IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002722

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Brian Leslie Aldridge
Date of birth:	12 March 1967
Date of death:	17 May 2024
Cause of death:	1a: COMPLICATIONS OF DOWN SYNDROME
Place of death:	31a Clark Street Wangaratta Victoria 3677
Keywords:	In care, disability, Specialist Disability Accommodation, SDA, natural causes

INTRODUCTION

1. On 17 May 2024, Brian Leslie Aldridge[1] was 57 years old when he died from natural causes in Specialist Disability Accommodation (**SDA**) provided by Home@Scope in Wangaratta, Victoria.

2. Brian's medical history included down syndrome, cerebral palsy, intellectual disability, hypothyroidism, depression, glaucoma and autism. Brian was non-verbal and he required assistance walking due to a club foot. Scope staff assisted Brian with all daily tasks.

3. Brian required full time support and from the age of 18 years old, he lived in full time supported accommodation. Most recently, Brian lived in an SDA-enrolled dwelling provided by Home@Scope.

4. In September 2022, Brian was diagnosed with Alzheimer's dementia, and his health began to decline. He started losing weight, and staff began to find it difficult to feed him due to frequent choking and significant difficulties with swallowing.

5. Following review by a psychiatrist from the Victorian Dual Disability Service at St Vincent's hospital on 15 August 2023 and discussions with his family, Brian was referred to Northeast Health Wangaratta Palliative Care (**NHW Palliative Care**) for community-based care. NHW Palliative Care first provided palliative support to Brian from 10 September 2023 – 6 March 2024, when he was discharged after assessment that his symptoms were being sufficiently managed and that he was clinically stable.

CORONIAL INVESTIGATION

6. Brian's death fell within the definition of a reportable death in the *Coroners Act 2008* (the Act) as he was a *'person placed in custody or care'* within the meaning of the Act, as a person in Victoria who was an *'SDA resident residing in an SDA enrolled dwelling'* immediately prior to his death.

7. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort, and is reflected in the definition of a *'person placed in custody or care'* in section 3(1) of the Act, read in conjunction with Regulation 7 of the *Coroners Regulations 2019*.

[1] Referred to throughout my finding as 'Brian' unless more formality is required.

8. 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.

9. 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.

10. There is a requirement under section 52(2)(b) of the Act to hold an Inquest into the death of a person who was in custody or care immediately prior to passing, though pursuant to section 52(3A) of the Act, the coroner is not required to hold an Inquest if the coroner considers the death was due to natural causes. I exercise my discretion under this provision not to hold an Inquest in the present case on the basis that Brian's passing was due to natural causes and there are no further issues I have identified that require the hearing of *viva voce* evidence.

11. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Brian's death. The Coronial Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence

12. This finding draws on the totality of the coronial investigation into the death of Brian Leslie Aldridge 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]

[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.

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

Circumstances in which the death occurred

13. Between 29 - 31 March 2024, Brian presented at Wangaratta Hospital Emergency Department on three occasions for constipation. Between 31 March 2024 – 15 April 2024, Brian was admitted to hospital for treatment of his constipation and impaction. During this inpatient stay, Brian began refusing food, fluids and medication and he lost a significant amount of weight.

14. On returning home, Brian's health continued to deteriorate. On 20 April 2024, Brian collapsed at his home, and NHW Palliative Care were re-engaged to provide community-based care. Which they continued to do until his death.

15. On 16 May 2024, Brian was assessed at home by a palliative care nurse to be in a terminal phase of care. The option to admit Brian to Northeast Health Wangaratta was explored, however, there were no available beds. The decision was made to recontact the hospital the following morning.

16. At 6:30am on 17 May 2024, a Scope staff member found Brian deceased in his bed. Emergency services were contacted and resuscitation was not attempted as stated in Brian's advanced care directive. Paramedics declared Brian deceased.

Identity of the deceased

17. On 17 May 2024, Brian Leslie Aldridge, born 12 March 1967, was visually identified by his brother.

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

Medical cause of death

19. On 20 May 2024, Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination and reviewed the post-mortem computed tomography (**CT**) scan and other relevant materials and provided a written report of her findings dated 30 September 2024.

20. The CT scan found brain atrophy, enhanced markings of both lower lung lobes and fatty liver. The post-mortem examination was consistent with Brian's medical history.

21. Dr Fronczek provided an opinion that the medical cause of death was '*1(a) complications of Down's syndrome.'* She also opined that Brian's death was due to natural causes.

22. I accept Dr Fronczek's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Brian Leslie Aldridge, born 12 March 1967;

    b) the death occurred on 17 May 2024 at 31a Clark Street Wangaratta Victoria 3677, from '*1(a) complications of Down syndrome*;' and

    c) the death occurred in the circumstances described above.

24. Taking into account all available information, I am satisfied that Brian died from natural causes, in the setting of multiple health conditions.

25. I am satisfied that the treatment and care provided death was not caused, or contributed to, by any issue in relation to the care and management provided by Home@Scope or by his clinicians, including those from NHW Palliative Care service. Indeed, Brian's sisters recall that the staff at Scope were *"caring and dedicated"* and that the care provided to Brian throughout his life was *"above and beyond."*

26. The factual matrix of Brian's death does not, therefore, support a conclusion that him being 'in care' at the time of his death – according to the Act – had a causal relationship with his death. In such circumstances, I have not identified any opportunities for prevention.

I convey my sincere condolences to Brian's family for their profound loss.

ORDERS AND DIRECTIONS

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:

Kim Gilbert, Senior Next of Kin

Scope Australia Ltd

Dr Syed Shuaib

Senior Constable Joshua Stafford, Coronial Investigator

Signature:

Coroner Ingrid Giles

Date: 30 January 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.