IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004815

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:	Faye Cosgrave
Date of birth:	5 June 1958
Date of death:	9 June 2023
Cause of death:	1(a) Catastrophic cerebellar haemorrhage 2 pulmonary embolic, subarachnoid haemorrhage and hypertension
Place of death:	Werribee Mercy Hospital
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 9 June 2023, Faye Maree Cosgrave (**Ms Cosgrave**) was 65 years old when she died at Werribee Mercy Hospital from a brain bleed.

2. At the time of her death, Ms Cosgrave was a National Disability Insurance Scheme (**NDIS**) participant. She received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by Accommodation And Care Solutions and to receive Supported Independent Living (**SIL**) services provided by Claro Aged Care and Disability Services.

3. Ms Cosgrave had moved from previous accommodation in Grovedale and had been looking forward to living closer to her daughter and grandchildren. She was a Collingwood supporter and part of her NDIS plan was building capacity to be able to go to a football match in Melbourne.

THE CORONIAL INVESTIGATION

4. Ms Cosgrave'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.

5. 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.

6. 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

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

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. 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.

8. This finding draws on the totality of the coronial investigation into the death of Faye Maree Cosgrave 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 Werribee Mercy Hospital.

9. 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

10. On 7 June 2023, Ms Cosgrave presented unwell and vomiting on the evening shift. Faye continued to vomit while outside having a cigarette and was struggling with her words. She was assisted into bed with ongoing nausea but did not vomit nor require assistance overnight.

11. On 8 June 2023, Ms Cosgrave was found unresponsive by care staff and was conveyed to hospital by ambulance. Ms Cosgrave was diagnosed with a bleed in the brain.

12. On 9 June 2023, Ms Cosgrave passed away in the early afternoon.

Identity of the deceased

13. On 26 December 2022, Faye Maree Cosgrave born 5 June 1958, was identified by Medical Practitioner Dr Dina Erceg, who completed the MCCD.

14. 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

15. On 9 June 2023, Dr Erceg reviewed Ms Cosgrave's complete medical history, conducted an examination on the body, and completed a MCCD. Dr Erceg provided an opinion that the medical cause of death was a catastrophic cerebellar haemorrhage, with other significant contributing conditions of pulmonary embolic, subarachnoid haemorrhage, and hypertension.

16. 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.

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

FINDINGS AND CONCLUSION

18. Pursuant to section 67(1) of the Act I make the following findings:

    a) the identity of the deceased was Faye Maree Cosgrave born 5 June 1958;

    b) the death occurred on 9 June 2023 at Werribee Mercy Hospital, Werribee, from catastrophic cerebellar haemorrhage in the setting of pulmonary embolic, subarachnoid haemorrhage, and hypertension; and

    c) the death occurred in the circumstances described above.

19. 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 Werribee Mercy Hospital that caused or contributed to Ms Cosgrave's death.

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

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

Katrina Rixon, Senior Next of Kin

Claro Aged Care and Disability Services

Werribee Mercy Hospital

Signature:

Date : 11 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.