IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004841

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Peter Keating
Date of birth:	17 July 1985
Date of death:	18 December 2022
Cause of death:	1(a) Pseudomonas pneumonia 2 Cerebral palsy and cognitive impairment
Place of death:	Monash Medical Centre, 246 Clayton Road Clayton, Victoria, 3168
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 18 December 2022, Peter Keating (**Mr Keating**) was 37 years old when he died at Monash Medical Centre, Clayton, 3168, from pseudomonas pneumonia.

2. At the time of his death, Mr Keating was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by the then-Department of Health and Human Services at 13 Steedman Street, Mordialloc, 3195. Mr Keating was receiving these supports due to cerebral palsy and an intellectual disability.

3. Mr Keating lived in his SDA supported home with four residents, all of whom, including Mr Keating, had high care needs. However, Mr Keating enjoyed good support from his carers and support staff. His support included personal care needs and assistance with his percutaneous endoscopic gastronomy (**PEG**) feeding regime.

4. Mr Keating had been suffering with respiratory infections for many years and, during the COVID-19 pandemic, extra measures were put in place to ensure his safety so that his health would not be compromised any further.

5. When Mr Keating was well enough, his support worker took him on excursions to allow him to participate in community activities of his choice like swimming. Mr Keating played Balloon Football League (BFL) football and enjoyed the time he spent with his teammates.

6. Mr Keating's treatment for his healthcare needs and concerns included hydrotherapy and physiotherapy which he attended on the days he went out, accompanied by his support worker.

7. Further, Mr Keating's twin-brother, Mark Keating, visited him regularly to spend quality time with his brother who loved being with people and liked social outings.

[1] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Mr Keating's death, is a permanent dwelling that provides long-term accommodation for one or more SDA residents, that is enrolled as an SDA dwelling under relevant NDIS (Specialist Disability Accommodation) Rules in force at the relevant time. An SDA resident means a person who is an NDIS participant funded to reside in an SDA enrolled dwelling, or who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program). The definition of SDA resident was amended on 1 July 2024 pursuant to the *Disability and Social Services Regulation Amendment Act 2023* to extend to include persons who are residing, or propose to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement.

THE CORONIAL INVESTIGATION

8. Mr Keating's death fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as he was a 'person placed in custody or care' within the meaning of the Act, as a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling immediately prior to his death. 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 Peter Keating, including information from the National Disability Insurance Agency (**NDIA**) and the NDIS Quality and Safeguards Commission, as well as a Medical Certificate Cause of Death (**MCCD**) completed by a medical practitioner at Monash Medical Centre. 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]

[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. On 16 November 2022, Mr Keating became ill, presenting with a high temperature after experiencing issues with his PEG. Taking the advice of the PEG Outreach Team, Mr Keating's carers called emergency services.

13. Ambulance Victoria (**AV**) paramedics arrived at Mr Keating's home and after they assessed Mr Keating's condition, he was conveyed to Monash Medical Centre for further treatment. Mr Keating was admitted to hospital on the same day.

14. Over the course of the next month, Mr Keating was treated with antibiotic therapy to manage his infections. Attending clinicians also administered oxygen at 100% concentration to assist Mr Keating with his respiratory issues. While in hospital, Mr Keating detached his PEG from the PEG site and required surgery to reattach the PEG.

15. On 8 December 2022, Mr Keating contracted a further infection, distinct from the infection previously diagnosed. With further antibiotic therapy treatment, attending clinicians noted that Mr Keating was becoming resistant to antibiotics. Despite the treatment he received at Monash Medical Centre, Mr Keating's health continued to deteriorate.

16. On 18 December 2022, Mr Keating passed away.

Identity of the deceased

17. On 18 December 2022, Peter Keating, born 17 July 1985, was identified by Medical Practitioner Dr Ryan Ammendolea via review of medical records and visual identification.

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

Medical cause of death

19. On 18 December 2022, Medical Practitioner Dr Ryan Ammendolea reviewed Mr Keating's complete medical history, conducted an examination upon the body of Peter Keating and completed a MCCD. Dr Ammendolea provided an opinion that the medical cause of death was pseudomonas pneumonia, with other significant contributing conditions of cerebral palsy and cognitive impairment.

20. On 18 August 2024, a Medical Liaison Nurse (**MLN**) at the Victorian Institute of Forensic Medicine, reviewed the MCCD at my direction and confirmed that the cause of death was due to natural causes.

21. I accept Dr Ammendolea's opinion, and I am satisfied that the death was due to natural causes.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Peter Keating born 17 July 1985;

    b) the death occurred on 18 December 2022 at Monash Medical Centre, 246 Clayton Road, Clayton, Victoria, 3168 from pseudomonas pneumonia in the setting of cerebral palsy and cognitive impairment. and

    c) the death occurred in the circumstances described above.

23. The available evidence does not support a finding that there was any want of clinical management or care on the part of the SIL provider, or clinical staff at Monash Medical Centre, that caused or contributed to Mr Keating's death.

24. Having considered all the available evidence, I find that Mr Keating'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 his death and to finalise the investigation of Mr Keating's death in chambers.

I convey my sincere condolences to Mr Keating's family, friends and carers for their loss, and acknowledge the distress caused by the delay in the reporting and investigation of Mr Keating's death.

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.

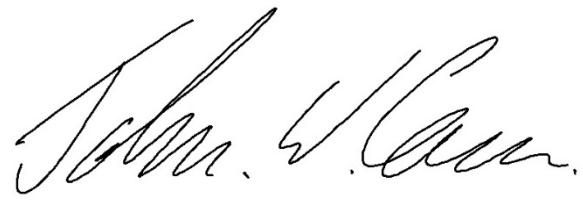
I direct that a copy of this finding be provided to the following:

Mark Keating, Senior Next of Kin

Scope Australia Ltd

Monash Health

Signature:



Date: 9 December 2024

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.