IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 001680

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Mr C[1]
Date of birth:	[redacted] 1965
Date of death:	[redacted] 2021
Cause of death:	*Ascending cholangitis due to choledocholithiasis*
Place of death:	St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria
Key words:	*In care; Natural causes;*

1. *At the direction of Coroner Sarah Gebert, the name of the deceased and his family members have been replaced with pseudonyms to protect their identities. Identifying dates have also been redacted.*

INTRODUCTION

1. On 3 April 2021, [redacted] (**Mr C**) was 55 years old when he died in hospital following a deterioration in his health.

2. He was diagnosed with Down Syndrome at birth and required assisted living support which was provided through the National Disability Insurance Scheme (**NDIS**). At the time of his death, Mr C was a Specialist Disability Accommodation (**SDA**) resident, residing in an SDA enrolled dwelling in Glenroy.

3. Mr C's parents were both deceased, and he was supported by his house staff daily. He enjoyed going for walks, to the shops and going to the barber. He is survived by his cousin Mr P.

THE CORONIAL INVESTIGATION

4. Mr C'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 the death, the death is reportable even if it appears to have been from natural causes.[1]

5. While Mr C's death was reported to the Coroner, I note that as funding for disability services shifted from the Department of Families Fairness and Housing (**DFFH**) to the NDIS, the definition of a person placed in care in section 3(1) of the Act no longer captured the group of vulnerable people in receipt of disability services as envisaged by the legislation when it was passed. This meant that where the deaths of those people were from natural causes and not otherwise reportable, their deaths and the circumstances in which they died – including the quality of their care – were not subjected to coronial scrutiny despite this cohort being as vulnerable as ever.

6. More recently, on 11 October 2022, this lacuna in the legislation was rectified when amendments to the *Coroners Regulations 2019* came into effect. Sub-regulation 7(1)(d) provides that a person placed in custody or care now includes "*a person in Victoria who is an*

[1] See the definition of '*reportable death'* in section 4 of the *Coroners Act 2008* (**the Act**), especially section 4(2)(c) and the definition of *'person placed in custody or care'* in section 3(1) of the Act.

SDA resident residing in an SDA enrolled dwelling".[2] Mr C would now likely meet the new definition of a person in care under the Act. For this reason, I intend to treat his death as one occurring in care, and I will publish this finding in accordance with the rules.

7. 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.

8. 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.

9. Victoria Police assigned Senior Constable Joshua Deschepper (**SC Deschepper**) to be the Coroner's Investigator for the investigation of Mr C's death. SC Deschepper conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

10. This finding draws on the totality of the coronial investigation into the death of Mr C including evidence contained in the coronial brief. 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]

BACKGROUND

11. Mr C's clinicians reported that he was a complex patient who suffered from Down Syndrome, Alzheimer's disease, depression with self-harm tendencies, hypothyroidism,

[2] SDA resident' has the same meaning as in the *Residential Tenancies Act 1997* (Vic) and captures a person who is an SDA recipient (that is, an NDIS participant who is funded to reside in an SDA enrolled dwelling). 'SDA enrolled dwelling' also has the same meaning as in the *Residential Tenancies Act 1997* and is defined as a: *"long-term accommodation for one or more SDA resident and enrolled as an SDA dwelling under the National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016 of the Commonwealth as in force from time to time or under other rules made under the National Disability Insurance Scheme Act 2013 of the Commonwealth."*

[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.

hypertension and cardiac dysfunction, gout, asthma, sleep apnoea and mild cataract with myopia.

12. He was reportedly very resistant to attending doctor's clinics and hospitals and would become extremely distressed and hostile in those environments. His General Practitioner (**GP**) would often assess him while he was seated in the car with his carer, as Mr C felt more comfortable in familiar environments.

13. In the six months leading up to his passing, Mr C's GP observed physical and mental deconditioning. His carers reported that he declined cognitively in the lead up to his passing.

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

Circumstances in which the death occurred

14. On [redacted] 2021, Mr C was admitted to St Vincent's Hospital (**St Vincent's**) for 19 days for septic shock and pneumonia secondary to ascending cholangitis[4]. He was treated in the Intensive Care Unit (**ICU**) with antibiotics, vasopressors, and biliary tract stenting, before being discharged back to his residence on [redacted] 2021.

15. On [redacted] 2021, Mr C attended St Vincent's again for repeat biliary tract stenting. He was found to be in severe septic shock and many gallstones were noted. Further medication and another biliary stent was required for the biliary sepsis.

16. On [redacted] 2021, Mr C was admitted to St Vincent's under the care of the Intensive Care Unit. It was determined that he was in severe septic shock and was eventually transitioned to comfort care.

17. On [redacted] 2021, Mr C was transferred to palliative care. He sadly passed away the following day on [redacted] 2021.

Identity of the deceased

18. On [redacted] 2021, Mr C, born [redacted] 1965, was visually identified by his cousin, Mr P.

19. Identity was not in dispute and required no further investigation.

[4] A serious condition caused be an ascending bacterial infection in the biliary tree.

Medical cause of death

20. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine conducted an examination on [redacted] 2021 and provided a written report of her findings dated [redacted] 2021.

21. The post-mortem CT scan showed no intracranial abnormality. There was a stent in the common bile duct and intra-abdominal fat stranding, as well as bibasal consolidation.

22. The post-mortem examination did not identify any injuries of a type likely to have caused or contributed to death.

23. Dr Glengarry provided an opinion that the cause of death was *ascending cholangitis due to choledocholithiasis.*

24. I accept Dr Glengarry's opinion as to medical cause of death.

FINDINGS AND CONCLUSION

25. Pursuant to section 67(1) of the Act I make the following findings:

    a) the identity of the deceased was Mr C, born [redacted] 1965;

    b) the death occurred on [redacted] 2021 at St Vincent's Hospital, from *ascending cholangitis due to choledocholithiasis*; and

    c) the death occurred in the circumstances described above.

26. Having considered all of the circumstances, I am satisfied that Mr C's death was due to natural causes, and ultimately a consequence of critical illness.

27. I convey my sincere condolences to Mr C's family and friends for their loss.

28. Pursuant to section 73(1B) of the Act, I order that this finding (redacted) be published on the Coroners Court of Victoria website in accordance with the rules.

29. I direct that a copy of this finding be provided to:

    Mr and Mrs P, Senior Next of Kins

    Ms Donna Filippich, St Vincent's Hospital Melbourne

Dr Al Tawil Ibithal, c/- Mr Alex Donnan, Avant Law Pty Ltd

Senior Constable Joshua Deschepper, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date : 19 June 2023

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.