IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002267

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Gary Mayrhofer
Date of birth:	18 September 1969
Date of death:	22 April 2024
Cause of death:	1(a): Complications following an old prior cerebrovascular accident - aspiration pneumonia
Place of death:	1-3 Smith Street Grovedale Victoria 3216
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 22 April 2024, Mr Gary Mayrhofer was 54 years old he died after an aspiration event.

2. At the time of his death, Mr Mayrhofer resided in Supported Disability Accommodation (**SDA**) operated by Scope (Aust) Limited. Mr Mayrhofer was participant of the National Disability Insurance Scheme (**NDIS**) and received these supports due to his medical conditions including cerebral palsy, intellectual disability and epilepsy. Mr Mayrhofer was also born visually impaired.

3. Mr Mayrhofer loved music and he enjoyed long walks around his neighbourhood. He was visited regularly by his sister and father.

THE CORONIAL INVESTIGATION

4. Mr Mayrhofer'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 Mayrhofer was a 'person placed in care' within the meaning of the Act, as he was a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling[1] immediately prior to his death. 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.

5. 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.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration o f justice through the making of

[1] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Mr Mayrhofer's death, is a permanent dwelling that provides long-term accommodation for one or more SDA residents, that is enrolled as an SDA dwelling under relevant NDIS (Specialist Disability Accommodation) Rules in force at the relevant time. An SDA resident means a person who is an NDIS participant funded to reside in an SDA enrolled dwelling, or who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program). The definition of SDA resident was amended on 1 July 2024 pursuant to the *Disability and Social Services Regulation Amendment Act 2023* to extend to include persons who are residing, or propose to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement.

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

7. Victoria Police assigned Senior Constable Andrew Scobell to be the Coronial Investigator for the investigation of Gary's death. Senior Constable Scobell complied a coronial brief of evidence which included statements from family, the forensic pathologist, treating clinicians band investigating officers.

8. This finding draws on the totality of the coronial investigation into the death of Mr Mayrhofer 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

9. In September 2023, Mr Mayrhofer suffered a stroke, resulting in right side paraplegia and a change in his swallowing ability.

10. Mr Mayrhofer spent eight weeks in hospital before being discharged home. He was then supported by family, staff at Scope, Barwon Health and community nursing services with pain management and end-of-life care.

11. Mr Mayrhofer passed away on 22 April 2024 with his father by his beside.

Identity of the deceased

12. On 22 April 2024 Mr Gary Mayrhofer, born 18 September 1969, was visually identified by his support worker.

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

Medical cause of death

14. Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine (**VIFM**) performed an external examination on 23 April 2024 and reviewed medical records,

[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.

postmortem computed tomography scans and the Police Report of Death (Form 83). Dr Beer provided a written report of his findings dated 29 April 2024.

15. The post-mortem examination showed findings in keeping with Mr Mayrhofer's clinical history.

16. Dr Beer provided an opinion that the medical cause of death was 1(a) complications following a prior cerebrovascular accident - aspiration pneumonia.

17. I accept Dr Beer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr Gary Mayrhofer, born 18 September 1969;

    b) the death occurred on 22 April 2024 at 1-3 Smith Street, Grovedale, Victoria 3216, from 1(a) complications following an old prior cerebrovascular accident - aspiration pneumonia; and

    c) the death occurred in the circumstances described above.

19. The available evidence does not support a finding that there was any want of clinical management or care on the part of Scope that caused or contributed to Mr Mayrhofer's death.

20. Having considered all of the circumstances, I find that Mr Mayrhofer's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation of Mr Mayrhofer's death in chambers.

I convey my sincere condolences to Mr Mayrhofer'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:

Gerhard Mayrhofer, Senior Next of Kin

Senior Constable Andrew Scobell, Coronial Investigator

Scope (Aust) Limited

Signature:

Coroner Leveasque Peterson

Date: 29 May 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.