IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 006357

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Donald Raymond Muir
Date of birth:	17 January 1965
Date of death:	31 October 2024
Cause of death:	1a : Urosepsis and aspiration pneumonia 2 : Trisomy 21
Place of death:	Monash Medical Centre, 246 Clayton Road, Clayton, Victoria
Keywords:	In care – Specialist disability accommodation – Natural causes

INTRODUCTION

1. On 31 October 2024, Donald Raymond Muir was 59 years old when he passed away at Monash Medical Centre (**MMC**) in Clayton. At the time of his death, Donald lived in a residential Specialist Disability Accommodation (**SDA**) in Oakleigh South, managed by OC Connections.

2. Donald is survived by his brother Neil, who was actively involved in his care.

3. Donald's medical history included Trisomy 21, non-verbal autism, hypothyroidism, epilepsy, Alzheimer's dementia and dermatitis. He also had a history of recurrent falls. Donald's prescribed medications included dutasteride, Eutroxsig (thyroxine), Topamax (topiramate), Valium (diazepam), sodium valproate, and melatonin.

4. Donald communicated with family and carers using gestures and facial expressions. He enjoyed music, dancing, and receiving visits from therapy animals.

BACKGROUND

5. At the time of his death, Donald required assistance for all activities of daily living, including showering, dressing, eating and mobilising. He remained on a pureed diet with thickened fluids and was known to be a slow eater.

6. Throughout 2023, Donald experienced a functional decline. During a consultation with Donald's treating general practitioner (**GP**) on 13 April 2023, his carer reported that Donald was "*barely leaving the house*", experiencing occasional seizures and regular incontinence, and had become "*quite frail*". Donald's GP emphasised that his current care goals were "*comfort and happiness*".

7. Following an unwitnessed fall on 5 October 2023, Donald's carers observed that he was more hunched over and less interactive than usual, appeared more unsteady on his feet, and had increased incontinence. He was assessed at the MMC emergency department (**ED**) and found to have sustained an abrasion and lump above his right eyebrow. He did not appear to have sustained any other obvious injuries and did not appear distressed or in pain. Donald was discharged home a short time later for review by his GP.

20–28 November 2023, Admission to MMC for treatment of pneumonia

8. At around 8.08am on 20 November 2023, Donald was taken to MMC by ambulance after experiencing shortness of breath, fever, sore throat and runny nose. He tested negative for Covid-19. During his admission, he was treated with oxygen and antibiotics and discharged in the evening on 22 November 2023 with a further seven days of antibiotics.

9. Donald returned to MMC later that evening as staff at the residential care facility were not advised of his condition on discharge and were not equipped with a hoist or slides to manage him while bedbound. He returned to the general medical ward.

10. Ongoing occupational therapy (**OT**) reviews considered Donald's increasing care needs and his family's concerns regarding his gradual decline over the previous 6 to 12 months. A hospital bed was arranged for his discharge home and Neil separately arranged a new adjustable day chair. Donald was discharged home on the morning of 28 November 2023.

May–September 2024, Admission to MMC post-fall and further decline

11. On the morning of 22 May 2024, Donald was in the shower with two carers when he slipped down to the ground. He did not hit his head or lose consciousness, however he was observed to struggle with mobilising, even with two carers, and become unresponsive later in the day with a fever.

12. Donald was transferred to MMC by ambulance and paramedics noted a productive cough and foul-smelling urine. On assessment in the ED, Donald's lungs were clear and his pupils were equal but sluggish. He was noted to grimace when trying to extend his right elbow. He was admitted and commenced on enoxaparin, an anticoagulant, as venous thromboembolism prophylactic treatment (**VTEP**). X-rays suggested an acute fracture but there was no evidence of joint effusion and clinicians considered it may have related to a previous injury.

13. Throughout his admission, Donald experienced mild dehydration and received intravenous (**IV**) fluids. He was also trialled on baclofen for lower limb contractures and commenced on topiramate and sodium valproate to manage myotonic jerks and seizure activity. He was eventually weaned from baclofen due to experiencing side effects, including drowsiness, impaired bladder function, seizures and aspiration pneumonia.

