IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004866

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:	Donald Charleson
Date of birth:	14 March 1954
Date of death:	29 January 2023
Cause of death:	1(a) pneumonia 2 metastatic malignancy of unknown primary, likely bowel
Place of death:	Monash Medical Centre, 246 Clayton Rd, Clayton Victoria 3168
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 29 January 2023, Donald Charleson (**Mr Charleson**) was 68 years old when he died at the Monash Medical Centre following a nine-day admission for pneumonia.

2. At the time of his death, Mr Charleson 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. Mr Charleson was receiving these supports due to epilepsy.

3. Mr Charleson had three brothers, Laurie, Christopher, and Peter, as well as one sister, Margaret. He enjoyed going to the Malvern library either every Wednesday or second Wednesday with his brother Laurie to borrow books, with a particular interest in Russian history. Mr Charleson also enjoyed visits from family, going to the cinema, musicals, classical music, cooking, reading and art.

4. In December 2022, Mr Charleson was diagnosed with metastatic malignancy of unknown origin although thought to be from the bowel. On the advice of his general practitioner (**GP**) and in accordance with the wishes of Mr Charleson, the cancer was managed conservatively, and chemotherapy and radiation treatment were withheld.

THE CORONIAL INVESTIGATION

5. Donald Charleson'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.

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

6. 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.

7. 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.

8. This finding draws on the totality of the coronial investigation into the death of Donald Charleson, 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

9. On 19 January 2023, Mr Charleson's became unwell at his SDA operated by Scope in Hampton East. He experienced vomiting and shortness of breath and complained of a "big pain" to staff while pointing to the right side of his chest below his ribcage. Staff contacted emergency services and Mr Charleson was conveyed to the Monash Medical Centre in Clayton.

10. Investigations in hospital revealed Mr Charleson had developed pneumonia. Intravenous antibiotics were commenced however Mr Charleson's condition continued to decline over the coming days. He remained in hospital until he passed away at approximately 5.15 am on 29 January 2023.

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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.

Identity of the deceased

11. On 29 January 2023, Donald Charleson, born 14 March 1954, was identified by Medical Practitioner Dr Rahul Panchal via review of medical records and visual identification.

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

Medical cause of death

13. On 29 January 2023, Medical Practitioner Dr Rahul Panchal reviewed Mr Charleson's complete medical history and completed a MCCD. Dr Panchal provided an opinion that the medical cause of death was pneumonia, with other significant contributing conditions noted as metastatic malignancy of unknown primary, likely bowel.

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 Panchal'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 Donald Charleson, born 14 March 1954;

    b) the death occurred on 29 January 2023 at Monash Medical Centre, 246 Clayton Rd, Clayton Victoria 3168 from pneumonia in the setting of metastatic malignancy of unknown primary, likely bowel; and

    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 Charleson's death.

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

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

Laurie Charleson, Senior Next of Kin

Scope (Aust) Limited

Monash Health

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.