IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 005097

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Agnes Florence Stewart
Date of birth:	12 November 1940
Date of death:	13 September 2020
Cause of death:	1(a) Left neck metastatic malignancy of unknown primary source
Place of death:	Northeast Health, Wangaratta Hospital, 35-47 Green Street, Wangaratta, Victoria, 3677
Keywords:	Natural causes, Specialist Disability Accommodation

INTRODUCTION

1. On 13 September 2020, Agnes Florence Stewart (Ms Stewart) was 79 years old when she passed away at Wangaratta Hospital. At the time of her death, Ms Stewart lived in a group home at 7-11 Larkins Street, Wangaratta, where she had been a resident since the 1980s.

2. The group home is managed by Scope Australia (also known as Home@Scope). It was previously managed by the Department of Health and Human Services[1] (**DHHS**) until 26 May 2019.

3. Ms Stewart's hobby was knitting and crocheting. She was described as having a great sense of humour and enjoyed participating in community visits.

4. Ms Stewart was born with a mild intellectual disability. Her medical history included arthritis, dysphagia, hypertension, hypothyroidism, faecal and urine incontinence, Parkinson's disease and schizophrenia.

5. Ms Stewart underwent a total hip replacement in 1999 and became primarily dependent on a wheelchair to ambulate.

THE CORONIAL INVESTIGATION

6. Ms Stewart's 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. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.[2]

7. Although Ms Stewart was not a person considered to be 'in care' pursuant to section 3(1) of the Act, she was a Specialist Disability Accommodation (**SDA**) resident living in an SDA-enrolled dwelling at the time of her death.

[1] Currently the Department of Families, Fairness and Housing (**DFFH**).
[2] See the definition of "reportable death" in section 4 of the *Coroners Act 2008*, especially section 4(2)(c) and the definition of "person placed in custody or care" in section 3 of the Act.

8. The Coroners Regulations 2019 were amended on 11 October 2022 to create a new category of person considered to be 'in care' under Regulation 7 of the Coroners Regulations 2019, being a 'person in Victoria who is an SDA resident residing in an SDA enrolled dwelling'. The amendments also introduced an associated reporting obligation under Regulation 8 for a person who: (ii) is funded to provide an SDA resident with daily independent living support; and (ii) has reasonable grounds to believe that the resident's death has not been reported to a coroner or the Institute.

9. While Ms Stewart was not formally 'in care' at the time of her passing on 13 September 2020, she was an SDA resident residing in an SDA-enrolled dwelling at the time of her passing. If reported today, her death would be considered to be an 'in care' death that requires additional steps be taken in the coronial process, including that an inquest (public hearing) be held unless the Coroner considers the death was due to natural causes, and that the findings be published.

10. 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.

11. This finding draws on the totality of the coronial investigation into the death of Agnes Florence Stewart. 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

12. In April 2020, disability support staff noticed a lesion on the left side of Ms Stewart's neck. The biopsy result came back in late May 2020 where the lesion was determined to be cancerous.

[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.

13. In early June 2020, following discussions with her family, the general medical practitioner and Wangaratta Health palliative care, it was decided that disability support staff at the group home would provide Ms Stewart comfort care as long as they could.

14. Outpatient palliative care was also arranged to manage her pain, with an ultimate plan where Ms Stewart be transferred to inpatient palliative care once her level of comfort care exceeded the group home capabilities of providing comfort care.

15. On 21 June 2020, Ms Stewart told disability support staff that she was unwell. Staff noticed she was *"shaking, unable to stand up [and was] breathing differently"*. She was immediately conveyed to Wangaratta Hospital Emergency Department, and admitted swiftly.

16. During admission, Ms Stewart was diagnosed with sepsis and administered antibiotics.

17. On 24 June 2020, Ms Stewart's condition resolved, and she was discharged back to the group home.

18. In the middle of July, Ms Stewart's health began to deteriorate. Staff noted her appetite became poor, and she was unable to swallow. Given her overall poor health condition, it was decided that her care could no longer be provided at the group home.

19. On the evening of 29 July 2020, Ms Stewart was admitted to Wangaratta Hospital, and her admission diagnosis was *"non-operable invasive neck malignancy"*. Palliative care was commenced shortly afterwards.

20. Ms Stewart remained in palliative care throughout August and September 2020. She passed away on 13 September 2020.

Identity of the deceased

21. On 13 September 2020, Agnes Florence Stewart, born 12 November 1940, was visually identified by Richard Kendall, a group home disability support-staff worker.

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

Medical cause of death

23. On 15 September 2020, Forensic Pathologist Dr Brian Beer from the Victorian Institute of Forensic Medicine conducted an examination and provided a written report of his findings dated 30 September 2020.

24. Dr Beer noted the post-mortem examination revealed findings in keeping with Ms Stewart's clinical history. Post-mortem computed tomography scanning revealed right total hip replacement, a large invasive soft tissue mass on the left of her neck, fatty liver and non-specific lung markings.

