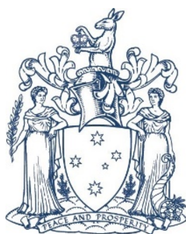

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006572

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the ***Coroners Act 2008***

Findings of:	Judge John Cain
Deceased:	Rebecca Jayne May
Date of birth:	8 February 1981
Date of death:	15 November 2022
Cause of death:	1(a) Aspiration Pneumonia 1(b) Huntington's Disease
Place of death:	16 Bowen Crescent Burwood East

INTRODUCTION

1. On 10 January 2023, having commenced an investigation into the death of Ms Rebecca Jayne May. I discontinued that investigation pursuant to section17 of the Coroners Act 2008 (the Act). It has now come to my attention that Ms May's death was a death that is referred to in section 4(2)(c) of the Act as the Ms May was immediately before death placed in care or custody. In those circumstances I am required by the Act to make findings with respect to the circumstances of Ms May's death. I have accordingly determined to continue the investigation notwithstanding my previous determination and make findings with respect to the circumstances of Ms May's death.

2. On 15 November 2022 Ms May was 41 years old when she died at 16 Bowen Crescent Burwood East. At the time, Ms May lived in Specialist Disability Accommodation (SDA) Yooralla Neurological Support Services where she had lived since 1 May 2018. The National Disability Insurance Service (NDIS) had provided a Care Package for Ms may and the Care package included funding of his accommodation at Yooralla Neurological Support Services 16 Bowen Crescent East Burwood.

3. The National Disability Insurance Agency (NDIA) had approved a NDIS Care plan for Ms May and the plan was approved to commence on 18 August 2022.

4. In her NDIS plan Ms May stated:

   My name is Bec, I am 41 years old and live in Yooralla SDA in Burwood.

   I am a funny, talkative, and social person who loves getting involved in all the house activities including music and art therapy. I also love embracing the community, and getting involved in the natural environment and interacting with animals.

   I have a diagnosis of Huntingtons Disease (HD). This is a genetic neurodegenerative disease (progressive disease of the brain). HD impacts on me physically, cognitively and behaviorally/emotionally however since moving into UNSS, I have made significant improvements and am looking to increase my social, community and civic participation, and undertake some more activities of my interest. I am now very comfortable with my living arrangements and have a good relationship with my carers. I am more engaged and happy.

   I'd like to get back to visiting my sister Cassandra at her house more often. I am well supported by my sister Cassandra who supports me emotionally and with sourcing the supports and services I need.

   I have a specialist Neurologist at Royal Melbourne Hospital whom I see once or twice a year. I am also well connected to a range of allied health staff at my accommodation

THE CORONIAL INVESTIGATION

5. Ms May'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. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.[1]
6. 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.

7. 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.

8. This finding draws on the totality of the coronial investigation into the death of Ms May. 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]

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

Identity of the deceased

9. On 15 November 2022, Rebecca May, born 8 February 1981, was visually identified by her sister, Cassandra O'Brien, who signed a formal Statement of Identification to this effect.

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

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[1] See the definition of *"reportable death*" in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of *"person placed in custody or care"* in section 3 of the Act.

[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.

Medical cause of death

11. Forensic Pathologist Dr Paul Bedford, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination of Ms May's body in the mortuary on 17 November 2022 and provided a written report of his findings dated 25 November 2022.

12. Dr Bedford provided an opinion that the medical cause of death was.

    1 (a) Aspiration pneumonia

    (b) Huntington's Disease

13. Dr Bedford considered that Ms May's death was due to natural causes.

14. I accept Dr Bedfords's opinion.

Circumstances in which the death occurred

15. Ms May had been a resident at Yooralla Neurological Support Services since 1 May 2018. Ms May suffered from Huntington's disease.
16. During the course of Sunday 13 November 2022 Ms May's health had begun to deteriorate. She had become febrile, and her respiratory rate had increased. Staff monitored her and were aware that her condition was continuing to deteriorate during Monday 14 November 2022.
17. On Tuesday 15 November 2022 in the early morning staff noticed that Ms May was increasingly short of breath and then became unresponsive. Ambulance paramedics were called and staff commenced cardiopulmonary resuscitation. Paramedics arrived and as there was a not for resuscitation directive in place, they ceased resuscitation and Ms May was pronounced diseased at 5.48 am.

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 Rebecca Jayne May, born 8 February 1981;

    b) the death occurred on 15 November 2022 at 16 Bowen Crescent Burwood East, Victoria, ;

    the cause of Ms May's death was *1 (a) Aspiration pneumonia*

(b) Huntington's Disease and

c) the death occurred in the circumstances described above.

19. The available evidence does not support a finding that there was any want of clinical management or care on the part of the SDA operator that caused or contributed to Mr May's death.

20. I note that Ms May's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before her death, she was a person placed in care. Section 52 of the Act requires an inquest to be held, except in circumstances where the death was due to natural causes. I am satisfied that Ms May died from natural causes and that no further investigation is required. Accordingly, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation of Ms May's death on the papers.

21. I convey my sincere condolences to Ms May's family and her carers and friends 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:

Cassandra O'Brien, senior next of kin

Signature:

Judge John Cain
STATE CORONER
Date 29 November 2023

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.