IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004808

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:	Julia Mary Case
Date of birth:	16 February 1969
Date of death:	14 August 2023
Cause of death:	1(a) Pneumonia 2 Cyanotic congenital heart disease
Place of death:	Peninsula Private Hospital, 525 McClelland Drive, Victoria 3910
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 14 August 2023, Julia Mary Case (**Ms Case**) was 54 years old when she died at Peninsula Private Hospital having contracted pneumonia.

2. At the time of her death, Ms Case was a National Disability Insurance Scheme (**NDIS**) participant. She received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by Focus Individualised Support Services in Mount Martha.

3. Ms Case had close relationships with her family, including with her mother, Brenda, and sister, Fiona. She enjoyed spending time with her family, particularly when being pampered such as through manicures and getting her hair done.

THE CORONIAL INVESTIGATION

1. Ms Case'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 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

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

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 Julia Mary Case, 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 Peninsula Private 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.[2]

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

Circumstances in which the death occurred

5. On 26 July 2023, Ms Case was admitted to Peninsula Private Hospital due to reduced mobility and shortness of breath. While hospitalised, her condition continued to decline. Suspecting an infection, medical practitioners administered intravenous antibiotics, however, these had little clinical affect and she continued deteriorating.
6. On 11 August 2023, Ms Case's treating team met with her family to discuss her continued treatment using antibiotics and plan the transition back to her SDA.
7. The following day, on 12 August 2023, Ms Case's condition significantly worsened, and she developed pneumonia. Medical practitioners determined to cease antibiotic treatment. The treating team liaised with the Case family including that Ms Case was refusing further treatment. The family implemented an Advanced Care Directive and Do Not Resuscitate order on her behalf, and Ms Case was subsequently transitioned to palliative care.
8. At 6:30am on 14 August 2023, Ms Case passed away in her sleep.

Identity of the deceased

9. On 14 August 2023, Julia Mary Case, born 16 February 1969, was identified by Medical Practitioner, Dr Anthony Pisaniello at the Peninsula Heart Centre of the Peninsula Private Hospital, via review of medical records and visual identification.

[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.

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

Medical cause of death

11. On 14 August 2023, Medical Practitioner Dr Anthony Pisaniello reviewed Ms Case's medical history including her final admission to hospital and completed a Medical Certificate Cause of Death (**MCCD**). Dr Pisaniello provided an opinion that the medical cause of death was pneumonia, with other significant contributing conditions of cyanotic congenital heart disease.

12. 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.

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

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Julia Mary Case, born 16 February 1969;

    b) the death occurred on 14 August 2023 at Peninsula Private Hospital, 525 McClelland Drive, Victoria 3910, from pneumonia in the setting of cyanotic congenital heart disease; and

    c) the death occurred in the circumstances described above.

15. 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 Peninsula Private Hospital, that caused or contributed to Ms Case's death.

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

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

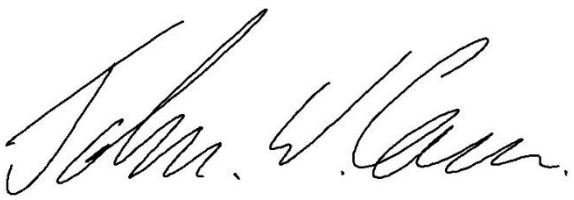
I direct that a copy of this finding be provided to the following:

Brendan Case, Senior Next of Kin

Focus Individualised Support Services

Peninsula Private Hospital

Signature:



Date: 28 October 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.