IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 001453

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Randal Robin Wilder
Date of birth:	6 May 1964
Date of death:	12 March 2024
Cause of death:	1(a) Aspiration pneumonia in a man with trisomy 21
Place of death:	Colac Hospital 2-28 Connor Street Colac Victoria
Keywords:	Supported Disability Accommodation (SDA), In care, Natural causes

INTRODUCTION

1. On 12 March 2024, Randal Robin Wilder was 59 years old when passed away at hospital in Colac. At the time of his death, Mr Wilder lived in Supported Disability Accommodation (**SDA**) in Colac that was managed by Scope Australia, from whom he received National Disability Insurance Scheme (**NDIS**) funded and regulated support.

2. Mr Wilder's medical history included trisomy 21, intellectual disability, epilepsy, osteoarthritis and hypertension.

THE CORONIAL INVESTIGATION

3. Mr Wilder's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Mr Wilder's death was reportable as he was a person placed *"in care"* under s4(2)(c) of the Act.[1] This category of deaths is reportable to ensure independent scrutiny of the circumstances given the vulnerability of the deceased and the level of level of power and control exercised by those who care for them. If such deaths occur as a result of natural causes, a coronial investigation must take place, but the holding of an inquest is not mandator.

4. 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.

5. 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.

6. This finding draws on the totality of the coronial investigation into Mr Wilder's death including information from the NDIS and a medical deposition completed at Colac Hospital. While I have reviewed all the material, I will only refer to that which is directly relevant to

[1] He was an SDA resident residing in an SDA enrolled dwelling before the time of her death; Reg 7(1)(d), *Coroners Regulations 2019.*

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

7. On 3 March 2024, Mr Wilder presented to Colac Hospital with aspiration pneumonia. He was treated with intravenous antibiotics but his condition deteriorated and he was transitioned to comfort care. He passed away on 12 March 2024.

Identity of the deceased

8. On 20 March 2024, Randal Robin Wilder, born 6 May 1964, was visually identified by his niece, Anthea Wilder.

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

Medical cause of death

10. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 14 March 2024 and provided a written report of her findings dated 25 March 2024.

11. Dr Glengarry reviewed a post-mortem computed tomography (**CT**) scan and there was no evidence of any skeletal trauma or other injury likely to have caused or contributed to death.

12. Dr Glengarry provided an opinion that the medical cause of death was 1 (a) Aspiration pneumonia in a man with trisomy 21. She expressed the opinion that the death was due to natural causes.

13. I accept Dr Glengarry's opinion.

[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.

CONCLUSION

14. Having carefully considered the available evidence, I am satisfied that the care Mr Wilder received in the period proximate to his death was reasonable and appropriate.

15. As noted above, Mr Wilder's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before his death, he was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Mr Wilder died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an Inquest into his death.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Randal Robin Wilder, born 6 May 1964;

    b) the death occurred on 12 March 2024 at Colac Hospital, 2-28 Connor Street, Colac, Victoria, from aspiration pneumonia in a man with trisomy 21; and

    c) the death occurred in the circumstances described above.

I convey my sincere condolences to Mr Wilder'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:

Bernard Wilder, Senior Next of Kin

National Disability Insurance Scheme Quality and Safeguards Commission

Senior Constable Alison McKay, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 12 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.