IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004845

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:	Paul Philpott
Date of birth:	25 May 1964
Date of death:	7 April 2023
Cause of death:	1(a) Aspiration pneumonia 2(a) Recurrent aspiration pneumonia 2(b) Heart failure
Place of death:	Olivia Newton John Palliative Care Unit, Austin Hospital, Heidelberg VIC 3084
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 7 April 2023, Paul Philpott (**Mr Philpott**) was 58 years old when he died at the Olivia Newton John Palliative Care Unit, Austin Hospital, Heidelberg from aspiration pneumonia.

2. At the time of his death, Mr Philpott 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 (formerly the Department of Health and Human Services). At the time of his birth Mr Philpott had been diagnosed with Down's Syndrome.

3. Mr Philpott had been living in the same supported accommodation since 1996. He was very happy and got along extremely well with the four other males he shared with. He attended a daily program throughout the week where he enjoyed activities including music, art, woodwork and volunteering at a nursing home. He was described as gentle and sociable and had a very supportive family who visited as often as they could. He had a packed social calendar including attending drama on Monday nights, personal training on Wednesdays and disco on Thursdays.

THE CORONIAL INVESTIGATION

4. Mr Philpott'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 Philpott'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 Paul Philpott 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 the Olivia Newton John Palliative Care Unit, 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. Mr Philpott was born with Down's Syndrome. On 28 March 2023 he was located within his bed at his Life Without Barriers SDA dwelling. Mr Philpott had vomited and was non-responsive to staff. He was transported to Austin Hospital and treated before being transferred on 3 April 2023 to the Olivia Newton John Palliative Care Unit where he passed away four days later on 7 April 2023.

Identity of the deceased

9. On 7 April 2023, Paul Philpott, born 25 May 1964, was identified by Medical Practitioner Dr Jack O'Shaughnessy via medical records review and visual identification.

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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.

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

Medical cause of death

11. On 7 April 2023, Medical Practitioner Dr Jack O’Shaughnessy reviewed Mr Philpott’s complete medical history, conducted an examination on the body and completed a MCCD. Dr O’Shaughnessy provided an opinion that the medical cause of death was aspiration pneumonia in the setting of recurrent aspiration pneumonia and heart failure.

12. 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.

13. I accept Dr O’Shaughnessy’s opinion and am satisfied that the death was due to natural causes.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Paul Philpott, born 25 May 1964;

    b) the death occurred on 7 April 2023 at the Olivia Newton John Palliative Care Unit, Austin Hospital, Heidelberg in Victoria from aspiration pneumonia in the setting of recurrent aspiration pneumonia and heart failure;

    c) the death occurred in the circumstances described above.

15. 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 the Olivia Newton John Palliative Care Unit, Austin Health that caused or contributed to Mr Philpott’s death.

16. Having considered all the available evidence, I find that Mr Philpott’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 Philpott’s death in chambers.

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

18. 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.

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

    a) Ian Philpott, Senior Next of Kin

    b) Life Without Barriers

    c) Olivia Newton John Palliative Care Unit, Austin Health

Signature:

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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.