IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004821

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:	SW
Date of birth:	5 August 1967
Date of death:	2 May 2023
Cause of death:	1a : ASPIRATION PNEUMONIA 2 : CERVICAL MYELOPATHY, DOWN SYNDROME AND ALZHEIMER'S DISEASE
Place of death:	Eastern Health, Wantirna Health Supportive and Palliative Care Unit, 251 Mountain Highway, Wantirna, Victoria 3152
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 2 May 2023, SW was 55 years old when he passed away from aspiration pneumonia[1] at Wantirna Health Supportive and Palliative Care Unit.

2. At the time of his death, SW was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[2] operated by Life Without Barriers. SW was receiving these supports due to Down Syndrome. He had also been diagnosed with cervical myelopathy[3] and Alzheimer's Disease[4] approximately five years before his death.

3. SW was very close with his mother, JM and stepfather, GM. He would speak with JM over the telephone every week. SW loved art, music and singing.

THE CORONIAL INVESTIGATION

4. SW's death was reported to the coroner as it 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.

5. 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

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[1] Aspiration pneumonia is a pulmonary infection resulting from the inhalation of bacterial-rich fluids, such as oropharyngeal secretions, particulate matter, or gastric content, into the lower respiratory tract. It predominantly affects older adults, particularly those with advanced age, poor mobility, frailty, and underlying comorbidities, posing significant risks for morbidity and mortality.

[2] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of SW'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] Cervical myelopathy is a form of myelopathy that involves compression of the spinal cord in the cervical spine (neck).

[4] Alzheimer's disease is a physical brain condition resulting in impaired memory, thinking and behaviour, where a person's abilities deteriorate over time.

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.

6. 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.

7. This finding draws on the totality of the coronial investigation into the death of SW including information from the National Disability Insurance Agency (**NDIA**) and the NDIS Quality and Safeguards Commission, as well as a Medical Certificate Cause of Death (**MCCD**) completed by a medical practitioner at Eastern Health. 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.[5]

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

Circumstances in which the death occurred

8. SW's health began to decline in the years prior to his death.

9. On 6 April 2023, SW was admitted to Box Hill Hospital. This admission occurred upon the recommendation of his treating Neurologist and Speech Pathologist. SW was determined to be at risk of aspiration, and he was unable to be appropriately supported at his SDA.

10. On 8 April 2023, SW was transferred to the Wantirna Health Supportive and Palliative Care Unit, where he received comfort care. His condition continued to deteriorate, and he passed away in the early hours of 2 May 2023.

Identity of the deceased

11. On 2 May 2023, SW, born 5 August 1967, was visually identified by Medical Practitioner Dr Vicky Yin via review of medical records and visual identification.

[5] 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.

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

Medical cause of death

13. On 2 May 2023, Medical Practitioner Dr Vicky Yin reviewed SW's complete medical history, conducted an examination on the body and completed a MCCD. Dr Yin provided an opinion that the medical cause of death was aspiration pneumonia, with other significant contributing conditions of cervical myelopathy, Down Syndrome and Alzheimer's Disease.

14. 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.

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

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was SW, born 5 August 1967;

    b) the death occurred on 2 May 2023 at Eastern Health, Wantirna Health Supportive and Palliative Care Unit, 251 Mountain Highway, Victoria 3152, from aspiration pneumonia in the setting of cervical myelopathy, Down Syndrome and Alzheimer's Disease; and

    c) the death occurred in the circumstances described above.

17. 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 Eastern Health, that caused or contributed to SW's death.

18. Having considered all the available evidence, I find that SW'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 his death and to finalise the investigation of SW's death in chambers.

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

JM, Senior Next of Kin

Life Without Barriers

Eastern Health

Signature:

Date: 8 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.