IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 005643

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	John Rose
Date of birth:	5 December 1963
Date of death:	1 October 2022
Cause of death:	1(a) ASPIRATION PNEUMONIA 1(b) EPILEPSY AND DOWN'S SYNDROME
Place of death:	Sunshine Hospital, Furlong Road, St Albans, Victoria, 3021
Keywords:	In care, disability, epilepsy, Down’s syndrome, aspiration pneumonia, natural causes

INTRODUCTION

1. On 1 October 2022, John Rose was 58 years old when he died at Sunshine Hospital. At the time of his death, Mr Rose lived in specialist disability accommodation provided by Possability in Brookfield, Victoria.

THE CORONIAL INVESTIGATION

2. Mr Rose'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. 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. Since 2019, funding for disability services in Victoria has shifted from the Department of Families, Fairness and Housing to the National Disability Insurance Scheme. This shift meant that the definition of person placed in custody or care in section 3(1) of the Act to include 'a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health' was no longer sufficient to capture the group of vulnerable people in receipt of disability services.

4. The *Coroners Regulations 2019* (Vic) (**the Regulations**) were amended on 11 October 2022 to create a new category of person considered to be 'in care' under Regulation 7, being a 'person in Victoria who is an SDA[1] resident residing in an SDA enrolled dwelling'.

5. Whilst Mr Rose was not 'in care' within the meaning of the Act at the time of his death on 1 October 2022, he was an SDA resident residing in an SDA-enrolled dwelling and the Regulations were amended only 10 days later. If his death had occurred on or after 11 October 2022, he would be a person 'in care' for the purposes of the Act with additional requirements attaching to the coronial process. These include the need for an inquest unless the coroner considers the death was due to natural causes and a requirement that the findings are published.

6. In the circumstances, I have considered it appropriate for the coronial process to proceed as though Mr Rose was a person 'in care' at the time of his death.

---

[1] Specialist Disability Accommodation.

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. This finding draws on the totality of the coronial investigation into the death of Mr Rose. 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

10. Mr Rose was born with epilepsy and Down's syndrome. He was abandoned at birth and lived in specialist disability accommodation. Mr Rose was cared for under a Guardianship Order and had no known family.

11. On 25 September 2022, Mr Rose was admitted to Sunshine Hospital after experiencing epileptic seizures at his residence. He experienced no further seizures whilst an inpatient at the hospital but he was diagnosed with aspiration pneumonia. This was treated with antibiotics but Mr Rose's condition did not improve. Despite treatment efforts, he became increasingly drowsy with worsening blood oxygen desaturation. Mr Rose was subsequently transferred to palliative care and passed away at the Sunshine Hospital on 1 October 2022.

---

[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

12. On 1 October 2022, John Rose, born 5 December 1963, was visually identified by one of his carers, Irene Gruis.

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

Medical cause of death

14. Forensic Pathologist, Dr Yeliena Baber from the Victorian Institute of Forensic Medicine, conducted an examination on 4 October 2022 and provided a written report of her findings dated 23 December 2022.

15. The post-mortem examination showed findings in keeping with the clinical history. A post-mortem computed tomography (CT) scan showed widened lateral ventricles, a full dilated bladder, fatty liver, bilateral lower lobe aspiration pneumonia and no evidence of coronary artery disease or aortic calcification. There were no acute or remote bony injuries.

16. Dr Baber provided an opinion that the medical cause of death was '1 (a) aspiration pneumonia and 1 (b) epilepsy and Down's syndrome' and that the death was due to natural causes.

17. I accept Dr Baber's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was John Rose, born 5 December 1963;

    b) the death occurred on 1 October 2022 at Sunshine Hospital, Furlong Road, St Albans, Victoria, 3021, from aspiration pneumonia, in the setting of epilepsy and down's syndrome; and

    c) the death occurred in the circumstances described above.

19. I am satisfied that the care and medical treatment provided to Mr Rose was appropriate.

I convey my sincere condolences to Mr Rose's carers 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:

Kathleen Stanton, Senior Next of Kin[3]

Lisa Smith, Western Health

First Constable Veronica Teofilo, Coroner's Investigator

Signature:

Coroner Paul Lawrie

Date : 30 November 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.

[3] Kathleen Stanton was one of Mr Rose's carers and, at her request, on 26 October 2022 Coroner Peterson directed that Ms Stanton be made senior next of kin for coronial purposes.