IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 007023

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Kate Despot
Deceased:	Gerard Richard Bailey
Date of birth:	5 May 1959
Date of death:	18 December 2023
Cause of death:	1(a) End stage Alzheimer's Disease 1(b) Trisomy 21
Place of death:	Bendigo Hospital 100 Barnard Street Bendigo, Victoria 3550

Keywords: Supported Disability Accommodation (SDA), In care death, Natural causes

INTRODUCTION

1. On 18 December 2023, Gerard Richard Bailey (**Mr Bailey**) was 64 years old when he died at Bendigo Hospital. At the time of his death, Mr Bailey resided at a Supported Independent Living facility located at 1 Owen Street Woodend, Victoria.

2. Mr Bailey had resided at the Woodend address since 2001 and received care from Supported Disability Accommodation **(SDA)** provider, Possability, and was a recipient under the National Disability Insurance Scheme (**NDIS**).[1]

3. His sister, Helen, and brothers, John and Greg, were in frequent contact with Mr Bailey. He remained *'engaged within his community'* and enjoyed participating in group activities. In his final years, Mr Bailey experienced a progressive decline in his cognitive function and required one-on-one support for all daily tasks.

4. Mr Bailey's medical history included Trisomy 21 (known as Down's Syndrome), Renaurd's Syndrome and Alzheimer's Disease. In late 2023, he began experiencing seizures and on 28 November 2023, he was diagnosed with epilepsy. Mr Bailey was prescribed a daily medication regime to manage his symptoms.[2]

THE CORONIAL INVESTIGATION

5. Mr Bailey's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Generally, 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. [3] Mr Bailey was a *"person placed in custody or care"* pursuant to the definition in section 4 of the Act, as he was *"a prescribed person or a person belonging to a prescribed class of person"* due to his status as an *"SDA resident residing in an SDA enrolled dwelling."*[4]

6. 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

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[1] Court File (**CF**), Statement of Dot Butler and National Disability Insurance Scheme plan.
[2] Ibid.
[3] Section 4(1), (2)(c) of the Act
[4] Pursuant to Reg 7(1)(d) of the *Coroners Regulations 2019*, a *"prescribed person or a prescribed class of person"* includes a person in Victoria who is an *"SDA resident residing in an SDA enrolled dwelling,"* as defined in Reg 5.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. This finding draws on the totality of the coronial investigation into the death of Mr Bailey. 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.[5]

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

Circumstances in which the death occurred

8. On 2 December 2023 at approximately 10:00 am, Mr Bailey experienced three myoclonic seizures lasting approximately one second each. Those episodes continued and at midday, he experienced twelve myoclonic seizures and one Tonic-clonic seizure. Possability staff contacted emergency services. His General Practitioner (**GP**) observed his vital signs. Mr Bailey returned to his residence at 2:10 pm and was *'alert and responsive'*.[6]

9. At 2:13 pm, Mr Bailey had a further series of eight myoclonic seizures over the course of ten minutes, followed by a Tonic-clonic seizure lasting one minute with continued seizure activity for eight minutes.

10. Emergency services were contacted, and he was relayed to Bendigo Hospital.[7]

11. Following his admission in the Emergency Department, Mr Bailey continued to exhibit seizure activity and was administered the sedative agent, midazolam. Medical practitioners consulted with the Neurology Department of Austin Health to determine a course of action.[8]

12. Sadly, Mr Bailey became unresponsive following these episodes and remained hospitalised until his death on 18 December 2023.[9]

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[5] 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.

[6] CF, Statement of Dot Butler.

[7] Ibid.

[8] Ibid.

[9] Ibid.

Identity of the deceased

13. On 18 December 2023, Gerard Richard Bailey, born 5 May 1959, was visually identified by his sister, Ms Helen Dodd.[10]

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

Medical cause of death

15. Senior Forensic Pathologist Dr Michael Burke (**Dr Burke**) from the Victorian Institute of Forensic Medicine, conducted an examination on 20 December 2023 and provided a written report of his findings dated 27 December 2023.[11]

16. Dr Burke provided an opinion that the medical cause of death was due to natural causes, being 1(a) End stage Alzheimer's Disease secondary to 1(b) Trisomy 21.[12]

17. I accept Dr Burke'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 Gerard Richard Bailey, born 5 May 1959;

    b) his death occurred on 18 December 2023 at Bendigo Hospital, 100 Barnard Street Bendigo, Victoria 3550 from end stage Alzheimer's Disease secondary to Trisomy 21; and

    c) his death occurred in the circumstances described above.

19. Having considered all of the circumstances, I am satisfied that Gerard Richard Bailey died due to natural causes.

I convey my sincere condolences to Mr Bailey's family 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.

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[10] CF, Statement of Identification dated 18 December 2023.
[11] CF, Medical Examiner's Report of Dr Michael Burke dated 27 December 2023.
[12] Ibid.

I direct that a copy of this finding be provided to the following:

Ms Helen Dodd, Senior Next of Kin

Mrs Stacy Thackray, Bendigo Health

Senior Constable Carl Burmester, Reporting Member

Signature:

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Coroner Kate Despot

Date: 23 September 2024

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.