IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004854

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:	Louise Spencer
Date of birth:	20 January 1965
Date of death:	22 April 2023
Cause of death:	1(a) Alzheimer's Dementia on a background of Trisomy 21
Place of death:	Austin Hospital, 145 Studley Road, Heidelberg Victoria 3084
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 22 April 2023, Louise Spencer (**Ms Spencer**) was 58 years old when she died at the Austin Hospital following palliation.

2. At the time of her death, Ms Spencer was a National Disability Insurance Scheme (**NDIS**) participant. She received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by the then-Department of Health and Human Services. Ms Spencer was receiving these supports due to an intellectual disability caused by genetic chromosomal anomaly Trisomy 21 (Down Syndrome).

3. Ms Spencer was one of seven siblings. She had regular contact with her siblings, nieces and nephews and was assisted by family members to attend family celebrations, participate in community outings, and make decisions.

THE CORONIAL INVESTIGATION

4. Ms Spencer'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. 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 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.

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

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 Louise Spencer, 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 Austin 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

8. Ms Spencer's physical and mental health had declined in the 12 months prior to her death in the context of a formal diagnosis of Alzheimer's Dementia.

9. On 12 April 2023, Ms Spencer was taken by ambulance under paramedic-administered sedation to the Austin Hospital in the setting of rapid deterioration three days after testing positive for Covid-19 and refusing food, liquids and medication.

10. Ms Spencer was admitted to the Austin Hospital and initially managed in isolation and respiratory wards where she was resistant to therapeutic and nursing interventions.

11. Following consultation between her medical team and family members (including her medical decision maker, Catherine Lefebvre), on 18 April 2023 Ms Spencer was transferred to the Palliative Care Unit of the hospital located in the Olivia Newton-John Cancer Wellness and Research Centre.

12. Ms Spencer remained in the Palliative Care Unit, where she was visited by family members, until her death on the morning of 22 April 2023.

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[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

13. On 22 April 2023, Louise Spencer, born 20 January 1965, was identified by Medical Practitioner Dr Harry Tibballs via review of medical records and visual identification.

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

Medical cause of death

15. On 22 April 2023, Medical Practitioner Dr Harry Tibballs reviewed Ms Spencer's medical history, conducted an examination on the body and completed a MCCD. Dr Tibballs provided an opinion that the medical cause of death was Alzheimer's Dementia on a background of Trisomy 21.

16. 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.

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

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Louise Spencer, born 20 January 1965;

    b) the death occurred on 22 April 2023 at Austin Hospital, 145 Studley Road, Heidelberg in Victoria from Alzheimer's Dementia on a background of Trisomy 21; 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 Austin Hospital, that caused or contributed to Ms Spencer's death.

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

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

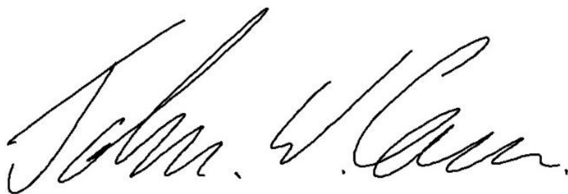
Catherine Lefebvre

Life Without Barriers

Scope

Austin Hospital

Signature:



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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.