IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 005700

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Jacqui Hawkins
Deceased:	Maria Assunta Agius
Date of birth:	4 April 1962
Date of death:	12 November 2018
Cause of death:	1(a) Complications of motor neuron disease
Place of death:	335 Clarendon Street, Thornbury, Victoria, 3071

INTRODUCTION

1. On 12 November 2018, Maria Assunta Agius was 56 years old when she died from complications of motor neuron disease, which she had been diagnosed with in 2014. At the time of her death, Ms Agius lived in supported disability accommodation in Thornbury. Ms Agius used the name 'Marisa' and was rarely known as 'Maria'.

THE CORONIAL INVESTIGATION

2. Ms Agius' death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the Coroner, even if the death appears to have been from natural causes.

3. 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.

4. 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.

5. This finding draws on the totality of the coronial investigation into the death of Ms Agius. 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.[1]

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[1] 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.

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

Circumstances in which the death occurred

6. Ms Agius had worked as a primary school teacher and enjoyed travel. In 2014, she was diagnosed with motor neuron disease (**MND**). MND is a progressive terminal neurological disease that affects the nerves that communicate between the brain and muscles that facilitate movement, speech, and breathing. There is no known cure for MND but supports and treatments are available to improve quality of life.

7. Ms Agius moved to a group home operated by Yooralla to support her care needs. In 2016, Ms Agius had a PEG tube inserted for feeding. She required a ventilator at night and when resting during the day. Ms Agius could no longer communicate verbally, but used an iPad and Eye Gaze to communicate.

8. Ms Agius experienced a decline in her condition in the six months prior to her death. She had an advanced care directive that refused CPR, intubation, tracheostomy, and any interventions that would require sedation or pose excessive discomfort.

9. At 7.35am on 12 November 2018, Ms Agius was observed asleep and breathing. About 25 minutes later she was found unresponsive. An ambulance was called, and paramedics subsequently confirmed that Ms Agius was deceased.

Identity of the deceased

10. On 12 November 2018, Marisa Agius, born 4 April 1962, was visually identified by her nurse, Mary Carbonilla.

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

Medical cause of death

12. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 13 November 2018 and provided a written report of her findings dated 13 November 2018.

13. Dr Baber commented that the post mortem findings were consistent with the clinical history of motor neuron disease.

14. Dr Baber commented that on the available information she was of the view that Ms Agius' death was due to natural causes. Dr Baber provided an opinion that the medical cause of death was 1 (a) Complications of motor neuron disease. I accept Dr Baber's opinion.

DISABILITY SERVICES COMMISSIONER

15. The Disability Services Commissioner (**DSC**) has oversight of certain deaths of persons with disability who are receiving disability supports at the time of their death, including Ms Agius.

16. On 18 March 2021, Samantha Dooley, Acting Deputy Commissioner of the DSC wrote to the court to advise that the DSC had finalised its investigation following the death of Ms Agius. The DSC had found that the disability services provided to Ms Agius were provided in a manner that sufficiently promoted her rights, dignity, wellbeing and safety, and no further action was required.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Maria Assunta Agius, born 4 April 1962;

    (b) the death occurred on 12 November 2018 at 335 Clarendon Street, Thornbury, Victoria, 3071, from complications of motor neuron disease; and

    (c) the death occurred in the circumstances described above.

18. I am satisfied that Ms Agius received appropriate care and support for her disability and declining health.

I convey my sincere condolences to Ms Agius' family for their loss.

ORDERS

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:

Rita Agius, Senior Next of Kin

Signature:

JACQUI HAWKINS

CORONER

Date: 28 June 2021

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.