IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004806

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:	Valerie Caithness
Date of birth:	13 July 1969
Date of death:	11 August 2023
Cause of death:	1(a) Aspiration pneumonia Contributing factor(s) 2 Cerebral palsy
Place of death:	Monash Health McCulloch House, 246 Clayton Road, Clayton Victoria 3168
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 11 August 2023, Valerie Caithness (**Ms Caithness**) was 54 years old when she died at McCulloch House, operated by Monash Health.

2. At the time of her death, Ms Caithness 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 Caithness was receiving these supports due to cerebral palsy and intellectual disability. She was also diagnosed with depression and schizophrenia.

3. Ms Caithness was close with her father, brother and sister-in-law. Prior to the COVID-19 pandemic, Ms Caithness enjoyed weekly visits with her brother and going for drives with him. Ms Caithness attended the Central Bayside Community Centre five days per week and participated in the various types of activities including swimming, visiting the library, bowling, art and craft, and massage therapy. She enjoyed knitting with wool and socialising with other people at the Community Centre.

THE CORONIAL INVESTIGATION

1. Ms Caithness'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.

2. 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 Caithness' 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.

3. 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.

4. This finding draws on the totality of the coronial investigation into the death of Valerie Caithness, 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 McCulloch House. 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

5. On 19 July 2023, Ms Caithness appeared to be experiencing abdominal pain, so she was transported to Dandenong Hospital as she had a history of bowel-related complications. She underwent a routine colonoscopy; however, she suffered an aspiration event and became unwell.

6. Ms Caithness' health declined, and she was admitted to the Intensive Care Unit (**ICU**), however her condition continued to deteriorate. A decision was made to palliate Ms Caithness, and she was transferred to Monash Health's McCulloch House for end of life and comfort care. Ms Caithness passed away on the morning of 11 August 2023.

[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

7. On 11 August 2023, Valerie Caithness, born 13 July 1969, was identified by medical practitioner Dr Benedict Low via a review of medical records.

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

Medical cause of death

9. On 11 August 2023, medical practitioner Dr Benedict Low reviewed Ms Caithness' complete medical history and completed a MCCD. Dr Low provided an opinion that the medical cause of death was aspiration pneumonia, with a significant contributing condition of cerebral palsy.

10. 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.

11. I accept Dr Low's opinion and am satisfied that the death was due to natural causes.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Valerie Caithness, born 13 July 1969;

    b) the death occurred on 11 August 2023 at Monash Health McCulloch House, 246 Clayton Road, Clayton, Victoria 3168, from aspiration pneumonia in the setting of cerebral palsy; and

    c) the death occurred in the circumstances described above.

13. 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 McCulloch House, that caused or contributed to Ms Caithness' death.

14. Having considered all the available evidence, I find that Ms Caithness' 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 Caithness' death in chambers.

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

Keith Caithness, Senior Next of Kin

Villa Maria Catholic Homes (**VMCH**)

Monash Health

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.