IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 1508

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Simon McGregor, Coroner
Deceased:	Troy, Brian
Date of birth:	27 September 1955
Date of death:	17 March 2020
Cause of death:	1(a) Complications of a cerebral tumour in the setting of multiple medical comorbidities
Place of death:	Gandarra Palliative Care Facility Ballarat Base Hospital, Ballarat, Victoria

INTRODUCTION

1. On 17 March 2020, Brian Troy was 64 years old when he died at Ballarat Base Hospital from a malignant brain tumour. At the time of his death, Brian lived in a supported group home on the outskirts of Ballarat.

THE CORONIAL INVESTIGATION

2. Brian'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.

3. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.[1]

4. 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.

5. 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.

6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Brian's death. The Coroner's 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.

7. This finding draws on the totality of the coronial investigation into the death of Brian Troy, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I

[1] See section 11 of the Act.

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

Circumstances in which the death occurred

8. Despite being born with significant disabilities, Brian was raised on his family's farm and then moved into supported accommodation as an adult.

9. Brian's general practitioner was Dr Andrew McDonald from Ballarat Group Practice. Dr McDonald confirmed Brian had an intellectual disability known as Pervasive Development Disorder, as well as autism, epilepsy, cerebral palsy, hearing impairment, visual impairment, cognitive impairment, congenital absence of his right kidney and club foot.[3]

10. As a result of these significant physical and intellectual disabilities, Brian needed support with all aspects of daily living, communication, self-care, meal support, mobility, health management and community. Since 2011, he had resided in a Melba Support Services (Melba) group home at 3 Whim Place, Canadian, on the outskirts of Ballarat.[4]

11. The disability services at Whim Place had been provided by Melba since they took over from the Department of Health and Human Services (now the Department of Families, Fairness and Housing) on 18 August 2019.[5] More recently, Brian became a registered participant with the National Disability Insurance Scheme.[6]

12. I pause here to observe that neither the transition from a state run care scheme to a Commonwealth funded one, nor the outsourcing of government services to private providers, ought in my view to place the deaths of those in receipt of such forms of disability services beyond the scrutiny of the coroner where these persons would otherwise be considered to have been 'in care' for the purposes of the Act. Victorian superior court common law and public law authorities have made it clear that from both perspectives, the government of the day will not

[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.
[3] Report of Dr McDonald, Coronial Brief.
[4] Letter from Disability Services Commissioner, 22 February 2021.
[5] Ibid.
[6] Statement of Simon Brennan, Coronial Brief.

be absolved of any responsibility by subcontracting out their non-delegable duty of care,[7] or their public authorities' obligations under the *Charter*, to third party providers.[8]

13. Brian was diagnosed with a malignant brain tumour on the 7th of January, 2020 at the Ballarat Base Hospital (the Hospital), after he experienced a seizure. His prognosis was poor and potential treatments were painful and distressing, so after careful consideration, Brian's family decided to take a palliative approach to his treatment. Brian remained living at Whim Place after this diagnosis.[9]

14. On the 14th of March 2020, Brian was transferred to the Hospital's emergency department due to his increasingly agitated behaviour and a fluctuating conscious state. He was assessed and it was determined that his tumour had progressed.[10]

15. Brian was transferred to the Hospital's Gandarra Palliate Care Unit at 9.30pm the same day for end of life care. On admission Brian was treated with a continuous subcutaneous infusion of phenobarbitone, midazolam and morphine.

16. Brian was assessed at 9.30 am on the 15th of March by Dr Greg Mewett, who administered glycopyrrolate to manage his upper airway secretions.[11]

17. Brian passed away in his bed at Gandarra at 2.15 am on the 17th of March, 2020.[12] Brian's sister Sharon Griffiths and brother James Troy were present at his bedside.

18. On 20 March 2020, the Disability Services Commissioner commenced an investigation under s. 128I of the *Disability Act 2006* (the Act), into the disability services provided by Melba to Brian. By letter dated 22 February 2021, the Commissioner advised me that the investigation was complete. Whilst the Commissioner's letter made it clear that Melba had identified several ways in which to improve their services, none of those matters would have prevented or altered this cause of death, so I shall not recite them here.

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[7] Kondis v State Transport Authority (1984) 154 CLR 672 at 685-7.

[8] *Metro West v Sudi* (Residential Tenancies) [2009] VCAT 2025 per Bell J at [62], [118], [129], [133], [137]-[139] & [140], appealed on a separate point in *Director of Housing v Sudi* [2011] VSCA 266; *YL v Birmingham City Council* [2007] UKHL 27; [2008] 1 AC 95; [2007] 3 All ER 957; 96 BMLR 1; [2007] 3 WLR 112 at [4]-[5], [18], [68] [27], [105], [148] & [167]. See also, Tate, "Protecting Human Rights in a Federation" (2007) 33 Mon LR 220 at 227; McGregor, "Public Bodies & Human Rights" (2008) 82 LIJ 62 at 64.

[9] Report of Dr McDonald, Coronial Brief.
[10] Report of Dr Mewett, and Ballarat Base Hospital records, Coronial Brief.
[11] Ibid.
[12] Ibid.

19. I shall however take this opportunity to comment that the caregivers provided reasonable and appropriate treatment in this matter.

Identity of the deceased

20. On 17 March 2020, Brian Troy, born 27 September 1955, was visually identified by his sister, Sharon Griffiths.

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

Medical cause of death

22. Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 18 March 2020 and provided a written report of her findings dated 26 May 2020.

23. The post-mortem examination revealed nothing inconsistent with the history above,

24. Dr Francis provided an opinion that the medical cause of death was due to natural causes which were more specifically described as '1(a) Complications of a cerebral tumour in the settingof multiple medical comorbidities.'

25. I accept Dr Francis's opinion.

26. This means that for the purposes of the Act, although Brian was a person 'in care' at the time of his death, an inquest into his death was not mandatory.[13]

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Brian Troy, born 27 September 1955;

    (b) the death occurred on 17 March 2020 at Gandarra Palliative Care Facility, Ballarat Base Hospital, Ballarat, Victoria, from complications of a cerebral tumour in the settingof multiple medical comorbidities; and

    (c) the death occurred in the circumstances described above.

[13] See subsection 52(3B) of the Act.

I convey my sincere condolences to Brian'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.

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

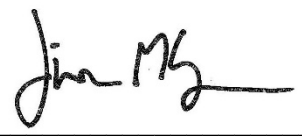
Sharon Griffiths, Senior Next of Kin

Simon Brennan, Melba Support Services, Interested Party.

Secretary for the Department of Families, Fairness and Housing, Interested Party.

First Constable Meg Farrell, Coroner's Investigator

Signature:



SIMON McGREGOR

CORONER

Date: 29 March 2021

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.