IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004814

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:	James Van Wyk
Date of birth:	19 December 1957
Date of death:	30 July 2023
Cause of death:	1(a) Metastatic Lung Cancer
Place of death:	Monash Medical Centre, Clayton
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 30 July 2023, James Van Wyk (**Mr Van Wyk**) was 65 years old he died at Monash Medical Centre from metastatic lung cancer.

2. At the time of his death, Mr Van Wyk 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 in Cranbourne.

3. Mr Van Wyk had lived at this accommodation for over 10 years and got along well with the other four residents. He was very independent and attended a day program four days a week. He also had 1:1 support on Wednesdays to go out in the community to attend places of interest.

4. Mr Van Wyk had two brothers: one in Geelong and one in Canberra. He enjoyed visiting his brother and sister-in-law in Geelong on special occasions.

THE CORONIAL INVESTIGATION

5. Mr Van Wyk'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.

6. 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.

7. 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 the 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.

8. 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.

9. This finding draws on the totality of the coronial investigation into the death of James Van Wyk, 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 Monash Medical Centre.

10. 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

11. On 16 July 2023, Mr Van Wyk was conveyed to hospital after reporting difficulty breathing and that he was in pain. He was admitted to Casey Hospital for review and was diagnosed with a *pleural effusion*, fluid in the chest outside of the lungs. Subsequent testing identified cancerous cells and clinicians suspected that Mr Van Wyk had lung cancer. Clinicians also noted that Mr Van Wyk was a non-smoker.

12. On 20 July 2023, Mr Van Wyk was transferred to Monash Medical Centre for further review and consultation with the oncology team. This confirmed a diagnosis of lung cancer with metastatic spread to his bones.

13. On 28 July 2023, after discussion with his family, a decision was made to not pursue chemotherapy, and a referral was made to a palliative care team with the aim of transferring Mr Van Wyk back home with palliative care.

[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.

14. On 30 July 2023, while still in hospital, Mr Van Wyk deteriorated and went into cardiac arrest. He was unable to be revived.

Identity of the deceased

15. On 26 December 2022, James Van Wyk, born 19 December 1957, was identified by Medical Practitioner Dr Isaac Sullivan via review of medical records.

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

Medical cause of death

17. On 30 July 2023, Medical Practitioner Dr Isaac Sullivan reviewed Mr Van Wyk's complete medical history, conducted an examination on the body and completed a MCCD. Dr Sullivan provided an opinion that the medical cause of death was metastatic lung cancer.

18. 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.

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

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was James Van Wyk born 19 December 1957;

    b) the death occurred on 30 July 2023 at Monash Medical Centre, Clayton, from metastatic lung cancer; and,

    c) the death occurred in the circumstances described above.

21. 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 Monash Medical Centre, that caused or contributed to Mr Van Wyk's death.

22. Having considered all the available evidence, I find that Mr Van Wyk'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 the death and to finalise the investigation of Mr Van Wyk's death in chambers.

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

Signature:

Date : 9 December 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.