IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004848

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Amended pursuant to Section 76 of the Coroners Act 2008 on 14 January 2025[1]

Findings of:	Judge John Cain, State Coroner
Deceased:	Maria Susan O'Rafferty
Date of birth:	11 August 1960
Date of death:	26 November 2022
Cause of death:	1a : END-STAGE ALZHEIMER'S TYPE DEMENTIA 2 : TRISOMY 21
Place of death:	Geelong Hospital 272-322 Ryrie Street Geelong Victoria 3220
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

[1] This version is an amended version of the Finding into the death of Maria Susan O'Rafferty dated 9 December 2024, amended to reflect Ms O'Rafferty's correct surname in paragraph 10.

INTRODUCTION

1. On 26 November 2022, Maria Susan O'Rafferty (**Ms O'Rafferty**) was 62 years old when she died at University Hospital Geelong following a short admission.

2. At the time of her death, Ms O'Rafferty was a National Disability Insurance Scheme (**NDIS**) participant. She received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[2] provided by the then-Department of Health and Human Services in Geelong West.

3. Ms O'Rafferty was born with Trisomy 21 – colloquially referred to as *'Down Syndrome'* – and had lived at the Geelong West facility for approximately 30 years. She received support with her daily living activities and had formed great relationships with her carers. She enjoyed socialising, excursions and being pampered including by hand massages and manicures.

4. In the years prior to her death, Ms O'Rafferty experienced a decline in her mobility and the onset of Alzheimer's type dementia. She was supported by her sister, Lynne O'Rafferty, who would frequently visit her.

THE CORONIAL INVESTIGATION

1. Ms O'Rafferty'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

[2] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Ms O'Rafferty'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.

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 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 Maria Susan O'Rafferty, 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 University Hospital Geelong. 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.[3]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

5. On 18 November 2022, Ms O'Rafferty was admitted to University Hospital Geelong, given that she was not eating or drinking.

6. Following assessment by medical practitioners, they determined to execute a palliative care plan and organise for Ms O'Rafferty to return to her SDA. However, her condition deteriorated and hospital staff contacted her disability support workers as family could not attend the hospital to visit.

7. Ms O'Rafferty's carers visited her and she passed away on 26 November 2022.

Identity of the deceased

8. On 27 November 2022, Maria Susan O'Rafferty, born 11 August 1960, was identified by Medical Practitioner Dr Alina Derkach (**Dr Derkach**) via review of medical records.

[3] 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.

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

Medical cause of death

10. On 27 November 2022, Medical Practitioner Dr Derkach reviewed Ms O'Rafferty's complete medical history, conducted an examination on the body and completed a MCCD. Dr Derkach provided an opinion that the medical cause of death was end-stage Alzheimer's type dementia with an antecedent cause of Trisomy 21.

11. 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.

12. I accept Dr Derkach's opinion, and am satisfied that the death was due to natural causes.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Maria Susan O'Rafferty, born 11 August 1960;

    b) the death occurred on 26 November 2022 at Geelong Hospital 272-322 Ryrie Street, Geelong, Victoria 3220, from end-stage Alzheimer's type dementia with a significant contributing condition of Trisomy 21; and,

    c) the death occurred in the circumstances described above.

14. 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 University Hospital Geelong, that caused or contributed to Ms O'Rafferty's death.

15. Having considered all the available evidence, I find that Ms O'Rafferty'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 O'Rafferty's death in chambers.

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

Ms Lynne O'Rafferty, Senior Next of Kin

Scope Australia

Barwon Health

Signature:

Judge John Cain, State Coroner
Date: 14 January 2025

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.