IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004849

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:	Luke McCormack
Date of birth:	14 March 1974
Date of death:	18 January 2023
Cause of death:	1(a) Aspiration pneumonia
Place of death:	Northern Hospital 185 Cooper Street Epping Victoria 3076
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 18 January 2023, Luke McCormack (**Mr McCormack**) was 48 years old when he died at Northern Hospital following an aspiration event.

2. At the time of his death, Mr McCormack was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by Life Without Barriers located in Mill Park.

3. Mr McCormack lived at the Mill Park accommodation since he was 18 years of age. He received support due to his epilepsy, causing seizures. Mr McCormack was at risk of aspiration and had two previous admissions to Northern Hospital on account of pneumonia in 2012 and 2016. He was supported by his mother, Maureen, father, Peter, and siblings. He found enjoyment by participating in programs at his accommodation, and when engaging with his community.

THE CORONIAL INVESTIGATION

1. Mr McCormack's 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

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

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 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 Luke McCormack, 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 Northern 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. On 6 January 2023, disability support workers noticed Mr McCormack had a mild cough and a runny nose. He was taken to visit a general medical practitioner (**GP**) and was prescribed antibiotics to be commenced the following day.

6. On 7 January 2023, between 8:30 and 9am, Mr McCormack was administered an antibiotic, and soon after, became unsteady on his feet. Carers contacted emergency services and paramedics arrived at around 9:45am. Paramedics advised staff it would take some time for the antibiotics to take effect and instructed them to monitor Mr McCormack over the ensuing days.

7. On 8 January 2023, Mr McCormack's developed a fever, and the nurse-on-call advised staff administer paracetamol and schedule a GP appointment. On 9 January 2023, staff noticed that Mr McCormack had right-sided facial drooping and lip-twitching. They contacted emergency services and Mr McCormack was transported to Northern Hospital via ambulance.

[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.

8. Following assessment, medical practitioners advised Mr McCormack's disability support workers that he had pneumonia and would be admitted. His condition deteriorated and Mr McCormack was transferred to the Intensive Care Unit (**ICU**).

9. On 17 January 2023, medical practitioners met with Mr McCormack's family and discussed his poor prognosis – it was determined to transition him to an end-of-life pathway. On 18 January 2023, Mr McCormack passed away.

Identity of the deceased

10. On 18 January 2023, Luke McCormack, born 14 March 1974, was identified by Medical Practitioner Dr Blake Cooper (**Dr Cooper**), based on his knowledge and relationship.

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

Medical cause of death

12. On 18 January 2023, Medical Practitioner Dr Cooper reviewed Mr McCormack's complete medical history, and from his knowledge of the clinical course completed a MCCD. Dr Cooper provided an opinion that the medical cause of death was aspiration pneumonia.

13. On 18 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 Cooper'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 Luke McCormack, born 14 March 1974;

    b) the death occurred on 18 January 2023 at Northern Health 185 Cooper Street, Epping, Victoria 3076 from aspiration pneumonia; 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 Northern Hospital, that caused or contributed to Mr McCormack's death.

17. Having considered all the available evidence, I find that Mr McCormack'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 Mr McCormack's death in chambers.

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

Mr Peter McCormack, Senior Next of Kin

Ms Mauren McCormack, Senior Next of Kin

Life Without Barriers

Northern Health

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.