25. Dr Beer provided an opinion that the manner of Ms Stewart's death was due to natural causes, and provided a medical cause of death as 1 (a) left neck metastatic malignancy of unknown primary source.

INVESTIGATIONS

26. At the inception of the coronial investigation into Ms Stewart's death, I became aware of the Disability Services Commissioner's (**DSC**) parallel investigation into the circumstances of Ms Stewart's death.

27. Pursuant to section 7(a) of the Act, a Coroner should liaise with other investigation bodies to avoid unnecessary duplication of investigations and inquiries. Accordingly, the coronial investigation was held in abeyance pending the DSC's review.

28. The DSC conducted a review of the service provision by Home@Scope to Ms Stewart. The DSC review has a different scope than a coronial investigation, although it can sometimes overlap. The DSC's jurisdiction expands to the services provided to persons who received disability services during their lifetime, whether those services are connected with death[4].

29. On 23 September 2020, the DSC commenced its review into disability services provided by Home@Scope and requested that Home@Scope conduct an internal review as part of the investigation.

30. Following the review, Home@Scope advised the DSC that they identified the following issues in relation to the service provision to Ms Stewart, as well as action plans to be taken in response to those issues:

    (i) Mealtime management risk

    Home@Scope conceded that while Ms Stewart had a mealtime management plan in place, it was not developed by a qualified speech pathologist. Home@Scope also conceded that a

[4] As opposed to a coroner's jurisdiction where a coronial investigation is limited to surrounding circumstances of death, which are limited to events that are sufficiently proximate and causally related to the death.

further reassessment was not fulfilled in the lead up to Ms Stewart's death when her mealtime abilities no longer meet her plan.

Home@Scope advised the DSC that the action plan is to review all group home residents' records to ensure residents with dysphagia are assessed by a speech pathologist and to ensure all mealtime management plans and health support needs summaries are up to date.

In addition to conducting Scope Mealtime Management Training across all disability support staff, a team meeting will be convened every three months to discuss resident records review.

(ii) Bowel management

Home@Scope conceded that Ms Stewart did not have a specific health management plan or bowel charting to support her chronic constipation.

Home@Scope advised the DSC that the action plan is to review all group home residents' records to ensure residents with chronic constipation are supported with bowel management plans, bowel charting and constantly updated support need summaries. Similarly, this will be part of the discussion in the team meeting mentioned above,

(iii) Managing specific health conditions

Home@Scope conceded that Ms Stewart did not have other specific health management plan to support her other health conditions.

Home@Scope advised the DSC that the action plan is to review all group home residents' records and health support needs summary to ensure residents with chronic health conditions are supported with specific health management plans for their respective conditions.

Additionally, disability support staff will liaise with family members and relevant healthcare providers to obtain specific health management plans to help manage their residents' specific health conditions.

(iv) Incident reporting

Home@Scope noted Ms Stewart's bruising on her body was reported accordingly in their electronic record system by disability support staff upon discovery in June 2020.

Home@Scope advised the DSC that the action plan is to regularly remind and discuss staff's obligations in incident reporting in the team meeting and to provide staff training on incident reporting.

(v) Record keeping

Home@Scope noted Ms Stewart's body mass index was incorrectly recorded on her Nutrition and Swallowing Issue Checklist.

Home@Scope advised the DSC that the action plan is to discuss proper record-keeping practices in the team meeting.

31. The DSC advised the Court in a letter that Home@Scope's Services and Delivery Team has conducted a document review for all group home residents at the Larkings Street address on 25 November 2020 to implement the proposed actions.

32. The DSC ultimately concluded that it is satisfied with Home@Scope's implementation of service improvements. Given these improvements, it was also determined that no further actions are required by Home@Scope arising out of the issues concerning the service provision to Ms Stewart.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Agnes Florence Stewart, born 12 November 1940;

b) her death occurred on 13 September 2020 at Northeast Health, Wangaratta Hospital, 35-47 Green Street, Wangaratta, Victoria, 3677 from left neck metastatic malignancy of unknown primary source;

c) her death occurred in the circumstances described above.

34. Having considered the outcome of the DSC investigation in the context of the available evidence, I am satisfied that Home@Scope has adequately addressed the issues identified from the DSC investigation. Notwithstanding that these issues were identified, I do not consider that they caused or contributed to Ms Stewart's death.

35. Having regard to the opinion of Dr Beer, I am satisfied that Agnes Florence Stewart died from natural causes.

I convey my sincere condolences to Ms Stewart's family and loved ones for their loss.

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:

Edith Norton, Senior Next of Kin

Disability Services Commissioner

Scope Australia (Home@Scope)

Senior Constable Zachary Griggs, Coroner's Investigator

Signature:

Coroner Kate Despot

Date : 30 July 2026

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.