IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004286

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Stephen Feltscheer
Date of birth:	30 June 1963
Date of death:	26 July 2024
Cause of death:	1a: aspiration pneumonia in a man with Down syndrome and early onset dementia
Place of death:	Eastern Health Wantirna 251 Mountain Highway Wantirna Victoria 3152
Keywords:	In care – natural causes, Specialist Disability Accommodation

INTRODUCTION

1. On 26 July 2024, Stephen Feltscheer was 61 years old when he died in hospital from aspiration pneumonia. Stephen had a history of previous pneumonia requiring prolonged hospital admission.

2. At the time of his death, Stephen lived in Specialist Disability Accommodation (**SDA**) and receiving Supported Independent Living (**SIL**) services funded through the National Disability Insurance Scheme (**NDIS**).

3. Stephen's other medical history included Down syndrome and early onset dementia.

4. Stephen attended a day program and was supported and funded to work towards his goals of improving his health, fitness and mobility, improving communication skills, and having greater capacity to get out into the community to socialise and participate in recreational activities with friends.

THE CORONIAL INVESTIGATION

5. Stephen's death fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as he was a 'person placed in custody or care' within the meaning of the Act, being a person who was an SDA resident living in an SDA enrolled dwelling.[1]

6. 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.

7. 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.

8. Coroner Katherine Lorenz, (as she then was), initially held carriage of this investigation. I took carriage of this matter upon my appointment in September 2024.

[1] *Coroners Regulations 2019*, r 7(1)(d).

9. This finding draws on the totality of the coronial investigation into the death of Stephen Feltscheer. 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

10. On 25 July 2024, Stephen was admitted to Eastern Health Wantirna with aspiration pneumonia. He had been experiencing symptoms of infection for the last two days.

11. Stephen was noted to have a hypoactive delirium and assessed as being in the terminal phase of illness.

12. Discussions with Stephen's family on the day of admission confirmed that Stephen should be transitioned to comfort care and that he was not for antibiotics.

13. Stephen was admitted to the Palliative Care Unit where he received a subcutaneous infusion of midazolam and morphine to manage the hypoactive delirium.

14. Stephen died peacefully in the early hours of 26 July 2024.

Identity of the deceased

15. On 26 July 2024, Stephen Feltscheer, born 30 June 1963, was visually identified by a long-term carer, who completed a statement of identification.

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

Medical cause of death

17. On 29 July 2024, Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and provided a written report of the findings.

[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.

18. There were no unexpected findings on examination.

19. Dr Ho provided an opinion that the medical cause of death was *1(a) aspiration pneumonia in a man with down syndrome and early onset dementia* and that the death was from natural causes

20. I accept Dr Ho's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Stephen Feltscheer, born 30 June 1963;

    b) the death occurred on 26 July 2024 at Eastern Health Wantirna from *aspiration pneumonia in a man with down syndrome and early onset dementia*

    c) the death occurred in the circumstances described above.

22. The available evidence does not support a finding that there was any want of clinical management or care on the part of staff at the SDA dwelling, or staff at Eastern Health Wantirna, which caused or contributed to the death.

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

I convey my sincere condolences to Stephen's family for their loss.

Pursuant to section 73(1B) of the Act, this finding is to be published on the Court's website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Deborah Ruff, Senior Next of Kin
Eastern Health
Scope Australia

Signature:

Coroner Dimitra Dubrow

Date: 17 August 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.