



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2025 001734**

**FINDING INTO DEATH FOLLOWING INQUEST**

*Form 37 Rule 63(1)*

*Section 67 of the Coroners Act 2008*

**Inquest into the Death of Robert James Mapleson**

Delivered On:	3 March 2026
Delivered At:	Southbank, Victoria
Hearing Dates:	3 March 2026
Findings of:	Coroner Paul Lawrie
Representation:	No appearances
Counsel Assisting the Coroner:	Bemani Abeysinghe, Coroner's Solicitor
Keywords:	In care, Specialist Disability Accommodation, SDA

## INTRODUCTION

1. On 31 March 2025, Robert James Mapleson was 63 years old when he passed away at Dandenong Hospital. He had been admitted to the Warragul Hospital on 9 March 2025 and then transferred to Dandenong Hospital on 24 March 2025 for excision of lip squamous cell carcinoma and reconstruction. Post-operatively he suffered from aspiration pneumonia on a background of continuing poor oral intake. He continued to deteriorate despite efforts to treat this complication.
2. At the time of his death, Mr Mapleson resided in Warragul, Victoria, at a Specialist Disability Accommodation (SDA) dwelling enrolled under the National Disability Insurance Scheme (NDIS). The SDA was operated by Bright Access, a registered NDIS provider. Mr Mapleson received funded daily independent living support through the NDIS.

## CORONIAL INVESTIGATION AND INQUEST

3. 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.
4. 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.
5. Pursuant to section 4(2)(c) of the *Coroners Act 2008* (**the Act**), the death of a person who immediately before their death was ‘a person placed in custody or care’, falls within the definition of a reportable death. A person in Victoria who is an SDA resident<sup>1</sup> residing in an

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<sup>1</sup> ‘SDA resident’ means a person with a disability – (a) who receives, or is eligible to receive, funded daily independent living support; and (b) who is residing, or proposes to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement, *Residential Tenancies Act 1997* – s.3(1)

SDA enrolled dwelling'<sup>2</sup> is a person 'in care' within the meaning of the Act.<sup>3</sup> The death of a person in care is a mandatory report to the Coroner, regardless of the apparent cause of death.

6. I am satisfied that Mr Mapleson was an SDA resident residing in an SDA enrolled dwelling, and therefore he was a person 'in care' for the purposes of the Act. Accordingly, pursuant to section 52(2)(b) of the Act, an inquest is mandatory where the apparent cause of death is not wholly attributable to natural causes.
7. I determined that the inquest should proceed in a summary manner as the evidence may be regarded as complete and uncontentious, and it is appropriate for the evidence to be admitted in a summary form without the need to examine witnesses. This took place on 3 March 2026.
8. First Constable (FC) Charles Kurban of Victoria Police acted as the Coronial Investigator for the investigation of Mr Mapleson's death. FC Kurban conducted inquiries on my behalf, including taking statements from treating medical practitioners, clinicians and care support workers, and submitted a coronial brief of evidence.
9. This finding draws on the totality of the coronial investigation into the death of Robert James Mapleson including the 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.<sup>4</sup>

## **PERSONAL BACKGROUND**

10. Mr Mapleson grew up in Warragul, Victoria with his parents and two brothers and was later married. He was subsequently estranged from his family, and little is known of his early adult life.

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<sup>2</sup> *Residential Tenancies Act 1997* – s.3(1) (definition of 'SDA enrolled dwelling').

<sup>3</sup> *Coroners Regulations 2019* – r.7(1)(d)

<sup>4</sup> 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

11. Mr Mapleson had been admitted to hospital many times since 2012 for short stays due to his declining physical and mental health. He resided in the Macalister Unit<sup>5</sup> at the Latrobe Regional Hospital between 2014 and September 2021.
12. Mr Mapleson's medical history included schizophrenia, epilepsy, intellectual disability, frontotemporal dementia and hypothyroidism. By 2021, he had extremely limited communication and physical capacity. On 15 September 2021, Mr Mapleson moved to Bright Access where he received full time care. There, he enjoyed movies and musicals and activities including arts and crafts, and cooking.
13. By 2025 Mr Mapleson was completely non-verbal and had baseline dysphagia<sup>6</sup>. A guardian had been appointed by the Victorian Civil and Administrative Tribunal.
14. Over the last 12 months of his life, Mr Mapleson suffered increased seizures, and he was hospitalised on multiple occasions.
15. Sometime in 2024, Mr Mapleson developed a lesion in his lower lip as a result of habitual biting of his lip. His carers raised concerns with his treating general practitioner, but basic treatments for the lesion proved to be ineffective.
16. On 22 November 2024, Mr Mapleson was seen by his general practitioner for blister-like marks on his ear. A referral was made to the Skin Cancer Clinic in Warragul for further investigation of the lesion on his lip and the blisters on his ear.
17. On 29 January 2025, biopsies were performed and Mr Mapleson was referred to the Dandenong Hospital for further assessment and treatment.

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<sup>5</sup> Macalister Unit has 10 acute beds for older people with complex needs relating to mental illness as well as 10 nursing home beds.

<sup>6</sup> Difficulty swallowing.

