deceased:	Tania Jane Baker
Date of birth:	13 May 1972
Date of death:	14 February 2024
Cause of death:	1a: METASTATIC ESOPHAGEAL CANCER (PALLIATED)
Place of death:	Wantirna Hospital 251 Mountain Highway Wantirna Victoria 3152
Keywords:	Specialist Disability Accommodation, SDA, supported independent living, disability, natural causes

INTRODUCTION

1. On 14 February 2024, Tania Jane Baker (**Tania**) was 51 years old when she died at Wantirna Hospital. She is survived by her parents, Richard and Jane Baker, and her siblings Adrian and Merkeeta.
2. When Tania was around two months old, her parents found her unresponsive in her cot. She was revived and taken to hospital, where doctors advised that Tania had experienced significant oxygen deprivation, resulting in brain injury.
3. Tania lived with cerebral palsy, epilepsy and an intellectual disability. She had a limited vocabulary and used a wheelchair to get around. In the years prior to her death, Tania's vision had begun to deteriorate and she experienced muscular atrophy.
4. At the time of her death, Tania was a Specialist Disability Accommodation (**SDA**) resident residing in an SDA- enrolled dwelling in Boronia. She received Supported Independent Living Services from Scope (Aust) Ltd (**Scope**) and funding through the National Disability Insurance Scheme (**NDIS**). Scope staff assisted Tania with all daily tasks.
5. In December 2023, Tania's appetite began to decrease. On 19 December 2023, Tania was transported to Angliss Hospital after Scope staff observed that Tania's abdomen was distended and sore to touch. When asked, Tania indicated that she was in pain. On 21 December 2023, Tania underwent a gastroscopy, which showed an oesophageal tumour with suspected malignancy.
6. On 4 January 2024, Tania was admitted to Box Hill Hospital, where she underwent a Positron Emission Tomography (**PET**) scan and was diagnosed with metastatic gastro oesophageal cancer. On 5 February 2024, Tania was referred to Eastern Palliative Care for assistance with in-community care and symptom management, so she could be comfortable and supported in her home environment.

THE CORONIAL INVESTIGATION

7. Tania's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as she was a '*person placed in custody or care*' within the meaning of the Act, as a

person with disability who received funded daily independent living support and resided in an SDA enrolled dwelling immediately prior to her death.¹

8. 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.
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. This finding draws on the totality of the coronial investigation into the death of Tania Jane Baker 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

Circumstances in which the death occurred

12. On 9 February 2024, Tania was admitted to the Wantirna Health Palliative Care Unit, as her symptoms were no longer able to be managed in community. Tania was unable to swallow medications and had developed abdominal pain, nausea, vomiting and delirium. These

¹ This class of person is prescribed as a ‘person placed in custody or care’ under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

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.

symptoms were consistent with upper gastrointestinal obstruction, which was caused by the advanced malignancy.

13. Tania was given treatment to relieve her symptoms and to keep her comfortable. Tania's condition continued to deteriorate. On 14 February 2024 at 11:10pm, Tania passed away peacefully.

Identity of the deceased

14. On 15 February 2024, Tania Jane Baker, born 13 May 1972, was visually identified by her father.
15. Identity is not in dispute and requires no further investigation.

Medical cause of death

16. On 19 February 2024, Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination, reviewed a post-mortem computed tomography (CT) scan and other relevant materials. He provided a written report of his findings dated 20 February 2024.
17. Dr de Boer provided an opinion that the medical cause of death was '*1(a) metastatic esophageal cancer (palliated)*.' Dr de Boer also provided an opinion that the cause of death was due to natural causes.
18. I accept Dr de Boer's opinion.

FINDINGS AND CONCLUSION

19. Pursuant to section 67(1) of the *Coroners Act 2008* (Vic) I make the following findings:
 - a) the identity of the deceased was Tania Jane Baker, born 13 May 1972;
 - b) the death occurred on 14 February 2024 at Wantirna Hospital, 251 Mountain Highway, Wantirna, Victoria from metastatic esophageal cancer (palliated); and
 - c) the death occurred in the circumstances described above.
20. I note that section 52 of the Act requires that an inquest be held, except in circumstances where the death was due to natural causes. I am satisfied that Tania died from natural causes, and I

have therefore exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death.

21. The available evidence does not support a finding that there was any want of clinical management or care on the part of Scope or Eastern Health.
22. The factual matrix of Tania's death does not, therefore, support a conclusion that her being 'in care' at the time of her death – according to the Act – had a causal relationship with her death. In such circumstances, I have not identified any opportunities for prevention.

I convey my sincere condolences to Tania's family, friends and carers for their profound loss. She is remembered as someone who enjoyed nature, books, plays and music, and her passing is felt keenly by her loved ones.

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:

Richard and Jane Baker, Senior Next of Kin

Scope (Aust) Ltd

Eastern Health

Senior Constable Zoe Capaldo, Coronial Investigator

Signature:



INGRID GILES

CORONER

Date: 11 March 2026



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.
