IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2024 004861**

# FINDING INTO DEATH WITHOUT INQUEST

*Form 38 Rule 63(2)*

*Section 67 of the **Coroners Act 2008***

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| Findings of: | Judge John Cain, State Coroner |
| Deceased: | Giulia Nesci |
| Date of birth: | 4 June 1993 |
| Date of death: | 25 July 2023 |
| Cause of death: | 1(a) Aspiration pneumonia<br>1(b) Small bowel obstruction<br>2 Rett Syndrome |
| Place of death: | Monash Medical Centre<br>246 Clayton Road<br>Clayton Victoria 3168 |
| Keywords: | Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes |

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## INTRODUCTION

1. On 25 July 2023, Ms Giulia Nesci was 30 years old when she died at Monash Medical Centre following an aspiration event.

2. Shortly before Ms Nesci's death, she moved into an enrolled Specialist Disability Accommodation (**SDA**) dwelling[1] in Mordialloc that was funded through her National Disability Insurance Scheme (**NDIS**) plan. Prior to this, she had lived and was cared for by her mother. Her father and sister visited regularly.

3. Ms Nesci was receiving support due to her diagnosis of Rett Syndrome which is a complex and rare neurological disorder resulting in a progressive loss of motor skills and language.

4. Ms Nesci attended the Central Bayside Day Program in Cheltenham three days a week. She loved being spending time with her friends and family as well as listening to music.

## THE CORONIAL INVESTIGATION

5. Ms Nesci'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 she was a 'person placed in custody or care' within the meaning of section 4 of the Act, as she was a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling immediately prior to her 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 Ms Nesci'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.

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 Ms Nesci including information from the National Disability Insurance Agency (**NDIA**), the NDIS Quality and Safeguard Commission as well as the 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

10. On 7 July 2023, Ms Nesci was admitted to Monash Medical Centre due to declining health in the setting of an aspiration event. Aspiration happens when food, liquid, or other material enters a person's airway and eventually the lungs, by accident. It can happen when a person has trouble swallowing normally and can lead to serious health issues such as pneumonia.

11. Despite treatment, Ms Nesci's condition continued to deteriorate, and she passed away nine days later on 25 July 2023.

### Identity of the deceased

12. On 25 July 2023, Ms Nesci, born 4 June 1993, was visually identified by Medical Practitioner Dr Jackey Guo via review of medical records and visual identification.

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

[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.

**Medical cause of death**

14. On 25 July 2023, Dr Jackey Guo reviewed Ms Nesci's complete medical history and completed a MCCD. Dr Guo provided an opinion that the medical cause of death was an aspiration event, with other significant contributing conditions including a small bowel obstruction and Rett syndrome.

15. 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.

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

## FINDINGS AND CONCLUSION

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

    a. the identity of the deceased was Ms Giulia Nesci, born 4 June 1993;

    b. the death occurred on 25 July 2023 at Monash Medical Centre, 246 Clayton Road, Clayton in Victoria from aspiration pneumonia in the setting of a small bowl obstruction and Rett syndrome; and

    c. the death occurred in the circumstances described above.

18. The available evidence does not support a finding that there was any want of clinician management or care on part of the SIL provider or clinical staff at Monash Medical Centre that caused or contributed to Ms Nesci's death.

19. Having considered all of the available evidence, I find that Ms Nesci'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 Nesci's death in chambers.

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

Ursula Nesci, Senior Next of Kin

Scope (Australia) Limited

Monash Medical Centre

Signature:


Date: 2 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.