IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004804

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:	Darryle Rodney Gilbert
Date of birth:	11 October 1957
Date of death:	30 December 2022
Cause of death:	1a : Aspiration pneumonia 2 : Secondary progressive multiple sclerosis
Place of death:	Austin Hospital 147 Studley Road Heidelberg Victoria 3084
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 30 December 2022, Darryle Rodney Gilbert (**Mr Gilbert**) was 65 years old when he died at Austin Hospital from aspiration pneumonia.

2. At the time of his death, Mr Gilbert was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] operated by MS Plus Ltd. Mr Gilbert was receiving these supports due to progressive multiple sclerosis.

3. Mr Gilbert enjoyed visits from his friends, and participating in social and recreational activities in the community. He also loved gardening, and continued to build gardens around his unit.

THE CORONIAL INVESTIGATION

4. Mr Gilbert'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.

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

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

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 Darryle Rodney Gilbert, 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 Austin Health. 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. On 19 December 2022, Mr Gilbert was admitted to Austin Hospital with diagnoses of aspirated pneumonia and chronic obstructive airways disease. He also had tested positive to COVID-19. Mr Gilbert continued to aspirate while under the care of the hospital and was administered intravenous antibiotics. He was discharged on 25 December 2022 and returned to his SDA enrolled dwelling.

9. On the morning of 26 December 2022, staff observed Mr Gilbert was unresponsive, with profuse sweating. They called emergency services to request an ambulance. A Mobile Intensive Care Ambulance (**MICA**) attended, stabilised Mr Gilbert and transported him to Austin Hospital.

10. Mr Gilbert was admitted to Austin Hospital. He had a not for resuscitation order in place, and was provided with comfort care. He passed away four days later, on the afternoon of 30 December 2022.

[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.

Identity of the deceased

11. On 30 December 2022, Darryle Rodney Gilbert, born 11 October 1957, was identified by Medical Practitioner Dr Margaret Zhou 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 30 December 2022, Medical Practitioner Dr Margaret Zhou reviewed Mr Gilbert's complete medical history, conducted an examination on the body and completed a MCCD. Dr Zhou provided an opinion that the medical cause of death was aspiration pneumonia with antecedent cause of secondary progressive multiple sclerosis.

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 Zhou'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 Darryle Rodney Gilbert, born 11 October 1957;

    b) the death occurred on 30 December 2022 at Austin Hospital, 147 Studley Road, Heidelberg in Victoria from aspiration pneumonia with antecedent cause of secondary progressive multiple sclerosis.

    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 Austin Hospital, that caused or contributed to Mr Gilbert's death.

18. Having considered all the available evidence, I find that Mr Gilbert'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 Gilbert's death in chambers.

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

Jack Handford, Senior Next of Kin

MS Plus Ltd

Austin Health

Signature:

Date: 27 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.