IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 006667

AMENDED FINDING INTO DEATH WITHOUT INQUEST

Amended pursuant to section 76A of the Coroners Act 2008 (Vic) on 8 November 2023 by order of the State Coroner, Judge Cain, in order to satisfy section 67(2) of the Coroners Act 2008.

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain
Deceased:	Gary Nicholls
Date of birth:	17 June 1961
Date of death:	20 November 2022
Cause of death:	1(a) Complications of Multi system atrophy
Place of death:	6 Binap Rd, Epping Victoria

INTRODUCTION

1. On 25 January 2023, having investigated the death of Mr Garry Nicholls I signed and published a finding in respect of Mr Nicholls death. The finding did not include information in relation to the circumstances of Mr Nicholls death other than the cause of death and date of death. I have had the opportunity to review this finding and consider that this case does not fall within one of the exemptions in section 67 (2) of the Coroners Act 2008 and I am therefore required to make findings with respect to the circumstances of Mr Nicholls death. This amended finding remedies the deficiency in the previous finding.

2. On 20 November 2022 Mr Gary Nicholls was 61 years old when he died at 6 Binap Road, Epping. At the time, Mr Nicholls lived in a Specialist Disability Accommodation. The National Disability Insurance Service (NDIS) had provided a Care Package for Mr Nicholls and the Care package included funding of his accommodation at 6 Binap Road Epping. Mr Nicholls had only moved into the accommodation three days prior to his death.

3. The National Disability Insurance Agency (NDIA) had approved a NDIS Care plan for Mr Nicholls and the plan was approved to commence on 29 September 2022. This plan had enabled Mr Nicholls to move to Specialist Disability Accommodation (SDA) where he was residing at the time of his death.

4. In his NDIS plan Mr Nicholls stated:

> *I am 61, and have moved from Royal Melbourne Hospital to Cyril Jewell aged care facility. I want to move out as soon as I am able to and be close to my children. I have been diagnosed with Multiple Systems Atrophy. This has impacted my ability to manage at home without support. This disease is a progressive disorder and will continue to impact my ability to maintain my independence at home.*
> *I have some very supportive adult children who have previously provided some care, however my care needs have increased to where I need NDIS support to be able to return home or to another suitable residence.*
> *I want to continue to live at home with my family, spend meaningful time with friends and maintain my dignity and quality of life.*
>
> *Currently I am in Cyril Jewell aged care and am largely confined to my room due to not having adequate supports to get out- i am renting a wheelchair and looking to explore alternate accommodation. I am being supported by my daughter Betty and my support coordinator.*

THE CORONIAL INVESTIGATION

5. Mr Nicholls 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 Garry Nicholls. 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 20 November 2022, Garry Nicholls, born 17 June 1961, was visually identified by his former wife, Eleonora Nadj, 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 Hans de Boer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination of Mr Nicholls body in the mortuary on 23 November 2022 and provided a written report of his findings dated 28 November 2022.

12. Dr de Boer provided an opinion that the medical cause of death was *1 (a) Complications of Multiple System Atrophy*

13. Dr de Boer considered that Mr Nicholls death was due to natural causes.

14. I accept Dr de Boer's opinion.

Circumstances in which the death occurred

15. Mr Nicholls had only moved into the SDA on 18 November 2022. Due to his medical condition, (Multiple Systems Atrophy) Mr Nicholls was confined to a wheelchair and required assistance moving from his bed to the wheelchair.
16. At approximately 8 am, staff at the SDA entered Mr Nicholls bedroom to wake him for breakfast. Mr Nicholls on being woken opened his eyes but did not respond verbally and then appeared to go back to sleep.
17. At approximately 9.50 am, staff again entered his room to rouse him so he could eat his breakfast. Upon entering the room staff noticed that Mr Nicholls face was blue and he was unresponsive. Staff immediately called 000 and began CPR.
18. At approximately 10am, Ambulance paramedics arrived and continued CPR for 1 minute before pronouncing Mr Nicholls deceased.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Gary Nicholls, born 17 June 1961;

    b) the death occurred on 20 November 2022 at 6 Binap Road, Epping, Victoria, ;

    c) the cause of Mr Nicholls death was Complications of multiple system atrophy; and

    d) the death occurred in the circumstances described above.

20. 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 Nicholls death.

21. I note that Mr Nicholls death was reportable by virtue of section 4(2)(c) of the Act because, immediately before his death, he 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 Mr Nicholls 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 Mr Nicholls death on the papers.

22. I convey my sincere condolences to Mr Nicholls family and his carers and friends at Orange Grove 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:

Betty Nicholls, senior next of kin

Signature:

Judge John Cain
STATE CORONER
Date:10 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.