IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2024 004810**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the **Coroners Act 2008***

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| Findings of: | Judge John Cain, State Coroner |
| Deceased: | Jennifer Ann Grieves |
| Date of birth: | 13 October 1952 |
| Date of death: | 27 November 2022 |
| Cause of death: | 1(a) Perforated diverticulitis |
| 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 27 November 2022, Jennifer Ann Grieves (**Ms Grieves**) was 70 years old when she died at University Hospital Geelong following a two-day admission due to a bowel perforation.

2. At the time of her death, Ms Grieves was a National Disability Insurance Scheme (**NDIS**) participant. She received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by genU in East Geelong.

3. Ms Grieves had regular contact with her niece, Paula Gaskin, and enjoyed spending her time baking cakes and visiting the library.

## THE CORONIAL INVESTIGATION

1. Ms Grieves' 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 Grieves' 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 Jennfer Ann Grieves, 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. On 20 November 2022, Ms Grieves attended the University Hospital Geelong emergency department on account of nausea, vomiting and abdominal pain. It was determined she was severely constipated, was prescribed corresponding medication and discharged the same day.

6. Ms Grieves' attended her regular general medical practitioner over the ensuing days for follow-up and to implement a bowel care management plan.

7. On the evening of 24 November 2022, Ms Grieves' symptoms worsened. The following day, 25 November 2022, she relayed these concerns to genU staff and was eventually relayed to the University Hospital Geelong emergency department that afternoon. Ms Grieves vomited water and blood and was administered intravenous fluids and a proton-pump-inhibiter, pantoprazole before being stabilised in the resuscitation bay.

8. On 26 November 2022, medical practitioners spoke with Ms Grieves' family, regarding the active Medical Power of Attorney and Do Not Resuscitate order.

9. On 27 November 2022, Ms Grieves' treating team identified a perforation of the bowel, and in line with directives in place, determined not to operate and to cease further treatment. Ms Grieves was declared deceased at 7:30pm.

[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**

10. On 27 November 2022, Jennifer Ann Grieves, born 13 October 1952, was identified by Medical Practitioner, Dr Yu Jian Teo, via a review of medical records and visual identification.

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

**Medical cause of death**

12. On 27 November 2022, Medical Practitioner, Dr Yu Jian Teo, reviewed Ms Grieves' medical history, conducted an examination on the body and completed a MCCD. Dr Teo provided an opinion that the medical cause of death was a perforated diverticulitis.

13. 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.

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

## FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Jennifer Ann Grieves, born 13 October 1952;

    b) the death occurred on 27 November 2022 at Geelong Hospital 272-322 Ryrie Street Geelong Victoria 3220, from a perforated diverticulitis; and

    c) the death occurred in the circumstances described above.

16. 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 Grieves' death.

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

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

Sue Greenwood, Senior Next of Kin

genU

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.