IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 002954

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge Liberty Sanger, State Coroner
Deceased:	Narelle Marie Compton
Date of birth:	19 December 1967
Date of death:	30 May 2025
Cause of death:	1a: Deterioration in setting of advanced dementia on a background of down syndrome
Place of death:	Eastern Health Wantirna 251 Mountain Highway Wantirna Victoria 3152
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 30 May 2025, Narelle Marie Compton was 57 years old when she passed away at Eastern Health Wantirna.

2. At the time of her death, Ms Compton resided at 19 View Road, Vermont, a Specialist Disability Accommodation (**SDA**) dwelling[1] enrolled under the National Disability Insurance Scheme (**NDIS**). Ms Compton received funded daily independent living support due to her medical conditions, which was provided by disability service provider, Scope (Aust) Limited (**Scope**).

3. Ms Compton was warmly remembered as a bright and loving person.

Background

4. Ms Compton had a medical history included intellectual disability, Down Syndrome, Alzheimer's dementia, epilepsy, osteopenia and intrahepatic cholestasis.

5. Ms Compton had been a resident of the Vermont SDA home since 12 June 2024. She previously lived at home with her parents until her early teens where she moved into government-managed group homes. She was previously employed as a supported employee for 25 years, until February 2021 when she received a diagnosis of dementia.

6. In the seven months immediately preceding her death, Ms Compton was noted to be declining functionally. Her speech pathologist noted that her speech function had decline markedly.

THE CORONIAL INVESTIGATION

7. Ms Compton's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as she was a *person placed in custody or care* within the meaning of the Act, as a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling immediately prior to his death.[2] This category of

[1] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Mr Rayner'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 a 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.

[2] Regulation 7 of the *Coroners Regulation 2019*.

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.

8. 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.

9. 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.

10. Victoria Police assigned Senior Constable Aaron Goldsmith to be the Coronial Investigator for the investigation of Ms Compton's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of Narelle Marie Compton including medical records obtained from Eastern Health and information from the National Disability Insurance Agency (**NDIA**) and Scope. 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.[3]

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

Circumstances in which the death occurred

12. Between 2 and 4 May 2025, support staff observed Ms Compton appeared flat in effect and was difficult to rouse for meals.

[3] 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. On 5 May 2025, Ms Compton was transported to Maroondah Hospital for a chest x-ray. A blood test had also been ordered per the instructions of her general practitioner who saw her on 2 May.

14. In the afternoon at approximately 4:00pm, support staff observed she became drowsy, and her blood pressure was abnormally low. Staff then contacted emergency services and Ms Compton was transported to Box Hill Hospital Emergency Department (**ED**). She remained in the ED until she was admitted on 7 May 2025.

15. On the afternoon 12 May 2025, Ms Compton was transferred to the palliative care unit at Eastern Health Wantirna with care commenced shortly after. She was kept comfortable until she passed away on 30 May 2025.

Identity of the deceased

16. On 13 May 2025, Narelle Marie Compton, born 19 December 1967, was visually identified by her father, Brian Compton.

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

Medical cause of death

18. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine conducted an external examination on 2 June 2025 and provided a written report of his findings dated 5 June 2025.

19. In preparing his report, Dr Beford considered information including medical records from Eastern Health, an E-Medical Deposition completed by an Eastern Health Medical Officer, and post-mortem computed tomography (**CT**) scan.

20. The post-mortem CT scan revealed marked cerebral atrophy, hydrocephalus, a fatty liver and changes in the right lobe of the lung.

21. Dr Bedford noted that Ms Compton had a general deterioration in a background of dementia and Down Syndrome in the weeks leading up to her passing.

22. Dr Bedford provided an opinion that the medical cause of death *was 1(a) deterioration in setting of advanced dementia on a background of down syndrome*. He opined that the death was due to natural causes.

23. I accept Dr Bedford's opinion as to the medical cause of death.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Narelle Marie Compton, born 19 December 1967;

    b) the death occurred on 30 May 2025 at Eastern Health Wantirna, 251 Mountain Highway, Wantirna, Victoria, 3152, from deterioration in the setting of advanced dementia and on a background of down syndrome; and

    c) the death occurred in the circumstances described above.

25. The available evidence does not support a finding that there was any want of clinical management or care on the part of the SIL provider, Scope, or clinical staff at Eastern Health that caused or contributed to Ms Compton's death.

26. Having considered all the available evidence, I find that Ms Compton'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 her death and to finalise the investigation of Ms Compton's death in chambers.

I convey my sincere condolences to Ms Compton'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:

Mr Brian Compton & Mrs Carol Compton, Senior Next of Kin

Eastern Health

Senior Constable Aaron Goldsmith, Coronial Investigator

Signature:

Judge Liberty Sanger, State Coroner

Date: 11 December 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.