IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000483

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Yan Jin
Date of birth:	2 January 1961
Date of death:	24 January 2025
Cause of death:	1a : PNEUMONIA 2 : ISCHAEMIC CEREBROVASCULAR INCIDENTS, HYPERTENSION, ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Place of death:	St. Vincent's Hospital Melbourne 41 Victoria Parade Fitzroy Victoria 3065
Keywords:	In care, Natural causes

INTRODUCTION

1. On 24 January 2025, Yan Jin was 64 years old when he died at St Vincent's Hospital. At the time of his death, Yan lived in Specialist Disability Accommodation at Unit 214, 627 Victoria Street, Abbotsford, Victoria 3067.

2. Yan was born in China and raised by his mother and grandmother during the Chinese cultural revolution. As a teenager he was questioned and imprisoned after voicing controversial political views at school. After completing university in China, Yan emigrated to Australia in about 1989.[1]

3. Yan was previously married, but the couple separated because of family violence. His estranged wife is believed to have returned to China.[2]

4. Yan's past relevant medical history includes aphasia, post-traumatic stress disorder, hypertension, atrial fibrillation, anxiety and depression.[3] In 2014, Yan was admitted to St Vincent's Acute Inpatient Service for depressive disorder with agitation, suicidal and homicidal ideation towards his estranged wife.[4]

5. In about March 2019, Yan suffered a significant middle cerebral artery stroke and since then, has required the assistance of National Disability Insurance Scheme (**NDIS**) carers for all personal activities of daily living.[5]

6. From February 2021 to the time of his passing, Yan lived at an apartment managed by Liverty Housing. He resided there alone and received 24-hour NDIS carer support until about November 2024, when his NDIS carer funding was cut to eight hours per day.[6] At the time of his death, his carer was in the process of applying for a full reinstatement of his funding.

THE CORONIAL INVESTIGATION

7. Yan'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. The death of a person in care or custody

[1] *Coronial Brief,* Functional Behaviour Assessment/ Comprehensive Behaviour Support Plan by Dr Bleydy Dimech-Betancourt.
[2] Ibid.
[3] *Coronial Brief,* Statement of Dr Chris Olszewiski.
[4] *Coronial Brief,* Functional Behaviour Assessment/ Comprehensive Behaviour Support Plan by Dr Bleydy Dimech-Betancourt.
[5] Coroners Court of Victoria (CCOV) e-Medical Deposition Form, Dr Vandita Mattoo.
[6] *Coronial Brief,* Statement Dr Veena Roberts.

is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

8. Because Yan was a Specialist Disability Accommodation (**SDA**) resident residing in an SDA enrolled dwelling[7] at the time of his death, his passing was determined to be 'in care' and, as such, is subject to a mandatory further investigation, pursuant to section 52(3A) of the Act. These findings are the result of that investigation.

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. Victoria Police assigned Senior Constable Andrew Sinclair to be the Coronial Investigator for the investigation of Yan's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

12. This finding draws on the totality of the coronial investigation into the death of Yan Jin including evidence contained in the coronial brief. 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.[8]

13. In considering the issues associated with this finding, I have been mindful of Yan's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

[7] See Regulation 7(1)(d) of the *Coroners Regulations 2019*.

[8] 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

14. On 13 January 2024, Yan experienced a witnessed fall. The NDIS carer who witnessed the fall described it as "sliding off the bed". There were no associated head-strike and no reported loss of consciousness.[9]

15. Yan's carer called emergency services, and he was transported to the St Vincents Hospital Emergency Department. On arrival to ED, Yan reported pain to his shoulder, elbow, wrist, ankle and foot.[10] An X-ray revealed no fracture. Although the did not sustain any injuries from the fall, Yan was admitted for additional discharge planning as medical staff found he could not be sufficiently supported at home with only eight hours of support per day.[11]

16. During his admission, he refused medication and shouted "no", gesturing with his hands to indicate his refusal.[12] According to Dr Veena Roberts, the refusal was in line with his longstanding refusal to take medication while in the community.[13]

