IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 003400

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Karin Jagusch
Date of birth:	17 March 1966
Date of death:	18 June 2025
Cause of death:	1a : Complications of end stage renal disease (Palliated)
Place of death:	Eastern Health Wantirna 251 Mountain Highway Wantirna Victoria 3152

INTRODUCTION

1. On 18 June 2025, Karin Jagusch (**Karin)** was 59 years old when she died at Eastern Health, Wantirna.

2. At the time of her death, Karin was a National Disability Insurance Scheme (**NDIS)** participant and resided in a shared specialist disability accommodation (**SDA)** enrolled dwelling in Ashwood provided by Yooralla.[1]

3. Karin's medical history included a congenital intellectual disability, right eye blindness, bilateral hip osteoarthritis, knee arthritis, anxiety and depression. She also had complex perianal fistula, for which she had colorectal drainage tubes. Karin was prescribed multiple medications for her pain management.

4. In 2020, Karin was also diagnosed with end stage renal failure.

THE CORONIAL INVESTIGATION

5. Karin's death was reported to the coroner as it fell within the definition of a reportable death under the *Coroners Act 2008* (Vic) (**the Act**) as she was a 'person placed in custody or care' within the meaning of the Act, as she resided in a SDA enrolled dwelling immediately prior to her death.[2].

6. Immediately before her death, Karin was a person placed in care. However, section 52(3A) of the Act provides an exception to the position under section 52(2), that the coroner is not required to hold an Inquest if the coroner considers the death to have been due to natural causes. Having considered all the evidence in this matter, pursuant to section 52(3A) of the Act, I determined not to hold an Inquest into Karin's death.

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

[1] An SDA enrolled dwelling is defined per s3 *Residential Tenancies Act* to mean a permanent dwelling that provides long-term accommodation for one or more SDA resident; and is enrolled as an SDA dwelling under the National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2020 of the Commonwealth as in force from time to time or under other rules made under the National Disability Insurance Scheme Act 2013 of the Commonwealth.

[2] s4(2)(c)

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

8. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Karin's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Karin Jagusch 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

10. On June 7 2025, Karin became unwell with vomiting and nausea, an inability to eat or drink and discomfort and agitation. On 9 June, she was transported to Wantirna Hospital for end-of-life care due to her deteriorating condition. She was then admitted to the Palliative Care Unit.

11. On 18 June 2025, Karin peacefully passed away.

Identity of the deceased

12. On 18 June 2025, Karin Jagusch, born 17 March 1966, was visually identified by her mother, Rita Jagush.

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

Medical cause of death

14. Forensic Pathologist Dr Victoria Francis of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 20 June 2025 and provided a written report of her findings dated 14 July 2025. Dr Francis also considered a post-mortem computer tomography (**CT**) scan and the medical deposition provided by Wantirna Health.

[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.

15. The post-mortem external examination and CT scan showed changes in keeping with the clinical history.[4]

16. Dr Francis provided an opinion that the medical cause of death was 1(a) Complications of end stage renal disease (Palliated) and commented that the death was due to natural causes

17. I accept Dr Francis's opinion.

FINDINGS AND CONCLUSION

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

    a. the identity of the deceased was Karin Jagusch, born 17 March 1966;

    b. her death occurred on 18 June 2025 at Eastern Health Wantirna 251 Mountain Highway Wantirna Victoria 3152

    c. I accept and adopt the medical cause of death as prescribed by Dr Francis and I find that Karin Jagusch died from 1(a) Complications of end stage renal disease (Palliated).

19. Having considered all the circumstances, I am satisfied that Karin's death was due to natural causes.

I convey my sincere condolences to Karin's family, carers and loved ones for their loss.

ORDERS AND DIRECTIONS

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:

[4] VIFM Inspection Report by Dr Victoria Francis.

Rita Jagusch, Senior Next of Kin

Eastern Health

Senior Constable Ashleigh Sullivan, Coroner's Investigator

Signature:

Coroner Kate DespotDate: 19 August 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.