IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004809

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:	Kelly Frith
Date of birth:	3 November 1974
Date of death:	4 September 2023
Cause of death:	1(a) Aspiration pneumonitis 2 Central nervous system vasculitis
Place of death:	University Hospital Geelong, 272-322 Ryrie Street, Geelong Victoria 3220
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 4 September 2023, Kelly Frith was 48 years old when she died at University Hospital Geelong due to aspiration pneumonitis.

2. At the time of her death, Ms Frith was a National Disability Insurance Scheme (**NDIS**) participant. She received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] situated in North Geelong. She received support in her daily activities due to a catastrophic acquired brain injury (**ABI**) and had received a diagnosis of acute haemorrhagic leukoencephalitis.

3. Ms Frith was supported by her partner, Peter Tournier, and son, Adam, and enjoyed listening to music.

THE CORONIAL INVESTIGATION

1. Ms Frith'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.

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

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 Kelly Frith, 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 University Hospital Geelong. 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. In the lead-up to her death, Ms Frith was experiencing nasal congestion and a chesty cough. On 19 July 2023, she attended upon her general practitioner (**GP**) and was prescribed medication to manage her symptoms. Four further follow-up appointments were held over the ensuing weeks and her condition did not improve despite updating her medications.

6. At approximately 1:15pm on 4 September 2023, a support worker arrived to commence their shift and observed Ms Frith to have laboured breathing, to be cold and that her mouth was dry. The support worker escalated their concerns and contacted emergency services.

7. Ms Frith was relayed to University Hospital Geelong. However, she died at hospital a short time later.

Identity of the deceased

8. On 4 September 2023, Kelly Frith, born 3 November 1974, was identified by Medical Practitioner, Dr Suzanne Rayner via review of the medical records and visual identification.

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

[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.

Medical cause of death

10. On 4 September 2023, Medical Practitioner, Dr Suzanne Rayner, reviewed Ms Frith's medical history, conducted an examination on the body, and completed a Medical Certificate Cause of Death (**MCCD**). Dr Rayner provided an opinion that the medical cause of death was aspiration pneumonitis, with the significant contributing condition of central nervous system vasculitis.

11. 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.

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

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Kelly Frith, born 3 November 1974;

    b) the death occurred on 4 September 2023 at Geelong Hospital, 272-322 Ryrie Street Geelong Victoria 3220, from aspiration pneumonitis in the setting of central nervous system vasculitis; and

    c) the death occurred in the circumstances described above.

14. 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 University Hospital Geelong, that caused or contributed to Ms Frith's death.

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

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

Peter Tournier, Senior Next of Kin

Barwon Health

Signature:

Date: 29 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.