



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004862

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:	Jannene Wilson
Date of birth:	30 November 1963
Date of death:	19 September 2023
Cause of death:	1(a) Urosepsis 2 Multiple Sclerosis
Place of death:	Alfred Health 75 Commercial Road Melbourne Victoria 3004
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 19 September 2023, Jannene Wilson was 59 years old when she died at Alfred Hospital after experiencing a deterioration in health associated with her disability.
2. At the time of her death, Ms Wilson, was a National Disability Insurance Scheme (**NDIS**) participant and received funding to reside in an enrolled Specialist Disability Accommodation (**SDA**) dwelling¹. Ms Wilson had been living in McKinnon for approximately eight years and required support in all aspects of daily life due to limited mobility in the context of multiple sclerosis.

THE CORONIAL INVESTIGATION

1. Ms Wilson's death 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 the Act, as a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling immediately prior to her 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.
2. 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.
3. 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

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

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

4. This finding draws on the totality of the coronial investigation into the death of Jannene Wilson, including information from the National Disability Insurance Agency (NDIA) and the NDIS Quality and Safety Commission, as well as a Medical Certificate Cause of Death (MCCD) completed by a medical practitioner at Alfred 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

5. On 13 September 2023 Ms Wilson began complaining of abdominal pain and nausea. Ms Wilson was transported to the Alfred Hospital via Complex Patient Ambulance Vehicle.
6. Ms Wilson remained in hospital for several days however after experiencing a further deterioration in her health, she passed away six days later, on 19 September 2023.

Identity of the deceased

7. On 19 September 2023 Ms Jannene Wilson, born 30 November 1963, was identified by Medical Practitioner, Dr Nina Murphy via review of medical records and visual identification.
8. Identity is not in dispute and requires no further investigation.

Medical cause of death

9. On 19 September 2023, Medical Practitioner Dr Murphy reviewed Ms Wilson's complete medical history, conducted an examination on the body and completed a MCCD. Dr Murphy provided an opinion that the medical cause of death was urosepsis, with other significant contributing conditions of multiple sclerosis.

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. 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.
11. I accept Dr Mr Murphy's opinion, and am satisfied that the death was due to natural causes.

FINDINGS AND CONCLUSION

12. Pursuant to section 67(1) of the Act I make the following findings:
 - a) the identity of the deceased was Jannene Wilson, born 30 November 1963;
 - b) the death occurred on 19 September 2023 at Alfred Health, 75 Commercial Road Melbourne Victoria 3004, from urosepsis in the setting of multiple sclerosis; and
 - c) the death occurred in the circumstances described above.
3. 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 Alfred Hospital, that caused or contributed to Ms Wilson's death.
4. Having considered all the available evidence, I find that Ms Wilson'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 Wilson's death in chambers.

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

Pamela Kirkham, Senior Next of Kin

Multiple Sclerosis Australia Ltd

Australian Home Care Services Pty Ltd

Alfred Hospital

Signature:



John W. Carr



Date: 5 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.
