IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004811

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:	James Robert Burns
Date of birth:	23 October 1960
Date of death:	25 January 2023
Cause of death:	1(a) Pulmonary oedema 1(b) Aspiration 2 Down Syndrome and chronic pulmonary obstructive disorder
Place of death:	Sunshine Hospital, 176 Furlong Road Victoria 3021
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 25 January 2023, James Robert Burns (**Mr Burns**) was 62 years old when he died at Sunshine Hospital after a short period of hospitalisation.

2. At the time of his death, Mr Burns was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] and relied on support workers to aid him with the majority of his daily tasks due to the progression of his Alzheimer's disease.

3. Mr Burns had occasional contact with his family, including with his cousins that he saw on special occasions.

THE CORONIAL INVESTIGATION

1. Mr Burns' 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.

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 Mr Burns' 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 James Robert Burns, 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 Sunshine 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. In the lead-up to his death, Mr Burns was increasingly unwell and had previous visits to Mercy Hospital and Sunshine Hospital. During his most recent admission to Sunshine Hospital, medical practitioners advised he had developed a third-degree atrioventricular block.

6. On 24 January 2023, Mr Burns attended upon a local medical practitioner for a regular check-up though emergency services were soon contacted, and he was relayed to Sunshine Hospital. Unfortunately, Mr Burns' condition deteriorated significantly and he passed away on 25 January 2023.

Identity of the deceased

7. On 25 January 2023, James Robert Burns, born 23 October 1960, was identified by Medical Practitioner, Dr Thao My Nguyen, via review of medical records and visual identification.

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

Medical cause of death

9. On 25 January 2023, Medical Practitioner, Dr Thao My Nguyen, reviewed Mr Burns' complete medical history, conducted an examination on the body and completed an MCCD. Dr Nguyen provided an opinion that the medical cause of death was pulmonary oedema and

[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.

aspiration, with other significant contributing conditions of Down Syndrome and chronic obstructive pulmonary disease (**COPD**).

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 Nguyen'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 James Robert Burns, born 23 October 1960;

    b) the death occurred on 25 January 2023 at Sunshine Hospital, 176 Furlong Road Victoria 3021, from pulmonary oedema and aspiration in the setting of Down Syndrome and chronic obstructive pulmonary disease; 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 Sunshine Hospital, that caused or contributed to Mr Burns' death.

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

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

Kim Tupper, Senior Next of Kin

Andrew Skeat, Senior Next of Kin

Signature:

Date: 13 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.