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

### **Circumstances in which the death occurred**

18. Between 19 February and 19 March 2025, Mr Mapleson was seen at the plastic surgery outpatient clinic of the Dandenong Hospital for a fungating lower lip squamous cell carcinoma and left ear basal cell carcinoma.
19. On 9 March 2025, Mr Mapleson had a seizure and was admitted to the Warragul Hospital. He was treated for functional decline and malnutrition, in addition to his increasing epileptic seizures. Medical records indicate that during this admission, he had hypoactive delirium and poor oral intake with negligible nutrition from 10 March 2025.
20. On 24 March 2025, Mr Mapleson was transferred from the Warragul Hospital to the Dandenong Hospital as an inpatient for a planned procedure under the plastic surgery unit for surgical excision of his lip lesion and bilateral myomucosal flaps<sup>7</sup>. This procedure was completed successfully and without any complications.
21. After the procedure, Mr Mapleson was admitted to the surgical ward for review and input from a speech pathologist and dietician. The aim was to transfer him back to Warragul Hospital for further management.
22. On 26 March 2025, Mr Mapleson was seen by a speech pathologist who recommended a short-term nasogastric tube (NGT) to facilitate nutrition in the context of his hypoactive delirium and poor oral intake. The nutrition and dietetics team, and his carers thought he would do poorly with the NGT given his dementia and cognitive capacity. The speech pathology team placed him at high risk of aspiration. Despite these concerns it was acknowledged by all concerned that Mr Mapleson needed a way to get nutrition.
23. On 27 March 2025, clinicians held a meeting with Mr Mapleson's carers and guardian. Ultimately, consent was given for the NGT to be put in place. This occurred the same evening with an enteral feeding plan in place from the dietetics team.

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<sup>7</sup> A reconstructive surgical procedure.

24. On 28 March 2025 at 4.45pm, Mr Mapleson pulled out his NGT. Consent was then obtained from his carers for it to be replaced.
25. Replacement of the NGT was deferred until a constant patient observer could be present to protect against Mr Mapleson pulling it out again. The NGT was replaced at 11.00pm on 29 March 2025 and the allied health team, including the speech pathologists and dieticians, remained involved in Mr Mapleson's care.
26. At 1.00pm on 30 March 2025, Mr Mapleson began coughing and gurgling. He also developed hypoxia and a chest X-ray demonstrated changes consistent with aspiration and a near total collapse of his right lung field. Mr Mapleson's NGT feeds were paused.
27. A computed tomography (CT) scan was performed on his chest to better characterise the changes seen in the X-ray. The CT scan confirmed right lung collapse. At the recommendation of the Respiratory Team, Mr Mapleson was started on antibiotics.
28. The various teams caring for Mr Mapleson, including the Respiratory Team and the Intensive Care Unit, discussed the appropriateness of invasive procedures including a bronchoscopy to remove any aspirated matter.
29. On 31 March 2025, the General Medicine Team concluded that Mr Mapleson's overall prognosis was poor and recommended ward-based comfort care as the ceiling of care. Mr Mapleson's carers were contacted, and they were accepting of the guarded prognosis and a transition to ward-based comfort care.
30. Mr Mapleson passed away at 6.30pm on 31 March 2025.
31. There is nothing to suggest that the care Mr Mapleson received from the staff at Bright Access was anything other than appropriate. I reach the same conclusion regarding the medical care provided by his general practitioner and the clinicians and staff at Warragul Hospital and Dandenong Hospital.

## **Identity and medical cause of death**

32. On 31 March 2025, Robert James Mapleson, born 11 August 1961, was visually identified by Sandeep Harkala, Facility Manager at Bright Access.
33. Identity is not in dispute and requires no further investigation.
34. On 2 April 2025, Associate Professor Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of Mr Mapleson's body which included a post-mortem CT scan.
35. The CT scan confirmed collapse of the right lung and consolidation of the lower lobe in keeping with the clinical history of aspiration.
36. On 7 May 2025, Associate Professor Parsons provided a report of her findings and detailed the cause of death as '1(a) ASPIRATION PNEUMONIA COMPLICATING LIP EXCISION AND RECONSTRUCTION FOR SQUAMOUS CELL CARCINOMA'.
37. I accept Associate Professor Parsons' opinion.

## **CONCLUSION**

38. Pursuant to section 67(1) of the Act I make the following findings:
  - (a) the identity of the deceased was Robert James Mapleson born on 11 August 1961;
  - (b) the death occurred on 31 March 2025 at Dandenong Hospital, 135 David Street, Dandenong Victoria 3175;
  - (c) the cause of death is 1(a): ASPIRATION PNEUMONIA COMPLICATING LIP EXCISION AND RECONSTRUCTION FOR SQUAMOUS CELL CARCINOMA; and
  - (d) the death occurred in the circumstances described above.

## ACKNOWLEDGEMENTS

I extend my sincere condolences to Mr Mapleson's family for their loss.

I thank the Coronial Investigator and those assisting for their work in the investigation.

## DIRECTIONS

Pursuant to section 73(1) of the Act, I direct that this finding be published on the Coroners Court website in accordance with the Rules.

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

Denise Mapleson, Senior Next of Kin, c/- Helen Hobbs

Bright Access

Monash Health

First Constable Charles Kurban, Coronial Investigator

Signature:



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Coroner Paul Lawrie  
Date: 03 March 2026



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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 inquest. 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.

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