IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004842

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:	David Chrystie Hall
Date of birth:	29 July 1977
Date of death:	16 March 2023
Cause of death:	1(a) Cardiac arrest 1(b) Hypoxia 1(c) Aspiration event 2 Small bowel obstruction
Place of death:	Monash Medical Centre, Monash Health, 246 Clayton Road, Clayton VIC 3168
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 16 March 2023, David Chrystie Hall (**Mr Hall**) was 45 years old when he died at Monash Medical Centre following a cardiac arrest, hypoxia and aspiration event.

2. At the time of his death, Mr Hall was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by Villa Maria Catholic Homes.

3. Mr Hall at the time of his passing was residing with five other residents in a group home managed by Villa Maria Catholic Homes. He had lived there since he was 18 years old and had been very happy residing there. He was visited by his family regularly on the weekends and he enjoyed spending time with them and going out in the community. He particularly enjoyed special occasions, including his birthday which his mother, stepfather and cousins made a great celebration each year. Five days a week Mr Hall attended a program run by Scope and he particularly enjoyed swimming as he loved the water and the muscle strength development that it provided. He particularly enjoyed listening to music, being outdoors and experiencing the breeze and the sounds from the birds and wildlife.

THE CORONIAL INVESTIGATION

4. Mr Hall'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.

[1] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Mr Hall'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 David Chrystie Hall, 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. 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 Hall attended his GP on 14 March 2023 because of a change in appetite, lethargy and increased vocalisation indicating that he was in pain. He was diagnosed with haemorrhoids and prescribed Panadol, zinc and lignocaine. The GP advised that if his condition continued to deteriorate that further medical attention should be sought.

9. Mr Hall was supported at his SDA up until the morning of 15 March 2023 when he was observed with breathing difficulties. As a consequence, urgent medical attention was sought and Ambulance Victoria requested and approximately 10.30am Mr Hall was transported to Monash Medical Centre for treatment.

[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.

10. Despite ongoing assessment and treatment, Mr Hall's condition continued to deteriorate and he passed away at 12.45am on 16 March 2023.

Identity of the deceased

11. On 16 March 2023, David Chrystie Hall, born 29 July 1977, was identified by Medical Practitioner Dr Meng Chia via medical records review and visual identification.

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

Medical cause of death

13. On 16 March 2023, Medical Practitioner Dr Meng Chia reviewed Mr Hall's complete medical history, conducted an examination on the body and completed a MCCD. Dr Chia provided an opinion that the medical cause of death was a combination of a cardiac arrest, hypoxia and aspiration with other significant contributing condition of a small bowel obstruction.

14. 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.

15. I accept Dr Chia'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 David Chrystie Hall, born 29 July 1977;

    b) the death occurred on 16 March 2023 at Monash Medical Centre, Monash Health, Clayton in Victoria from a combination of a cardiac arrest, hypoxia and aspiration in the setting of a small bowel obstruction;

    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 Monash Medical Centre, that caused or contributed to Mr Hall's death.

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

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

20. 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.

21. I direct that a copy of this finding be provided to the following:

    a) Ruth Hopkins, Senior Next of Kin

    b) Villa Maria Catholic Homes

    c) Monash Medical Centre, Monash Health

Signature:

Date : 29 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.