14. Chest imaging on 24 May 2024 showed a clear left lung but consolidation in the upper right lung, with possible areas of air bronchograms and ill-defined opacity in the lower lung.

Imaging of the pelvis did not reveal any acute fractures. Donald was then commenced on IV antibiotics to address his suspected chest sepsis and right upper lung pneumonia. An indwelling catheter (**IDC**) was inserted to manage urinary retention.

15. On 31 May 2024, Donald was transferred to Moorabbin Hospital for rehabilitation. He returned to the Kingston Centre on 5 June 2024.

16. On 8 July 2024, Donald was transferred to Casey Hospital ED for urology team input and management of paraphimosis. He returned to Kingston Centre overnight once his paraphimosis was resolved and an IDC was inserted. Chest imaging on 24 July 2024 showed patchy consolidation in the base of the right lung, with clear left lung and no pleural effusion or pneumothorax.

17. After testing positive to Covid-19 on 24 July 2024, Donald was treated with antivirals and transferred to an isolation ward where he remained for a two-week isolation period before returning to the Geriatric Evaluation and Management (**GEM**) ward. Further chest imaging on 3 August 2024 revealed that the consolidation had resolved and there was no evidence of acute infective change or pleural effusions.

18. Following his Covid-19 infection, OT recommended two weeks rehabilitation to improve and evaluate his baseline level of function.

19. By August 2024, Donald was reassessed as requiring two carers to support him in all personal care tasks, such as toileting, dressing and showering, and for transfers from bed to his wheelchair. He also required continence support overnight and 1:1 support for eating.

20. At around 1.00pm on 5 August 2024, Donald was found on the floor of his room. It was noted that he had been sitting in a chair since around 11.00am and the carer had stepped away. Post-fall observations were commenced and Donald appeared stable. Later that evening, he had a fever and was vomiting, however these resolved overnight with antiemetics.

21. In the weeks that followed, Donald remained unwell and precautions were introduced to reduce his risk of infection.

22. Donald experienced ongoing desaturation and fever, and a chest X-ray on 9 September 2024 showed evidence of patchy opacity in the lower lungs, consistent with infection or inflammation. Abdominal imaging also showed evidence of moderate to severe rectal faecal

loading. A further chest X-ray on 19 September 2024 showed reduced opacity in the right lower lung but collapse/consolidation on the left remained.

23. Donald was discharged home to his SDA on the morning of 20 September 2024.

Occupational Therapy input during Donald's prolonged admission

24. Donald underwent regular OT reviews at MMC. The OT team liaised with his National Disability Insurance Scheme (**NDIS**) support coordinator, who alerted the team to the fact that his current NDIS plan did not have sufficient funding to meet his now increased care needs. In particular, Donald would require 1:1 24-hour care and active overnight care due to his incontinence and risk of falls from bed. The support coordinator advised that she had been liaising with Donald's brother regarding a change of circumstances application to the NDIS for increased funding, for which it was determined that a multidisciplinary report was required.

25. Further collaborative discussions also took place between the NDIS support coordinator, Donald's brother, OT, Social Work, and the house manager regarding Donald's support needs, available NDIS funding and discharge planning.

26. In early July 2024, the OT team liaised with the house manager of Donald's accommodation, who expressed concerns regarding his reduced mobility. A home assessment was completed which considered the setup of Donald's bedroom and bathroom for a manual wheelchair, wheeled commode and portable hoist. OT arranged for Donald's required equipment to be hired for 30 days via Medicare following his discharge, with any ongoing costs drawn from NDIS funding.

27. Due to Donald's decline following Covid-19 infection, his NDIS support coordinator and OC Connections sought a functional capacity assessment and indicated that the multidisciplinary report would need to be updated post-rehabilitation to reflect any changes to Donald's care needs. The report would then be reviewed and modified as required, after which a planning meeting would occur regarding funding for his care and equipment needs.

28. In late August 2024, the OT team advised Neil that if an NDIS planning meeting took place prior to Donald's discharge, it could take place within 2 to 4 weeks, but in the community it would not likely occur for up to 6 to 9 months. Further, if Donald's support funding was exhausted due to his discharge prior to the planning meeting, he may need to return to hospital.

