IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 003184

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Daina Louise Clark
Date of birth:	24 December 1976
Date of death:	9 June 2025
Cause of death:	1a: Complications of early onset dementia
Place of death:	Ventilator Accommodation Support Service 335 Clarendon Street Thornbury Victoria 3071

INTRODUCTION

1. On 9 June 2025, Daina Louise Clark was 48 years old when she died of complications of early onset dementia. Daina is survived by her husband, Brian, and their two daughters.

2. At the time of her death, Daina resided at the Ventilator Accommodation Support Service (**VASS**), a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**). Daina received funded daily independent living support due to her diagnosis of early onset dementia, which was provided by disability service provider, Yooralla.

3. Brian noticed a change in Daina's behaviour during 2018. She became aggressive towards him and their children and would yell and throw things. She was examined by a neurologist and subsequently diagnosed with dementia. By late 2019, she was diagnosed with early onset dementia, with a life expectancy of five to eight years.

4. Following her diagnosis of early onset dementia, Brian arranged for full-time care staff to care for Daina at home. She remained at home until September 2023, when her medical needs were such that she required full-time residential care. At that time, she moved to VASS. Daina's family visited her regularly.

5. Daina's cognitive state declined significantly during the time she lived at VASS. She required support from staff for all activities of daily living.

6. As Daina's condition progressed, she required further supports for her mobility requirements. Her NDIS support coordinator made several applications to the NDIS for increased funding, which were declined, resulting in her being bedbound for several months due to a lack of appropriate equipment. The application was finally approved around two weeks prior to her death.

7. Toni Pavia, Service Manager at Yooralla provided a statement for the Coronial Brief in which she reflected on the difficulties in seeking the necessary funding for Daina's care. She said:

   It was very challenging to deal with the numerous failed applications for increased funding for Daina. It was challenging to witness her deterioration at such a young age. We all knew what Daina required and it was heartbreaking to see that the NDIA did not approve what she needed to improve those final months of her life.

The approval of her funding being announced 2 weeks prior to her death was the final blow for me. I found this very difficult to accept.

THE CORONIAL INVESTIGATION

8. Daina's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as she 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 her 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.

9. 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.

10. 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.

11. This finding draws on the totality of the coronial investigation into the death of Daina Louise Clark including evidence contained in the coronial brief and 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]

[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).

[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.

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

Circumstances in which the death occurred

12. Around six weeks prior to her death, Daina entered palliative care. Registered Nurses from Melbourne City Mission visited her regularly to ensure her symptoms were managed and she was comfortable.

13. On 8 June 2025, Daina was noted by her nurses to not be eating or drinking. She was given clonazepam drops to assist with agitation. She had shallow breathing while she slept but appeared comfortable. She was monitored regularly.

14. Daina died peacefully at around 5:30am on 9 June 2025.

Identity of the deceased

15. On 9 June 2025, Daina Louise Clark, born 24 December 1976, was visually identified by Registered Nurse Anthony Hutchins, who completed a Statement of Identification.

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

Medical cause of death

17. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of Daina Clark on 11 June 2025. Dr Young considered the Victoria Police Report of Death (Form 83) and post mortem computed tomography (**CT**) scan and provided a written report of his findings dated 13 June 2025.

18. The external examination showed findings in keeping with the history. The post mortem CT scan showed cerebral atrophy, rectal faecal loading, dilated bowel loops with minimal air/fluid levels and increased lung markings.

19. Toxicological analysis of post mortem blood samples identified the presence of the clonazepam metabolite 7-aminoclonazepam.

20. Dr Young provided an opinion that the death was due to natural causes and ascribed the medical cause of death as 1(a) COMPLICATIONS OF EARLY ONSET DEMENTIA.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Daina Louise Clark, born 24 December 1976;

b) the death occurred on 9 June 2025 at Ventilator Accommodation Support Service, 335 Clarendon Street, Thornbury, Victoria 3071;

c) I accept and adopt the medical cause of death ascribed by Dr Gregory Young and I find that Daina Louise Clark died from complications of early onset dementia;

2. 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, that caused or contributed to Daina Louise Clark's death.

3. Having considered all the available evidence, I find that Daina Louise Clark'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 in chambers.

I convey my sincere condolences to Daina'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:

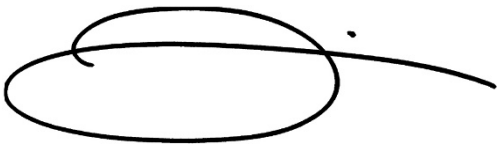
Brian Kemp, Senior Next of Kin

Yooralla

NDIS Quality and Safeguards Commission

First Constable Mackenzie Dodgshun, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 25 March 2026

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.