IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002197

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	John Mark Robinson
Date of birth:	24 March 1963
Date of death:	9 April 2024
Cause of death:	1(a): Aspiration pneumonia in a man with cerebral palsy
Place of death:	University Hospital (Barwon Health) Bellerine Street Geelong Victoria 3220
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 9 April 2024, Mr John Mark Robinson was 61 years old when he died at University Hospital following an aspiration event.

2. Prior to his death, Mr Robinson resided in Specialist Disability Accommodation (**SDA**)[1] operated by Scope (Aust) Limited. Mr Robinson received funding from the National Disability Insurance Scheme (**NDIS**) due to living with cerebral palsy, an intellectual disability, epilepsy and osteoporosis.

3. Mr Robinson loved listening to the radio and watching movies.

THE CORONIAL INVESTIGATION

4. Mr Robinson's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Mr Robinson was a 'person placed in care' within the Act as he was a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling immediately prior to his death. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

5. 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.

6. 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

[1] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Mr Robinson's death, is a permanent dwelling that provides long-term accommodation for one or more SDA residents, that is enrolled as an SDA dwelling under relevant NDIS (Specialist Disability Accommodation) Rules in force at the relevant time. An SDA resident means a person who is an NDIS participant funded to reside in an SDA enrolled dwelling, or who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program). The definition of SDA resident was amended on 1 July 2024 pursuant to the *Disability and Social Services Regulation Amendment Act 2023* to extend to include persons who are residing, or propose to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. Victoria Police assigned Senior Constable Michael Hageman to be the Coronial Investigator for the investigation of John's death. Senior Constable Hageman conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and Scope – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of Mr John Mark Robinson 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.[2]

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

Circumstances in which the death occurred

9. Mr Robinson's health began to decline in the months prior to his death. He presented to the University Hospital on 29 March 2024 with aspiration pneumonia and functional decline.

10. After discussions with Mr Robinson's brother, end of life care was initiated on 3 April 2024. However, the following day, Mr Robinson began to improve and end of life processes were terminated. Arrangements were made for Mr Robinson to be transported back to his home on 9 April 2024, however on the evening of 9 Aril 2024, Mr Robinson suffered another aspiration event that was not amenable to treatment as Mr Robinson was noted to be not for intubation nor CPU. Mr Robinson died that night.

Identity of the deceased

11. On 24 April 2024, Mr John Mark Robinson, born 24 March 1963, was visually identified by his brother.

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

[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.

Medical cause of death

13. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) performed an external examination on 22 April 2024 and reviewed the Victoria Police Report of Death (Form 83), Medical Deposition from University Hospital and postmortem computed tomography (**CT**) scan. Dr Fronczek provided a written report of her findings dated 23 April 2024.

14. The post-mortem examination revealed findings consistent with Mr Robinson's medical history of cerebral palsy, epilepsy and osteoporosis.

15. Dr Fronczek provided an opinion that the medical cause of death was 1(a) *aspiration pneumonia in a man with cerebral palsy*.

16. I accept and adopt Dr Fronczek's opinion.

FAMILY CONCERNS

17. I acknowledge that Mr Robinson's brother raised concerns about the management of Mr Robinson's attendance at the Scope's Social Connections Day program, given he would often return from the day program feeling fatigued or unwell. Despite the family requesting in January 2024 that Mr Robinson's attendance be limited to two half days, Scope continued to send Mr Robinson five days a week. Mr Robinson's brother therefore believed that the failure to limit Mr Robinson's day program attendance was causal to the aspiration pneumonia.

18. The family also raised concerns about an aspiration event that Mr Robinson experienced several weeks prior to his death due a seizure he suffered while being fed by his carer. They noted that the day before he was hospitalised for two weeks prior to his death, he was experiencing coughing after a day at Scope. The following morning, he was still coughing and staff rolled him onto his side, causing him to bring up significant fluids from his breathing.

19. Having considered all of the available evidence, including the opinion provided by Dr Fronczek, I am not satisfied that the concerns described by Mr Robinson's brother are significantly proximate and therefore causative, or contributory to Mr Robinson's death. The aspiration pneumonia Mr Robinson suffered was recurrent and I cannot establish that he acquired the aspiration pneumonia infection from exposure to a specific environmental condition such as work.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr John Mark Robinson, born 24 March 1963;

    b) The death occurred on 9 April 2024 at Barwon Health, Bellerine Street, Geelong Victoria 3220, from 1(a) aspiration pneumonia in a man with cerebral palsy; and

    c) the death occurred in the circumstances described above.

21. The available evidence does not support a finding that there was a lack of proper clinical management or care on the part of Scope, or Barwon Health, that caused or contributed to Mr Robinson's death.

22. Having considered all of the circumstances, I am satisfied that Mr Robinson's death was from natural causes, and no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death and to finalise the investigation of Mr Robinson's death in chambers.

I convey my sincere condolences to Mr Robinson'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.

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

Russell Robinson, Senior Next of Kin

Senior Constable Michael Hageman, Coronial Investigator

Scope (Aust) Limited

Barwon Health

Signature:

Coroner Leveasque Peterson

Date: 29 August 2025

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.