17. On 15 January 2024, Yan experienced an acute decline in his conscious state.[14] His Glascow Coma Scale (**GCS**) was noted to be between 6 and 7.[15] Yan was found to be in hypoactive delirium, drooling and gurgling with his eyes closed. Medical staff believed his condition was likely due to the progression of an underlying disease caused by his previous stroke. The treating team identified little reversibility, and it was decided that end of life care would begin if his condition worsened.[16]

18. On the night of 16 January 2024, Yan experienced issues with his breathing and had intermittent apnoeic episodes.[17] Over the following days, he continued to deteriorate with

[9] Coroners Court of Victoria (CCOV) e-Medical Deposition Form, Dr Vandita Mattoo.
[10] Ibid.
[11] *Coronial Brief,* Statement of Dr Veena Roberts.
[12] Ibid.
[13] Ibid.
[14] Ibid.
[15] Coroners Court of Victoria (CCOV) e-Medical Deposition Form, Dr Vandita Mattoo; The Glascow Coma Scale (GCS) is a common scoring system used to describe a person's level of consciousness following a brain injury. A GCS of 8 or below is considered to be a 'severe' brain injury.
[16] *Coronial Brief*, Statement of Dr Veena Roberts.
[17] An apnoea is defined as a pause in breathing for 20 seconds or longer.

reduced conscious state and hypoxia, likely a combination of cerebral vessel ischemia[18] and aspiration.[19] He was commenced on tazocin to address any potential aspiration pneumonia.[20]

19. Over the following days, Yan's condition failed to improve and on 20 January 2024, he was transitioned to end of life care.[21]

20. Yan passed away on 24 January 2024.[22]

Identity of the deceased

21. On 24 January 2025, Yan Jin, born 2 January 1961, was visually identified by his carer, Mary Whyte.

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

Medical cause of death

23. Forensic Pathologist Adjunct Associate Professor Dr Hans De Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 28 January 2025 and provided a written report of his findings dated 29 January 2025.

24. The post-mortem examination and CT scan was consistent with the reported circumstances. There was no evidence of substantial injury.

25. Based on the all the information available, Dr De Boer formed the opinion that Yan's death was due to natural causes.

26. Dr De Boer provided an opinion that the medical cause of death was 1(a) PNEUMONIA, secondary to 2: ISCHAEMIC CEREBROVASCULAR INCIDENTS, HYPERTENSION, ATHEROSCLEROTIC CARDIOVASCULAR DISEASE and I accept his opinion.

FINDINGS AND CONCLUSION

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

[18] Cerebral ischemia or brain ischemia, is a condition that occurs when there isn't enough blood flow to the brain to meet metabolic demand.
[19] *Coronial Brief*, Statement of Dr Veena Roberts.
[20] Aspiration pneumonia is an infection caused by inhaling something other than air into your lungs. This could be food, liquid, saliva or stomach contents.
[21] *Coronial Brief*, Statement of Dr Veena Roberts.
[22] Ibid.

a) the identity of the deceased was Yan Jin, born 2 January 1961;

b) the death occurred on 24 January 2025 at St. Vincent's Hospital Melbourne 41 Victoria Parade, Fitzroy, Victoria 3065 from 1(a) PNEUMONIA secondary to 2: ISCHAEMIC CEREBROVASCULAR INCIDENTS, HYPERTENSION, ATHEROSCLEROTIC CARDIOVASCULAR DISEASE; and

c) the death occurred in the circumstances described above.

28. Having considered all of the circumstances, I am satisfied that Yan's care was reasonable and appropriate at all material times.

29. As Yan was residing in Specialist Disability Accommodation at the time of his passing, his death is considered to be 'in care' as defined by section 3 of the Act and subject to a mandatory inquest unless exceptions applied.[23] I am satisfied by the available evidence that Yan's death was due to natural causes and, pursuant to section 52(3A) of the Act, have therefore determined not to hold an inquest.

I convey my sincere condolences to Yan'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.

[23] Section 52(2) of the Act.

I direct that a copy of this finding be provided to the following:

Nicole Wang, Senior Next of Kin

St Vincents Hospital

Senior Constable Andrew Sinclair, Coronial Investigator

Signature:

Coroner Simon McGregor

Date: 15 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.