IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004812

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:	Michael Ruawai Robin
Date of birth:	18 June 1964
Date of death:	22 June 2023
Cause of death:	1(a) Respiratory failure Contributing factor(s) 2 Paraplegia
Place of death:	Werribee Mercy Hospital, 300 Princes Highway, Werribee, Victoria 3030
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 22 June 2023, Michael Ruawai Robin was 59 years old when he passed away at Werribee Mercy Hospital.

2. At the time of his death, Mr Robin was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by the then-Department of Health and Human Services. Mr Robin was receiving these supports due to paraplegia following an accident about 40 years earlier. He lived with incomplete quadriplegia (C4, C5, and C6) with associated loss of sensation and function below that level of injury including bladder/bowel control issues and body temperature regulation. Mr Robin's medical history also included depression, myocardial infarction, atrial fibrillation, recurrent urinary tract infections and chronic sacral pressure sores.

3. Mr Robin received daily informal support from his sister's partner, Janet, whilst his sister Kathleen, brother Ricky and elderly father provided emotional support. He had twin adult sons who live in Melbourne with their mother.

THE CORONIAL INVESTIGATION

4. Mr Robin'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.

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

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.

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 Michael Ruawai Robin including evidence 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 Werribee Mercy 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. Mr Robin presented to Werribee Mercy Hospital emergency department on 13 June 2023 a rash and a urinary tract infection. On 17 June 223, Mr Robin's condition deteriorated with acute coronary syndrome and decreased oxygen saturation.

9. Mr Robin's health continued to deteriorate with decreased mobility, fluctuating conscious state, increasing shortness of breath and a likely aspiration event. Mr Robin had an advanced care plan in place, so a decision was made to transition him to end of life care. Mr Robin passed away on 22 June 2023.

[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

10. On 22 June 2023, Dr Rami Zaine D Kashgari completed an MCCD in which he identified the deceased as Michael Ruawai Robin, born 18 June 1964.

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

Medical cause of death

12. On 22 June 2023, medical practitioner Dr Rami Zaine D Kashgari completed an MCCD and provided an opinion that the medical cause of death was respiratory failure with paraplegia as a significant contributing factor.

13. On 30 September 2024, a forensic pathologist 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 Kashgari'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 Michael Ruawai Robin, born 18 June 1964;

    b) the death occurred on 22 June 2023 at Werribee Mercy Hospital, 300 Princes Highway Werribee, Victoria 3030, from respiratory failure, with paraplegia as a significant contributing factor; 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 Werribee Mercy Hospital, that caused or contributed to Mr Robin's death.

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

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

Penny Robin, Senior Next of Kin

Mercy Health

Signature:

Date: 27 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.