IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004805

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:	Deren Yaan
Date of birth:	26 June 1994
Date of death:	24 April 2023
Cause of death:	1a : Aspiration Pneumonia 2 : Cerebral Palsy
Place of death:	Northern Hospital 185 Cooper Street Epping Victoria 3076
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 24 April 2023, Deren Yaan (**Mr Yaan**) was 28 years old when he died at Northern Hospital from aspiration pneumonia.

2. At the time of his death, Mr Yaan was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] with supports provided by Aruma Services. Mr Yaan was receiving these supports due to cerebral palsy.

3. Mr Yaan was part of a large supportive family, and was regularly visited by his parents, step-parents, siblings and cousin. He attended a day program with Yoorralla, five days a week where he enjoyed taking part in balloon football, aqua therapy and café corner.

THE CORONIAL INVESTIGATION

4. Mr Yaan'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 Yaan'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 Deren Yaan, 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 Northern 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 the morning of 24 April 2023, Mr Yaan was admitted to Northern Hospital due to declining health with aspiration pneumonia.

9. Aspiration pneumonia is the most common cause of respiratory death for people with disability, accounting for just under half of all respiratory deaths. 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 disability are at a higher risk of aspiration pneumonia.[3]

10. Mr Yaan was placed in palliative care and received end-of-life comfort measures. He passed away at approximately 6.45pm on 24 April 2023.

Identity of the deceased

11. On 24 April 2023, Deren Yaan, born 26 June 1994, was identified by Medical Practitioner Dr Ryan Fagan via review of medical records and visual identification.

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

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

Medical cause of death

13. On 24 April 2023, Medical Practitioner Dr Ryan Fagan reviewed Mr Yaan's complete medical history, conducted an examination of the body and completed a MCCD. Dr Fagan provided an opinion that the medical cause of death was aspiration pneumonia with antecedent cause of cerebral palsy.

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 Fagan'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 Deren Yaan, born 26 June 1994;

    b) the death occurred on 24 April 2023 at Northern Hospital, 185 Cooper Street, Epping in Victoria from aspiration pneumonia with antecedent cause of cerebral palsy; 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 Northern Hospital, that caused or contributed to Mr Yaan's death.

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

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

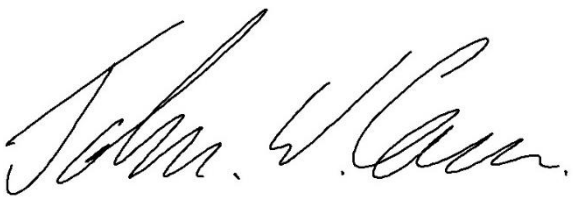
I direct that a copy of this finding be provided to the following:

Dilara Forte, Senior Next of Kin

Northern Health

Aruma Services

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.