IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004803

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:	Joanne Mostyn
Date of birth:	24 November 1965
Date of death:	9 September 2023
Cause of death:	1(a) Metastatic triple negative breast cancer 2 Lennox-Gastaut syndrome
Place of death:	Royal Melbourne Hospital, 300 Grattan Street Parkville Victoria 3052
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 9 September 2023, Joanne Mostyn (**Ms Mostyn**) was 57 years old when she died at Royal Melbourne Hospital from metastatic triple negative breast cancer.

2. At the time of her death, Ms Mostyn 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 Mostyn was receiving these supports due to Lennox Gastaut Syndrome with intellectual disability. She had been diagnosed with metastatic triple negative breast cancer approximately seven months prior to her death.

3. Ms Mostyn was very close with her family, particularly her mother and her sister Tammie who she regularly visited. She was described as a social butterfly, who enjoyed having a chat with others and going out into the community with her family, house mates and house staff. She also loved watching the film and stage productions of the Sound of Music, as well as knitting, cooking and art.

THE CORONIAL INVESTIGATION

4. Ms Mostyn's death was 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

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

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.

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 Joanne Mostyn, 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 Royal Melbourne Hospital and the discharge summary. 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

Circumstances in which the death occurred

8. In February 2023, Ms Mostyn underwent a left mastectomy and lymph node removal for treatment of metastatic triple negative breast cancer. She was also prescribed capecitabine, a type of chemotherapy, but the cancer continued to progress and in June 2023, a decision was made to transition to best supportive care.

9. On 6 August 2023, Ms Mostyn was admitted to the Royal Melbourne Hospital under the palliative care team with escalating distress and behavioural disturbance due to pain and anxiety. It was noted that Ms Mostyn also had recurrent falls with osteoporosis.

10. During her admission, Ms Mostyn was treated with medication to manage her symptoms, and underwent CT imaging which revealed progression of her skeletal metastases with no intracranial metastases. Following discussion with the neurology team, Ms Mostyn was trialled on brivaracetam, a medication used to control partial onset seizures, with mild

[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.

improvement. After two weeks of stability, Ms Mostyn's condition rapidly deteriorated and she developed recurrent seizures and increasing drowsiness. Despite recommencing her previous antiepileptic regime, her seizures continued.

11. Ms Mostyn passed away peacefully at Royal Melbourne Hospital on 9 September 2023.

Identity of the deceased

12. On 9 September 2023, Joanne Mostyn, born 24 November 1965, was identified by her treating medical practitioner, Dr Nayomi Perera via review of medical records.

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

Medical cause of death

14. On 11 September 2023, Dr Perera reviewed Ms Mostyn's complete medical history and completed a MCCD acting on advice from another doctor who had examined Ms Mostyn's body. Dr Perera provided an opinion that the medical cause of death was metastatic triple negative breast cancer, with other significant contributing condition contributing to the death of Lennox-Gastaut syndrome.

15. 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.

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

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Joanne Mostyn, born 24 November 1965;

    b) the death occurred on 9 September 2023 at Royal Melbourne Hospital, 300 Grattan Street Parkville Victoria 3052, from metastatic triple negative breast cancer in the setting of Lennox-Gastaut Syndrome; and

    c) the death occurred in the circumstances described above.

18. 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 Royal Melbourne Hospital that caused or contributed to Ms Mostyn's death.

19. Having considered all the available evidence, I find that Ms Mostyn'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 Mostyn's death in chambers.

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

Tammie Alysandratos, Senior Next of Kin

Royal Melbourne Hospital

Signature:

Date : 8 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.