29. Neil was eager for Donald's discharge home but understandably concerned to ensure that he received adequate funding. Neil initially offered to fund Donald's assistive technology on discharge but was subsequently advised of increased funds associated with Donald's tilt-in-space wheelchair.

30. After reviewing the multidisciplinary report, Neil advised that Donald was no longer attending his day program but requested to include a goal for community engagement by attending his local animal farm and pet therapy.

31. Neil expressed concerns about his brother's overnight toileting with incontinence, as OC Connections advised they were unable to support 2:1 care overnight. The Monash OT team advised they would raise the possibility of trialling condom drainage, fluid restriction or alternate continence aids with increased absorption.

32. Prior to his discharge, OT liaised with OC Connections and the National Disability Insurance Agency (**NDIA**) to ensure carers received adequate training in long-term IDC management, including its required changing every 6 weeks, and manual handling prior to his discharge.

THE CORONIAL INVESTIGATION

33. Donald's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the coroner, even if the death appears to have been from natural causes.

34. Donald was a person in care at the time of his death and was a SDA resident living in an SDA dwelling pursuant to Regulation 7 of the *Coroners Regulations 2019*. However, an inquest was not required to be held pursuant to section 52(3A) of the Act given that Donald's death was from natural causes.

35. 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.

36. 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.

37. This finding draws on the totality of the coronial investigation into Donald's death, including information obtained from his medical records and the NDIA. While 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.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

38. On the morning of 21 September 2024, carers found Donald on the crash mat beside his low bed. There was no evidence of external injury, however he had reduced oxygen saturation, his IDC had been dislodged and he had vomited a small amount of blood. Donald was transported by ambulance to MMC ED. He was admitted to the short stay unit for observation. After five hours' observation, he had not experienced any further vomits and was discharged home.

39. On 6 October 2024, Donald was accompanied to MMC ED to assess an IDC blockage. He was admitted to the medical ward and a new IDC was inserted the following day. Donald was treated with IV antibiotics for urosepsis. He experienced ongoing delirium and antibiotics were later ceased on 8 October 2024 in consultation with Neil as Donald was transitioning to palliative care.

[1] 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.

40. Discussions took place between treating clinicians and Donald's brother regarding his reduced quality of life and vulnerability to sudden deterioration. On 15 October 2024, Donald was transferred to McCulloch House for comfort care. The plan was to assess Donald on a daily basis and manage his symptoms, with a view to transitioning to end-of-life care if his condition worsened.

41. Donald later developed a moist cough and chest crackles, consistent with an aspiration event, and his oral intake was minimal. His condition continued to deteriorate and he subsequently passed away on 31 October 2024 at 5.15am.

Identity of the deceased

42. On 31 October 2024, Donald Raymond Muir, born 17 January 1965, was visually identified by his brother, Neil Muir.

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

Medical cause of death

44. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine conducted an examination on 1 November 2024 and provided a written report of her findings dated 28 November 2024.

45. Dr Archer reviewed a post-mortem computed tomography (**CT**) scan, which revealed a fatty liver, scoliosis, and patchy lung consolidation, particularly to the right upper and lower lobe. The post-mortem examination revealed evidence of medical intervention. Dr Archer did not observe any evidence of injury that could have caused or contributed to death.

46. Dr Archer provided an opinion that the medical cause of death was *1(a) Urosepsis and aspiration pneumonia, 2 Trisomy 21*. Dr Archer advised that the death was due to natural causes.

47. I accept Dr Archer's opinion.

FINDINGS AND CONCLUSION

48. Pursuant to section the Act, I make the following findings:

    a) the identity of the deceased was Donald Raymond Muir, born 17 January 1965;

b) the death occurred on 31 October 2024 at Monash Medical Centre, 246 Clayton Road, Clayton, Victoria, from urosepsis and aspiration pneumonia and Trisomy 21; and

c) the death occurred in the circumstances described above.

49. As noted above, Donald'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 Donald 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.

I convey my sincere condolences to Donald'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:

Neil Muir, Senior Next of Kin

Senior Constable John Taranto, Coronial Investigator

Signature:

Coroner David Ryan

Date: 15 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.