IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004802

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:	Kerry Patricia Johnston
Date of birth:	3 February 1959
Date of death:	26 December 2022
Cause of death:	1(a) Aspiration event 2 Cerebral palsy, intellectual disability and bowel cancer
Place of death:	Mildura Base Public Hospital, 231-237 Thirteenth Street, Mildura Victoria 3500
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 26 December 2022, Kerry Patricia Johnston (**Ms Johnston**) was 63 years old when she died at Mildura Base Public Hospital following an aspiration event.

2. At the time of her death, Ms Johnston was a National Disability Insurance Scheme (**NDIS**) participant. She received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by the then-Department of Health and Human Services. Ms Johnston was receiving these supports due to cerebral palsy and an intellectual disability. She had also been diagnosed with bowel cancer approximately two years prior to her death.

3. Ms Johnston was one of eight siblings and was regularly visited by her sisters Leonie and Gail, and brother Phillip. She also enjoyed weekly visits from her close friend Danny. Ms Johnston loved drawing and listening to music and attended the Christie Centre[2] five days a week where she participated in a variety of recreational and life skill activities.

THE CORONIAL INVESTIGATION

4. Ms Johnston's death fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as she 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 her 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.

5. 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

[1] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Ms Johnston'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.

[2] The Christie Centre is a Mildura-based NDIS organisation which provides quality individualised supports and opportunities for people with a disability, including group based support programs, and opportunities for community engagement and supported employment.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. 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.

7. This finding draws on the totality of the coronial investigation into the death of Kerry Patricia Johnston, including information from the National Disability Insurance Agency (**NDIA**) and the NDIS Quality and Safety Commission, as well as a Medical Certificate Cause of Death (**MCCD**) completed by a medical practitioner at Mildura Base Hospital. 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.[3]

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

Circumstances in which the death occurred

8. Ms Johnston's health began to decline in the months prior to her death, and she had three hospitalisations in September 2022, October 2022, and November 2022. She had most recently been discharged from hospital on Tuesday 19 December 2022.

9. On Friday 23 December 2022, Ms Johnston was re-admitted to Mildura Base Hospital due to declining health in the setting of an aspiration event. Aspiration happens when food, liquid, or other material enters a person's airway and eventually the lungs by accident. It can happen when a person has trouble swallowing normally and can lead to serious health issues such as pneumonia. People with intellectual disability are at a higher risk of aspiration.[4]

10. Despite treatment, Ms Johnston's condition continued to deteriorate, and she passed away three days later, on the morning of Monday 26 December 2022.

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[3] 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.

[4] NDIS Quality and Safet Commission, Practice Alert: Prevention of Respiratory Infections dated May 2022, p 3.

Identity of the deceased

11. On 26 December 2022, Kerry Patricia Johnston, born 3 February 1959, was identified by Medical Practitioner Dr Bryant Ng via review of medical records and visual identification.

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

Medical cause of death

13. On 26 December 2022, Medical Practitioner Dr Bryant Ng reviewed Ms Johnston's complete medical history, conducted an examination on the body and completed a MCCD. Dr Ng provided an opinion that the medical cause of death was an aspiration event, with other significant contributing conditions of cerebral palsy, an intellectual disability and bowel cancer.

14. On 17 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.

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

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Kerry Patricia Johnston, born 3 February 1959;

    b) the death occurred on 26 December 2022 at Mildura Base Public Hospital, 231-237 Thirteenth Street, Mildura in Victoria from an aspiration event in the setting of cerebral palsy, an intellectual disability, and bowel cancer; and

    c) the death occurred in the circumstances described above.

17. 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 Mildura Base Hospital, that caused or contributed to Ms Johnston's death.

18. Having considered all the available evidence, I find that Ms Johnston'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 her death and to finalise the investigation of Ms Johnston's death in chambers.

I convey my sincere condolences to Ms Johnston's family, friends and carers for their loss, and acknowledge the distress caused by the delay in the reporting and investigation of Ms Johnston'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:

Gail Casey and Leonie Johnston, Senior Next of Kin

Aruma Services Victoria Limited

Mildura Base Public Hospital

Signature:

Date : 15 November 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.