IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2024 003462**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

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| Findings of: | Coroner Leveasque Peterson |
| Deceased: | Noel John Biggs |
| Date of birth: | 15 November 1957 |
| Date of death: | 20 June 2024 |
| Cause of death: | 1(a) Undetermined (natural causes) |
| Place of death: | 2 Joffre Street, Croydon, Victoria 3136 |
| Keywords: | Suggested keywords: Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes |

## INTRODUCTION

1. On 20 June 2024, Noel John Biggs was 66 years old when he died at his home in Croydon, Victoria.

2. At the time of his death, Noel resided at 2 Joffre Street, Croydon, a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**). Noel received funded daily independent living support due to his diagnoses of spastic gait syndrome and cognitive impairment. His medical history also included hypertension, neurofibromatosis, Parkinson's disease, swallowing difficulties, seizures, atrial fibrillation and recurrent urinary tract infections.

3. Prior to Noel's mobility deteriorating, he used to enjoy attending the football and going to the pub, however his poor mobility reduced his ability to enjoy these activities. His main supports included his brothers, Anthony and Peter, Anthony's wife Alison and Noel's niece, Emily.

## THE CORONIAL INVESTIGATION

4. Noel's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as he 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 his death.[1] 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 of justice through the making of

[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).

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

7. This finding draws on the totality of the coronial investigation into the death of Noel John Biggs including information from the National Disability Insurance Agency (**NDIA**). 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

8. On 19 June 2024, Noel's general practitioner, Dr Imre Sagi, attended Noel's home as staff reported concerns that he was coughing up phlegm. Dr Sagi prescribed antibiotics and noted Noel did not have a fever and had not experienced any episodes of aspiration recently.

9. On the evening of 20 June 2024, one of Noel's carers noted that he was sitting upright in his bedroom and was experiencing difficulty breathing. The carer contacted Triple Zero and upon returning to Noel's room, noted that he had stopped breathing. The carer commenced cardiopulmonary resuscitation.

10. Ambulance Victoria paramedics attended the scene and noted Noel's wishes (not for resuscitation) and declared him deceased at the scene. Police also attended the scene and confirmed there were no suspicious circumstances or evidence of third-party intervention in connection with Noel's death.

### Identity of the deceased

11. On 20 June 2024, Noel Biggs, born 15 November 1957, was visually identified by his brother, Anthony Biggs.

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

### Medical cause of death

[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.

13. Senior Forensic Pathologist, Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 24 June 2024 and provided a written report of his findings dated 24 October 2024.

14. The post-mortem examination revealed findings consistent with the reported circumstances.

15. Examination of the post-mortem CT scan showed coronary calcification, no obvious pneumonic change, hydrocephalus ex vacuo and metal within the right radius.

16. Toxicological analysis of post-mortem samples identified the presence of levetiracetam, apixaban, baclofen, metoprolol, and paracetamol.

17. Dr Lynch provided an opinion that the medical cause of death was 1(a) Undetermined (natural causes).

18. Dr Lynch provided an opinion that the cause of death was due to natural causes.

19. I accept Dr Lynch's opinion.

**FINDINGS AND CONCLUSION**

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

    a) the identity of the deceased was Noel John Biggs, born 15 November 1957;

    b) the death occurred on 20 June 2024 at 2 Joffre Street, Croydon Victoria 3136 from undetermined (natural causes); and

    c) the death occurred in the circumstances described above.

21. The available evidence does not support a finding that there was any want of clinical management or care on the part of the disability service provider, or clinical staff at 2 Joffre Street, Croydon Victoria 3136, that caused or contributed to Noel's death.

22. Having considered all the available evidence, I find that Noel'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 Noel's death in chambers.

I convey my sincere condolences to Noel's family, friends and carers 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:

Anthony Biggs, Senior Next of Kin

Senior Constable Michael Fraser, Coronial Investigator

Signature:


Coroner Leveasque Peterson

Date: 02 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 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.