IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 002981

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	Mr SV[1]
Date of birth:	1950
Date of death:	29 May 2024
Cause of death:	1(a) Sepsis complicating pyelonephritis and pseudo large intestinal obstruction (palliated)
Place of death:	Austin Hospital, 145 Studley Road, Heidelberg, Victoria
Key words:	*In care, SDA resident, sepsis, pyelonephritis, intestinal obstruction*

[1] This finding has been deidentified.

INTRODUCTION

1. On 29 May 2024, Mr SV was 74 years old when he passed away in hospital following a decline in health.

2. At the time of his death, Mr SV lived in a Specialist Disability Accommodation, managed by Scope Australia (**Scope**).

THE CORONIAL INVESTIGATION

3. Mr SV'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.[2]

4. 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.

5. 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.

6. Victoria Police assigned Senior Constable Sheldon Malcolm to be the Coroner's Investigator for the investigation of SV's death. The Coroner's Investigator 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.

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[2] 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 of the Act. Regulation 7(1)(d) of the Coroners Regulations 2019 provides that a 'person placed in custody or care' now includes *"a person in Victoria who is an SDA resident residing in an SDA enrolled dwelling"*. '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."*

7. This finding draws on the totality of the coronial investigation into SV's death, 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

8. Mr SV was the eldest of three children to Mr and Mrs V. He was born with an intellectual disability, cleft palate, and speech impediment. Mr SV lived at home with his parents for most of his life. His father passed away in 1975 and, in 2002, his mother developed dementia and was unable to continue caring for Mr SV at home.

9. Mr SV subsequently moved to a residential unit managed by Scope Australia. He initially resided in Moonee Ponds and then moved in 2012. Mr SV was assisted with meals, personal care, and medication administration. Mr SV's sisters visited him at the residential unit regularly.

10. Mr SV continued to attend his day placement at Carinya Society, which he had attended for more than 45 years. He enjoyed social outings such as shopping, group activities, and attending camps. He also loved using his iPad, and playing music.

11. In April 2019, Mr SV was diagnosed with Parkinson's disease which impacted his independence in performing basic tasks for himself.

12. From late 2023, Mr SV's mobility declined, and he required the use of a four-wheel walker and electric wheelchair. In 2024, his overall health began significantly declining and he suffered a fall.

13. According to Scope, Mr SV's medical history also included dysphagia, hypercholesterolemia, constipation, incontinence, eyesight issues, and mild Vitamin D deficiency.

14. Mr SV was admitted to Austin Hospital in February 2024 for decreased mobility and functional decline. His hospital stay was prolonged and complicated by recurrent bowel pseudo-obstruction and sigmoid volvulus complicated by E Coli bacteraemia secondary to

[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.

pyelonephritis. During this period, there were discussions with Mr SV's family about various treatment options and outcomes depending on his condition.

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

Circumstances in which the death occurred

15. On 6 May 2024, Mr SV was transferred to Heidelberg Repatriation Hospital but returned to Austin Hospital the following day due to sepsis complicated by acute kidney injury. According to his sister, Mrs FR, Mr SV became frail during this period, and it was thought his condition was terminal.

16. Mrs FR continued to visit Mr SV in hospital, noting that Mr SV now needed assistance from two staff members to ambulate. It was determined that further medical interventions would not be in Mr SV's best interests.

17. On 24 May 2024, Mr SV transitioned to palliative care. He passed away at 10.45am on 29 May 2024.

Identity of the deceased

18. On 29 May 2024, Mr SV, born 1950, was visually identified by his sister, Mrs FR.

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

Medical cause of death

20. Forensic Pathologist, Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 31 May 2024 and provided a written report of his findings dated 4 June 2024.

21. The post-mortem examination revealed no intracranial haemorrhage or skull fracture, basal lung changes, coronary artery calcification, fatty liver, noticeable air in multiple areas of the bowel wall, probable rectal wall thickening, and marked right hydronephrosis and hydroureter with focal calcification.

22. Dr Bouwer provided an opinion that the medical cause of death was *"1(a) Sepsis complicating pyelonephritis and pseudo large intestinal obstruction (palliated)"* and noted the death was due to natural causes.

23. I accept Dr Bouwer's opinion.

FINDINGS AND CONCLUSION

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

(a) the identity of the deceased was Mr SV, born 1950;

(b) the death occurred on 29 May 2024 at Austin Hospital, 145 Studley Road, Heidelberg, Victoria, from sepsis complicating pyelonephritis and pseudo large intestinal obstruction (palliated); and

(c) the death occurred in the circumstances described above.

I convey my sincere condolences to Mr SV'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:

Mrs FR, senior next of kin
Austin Health
Scope Australia
Senior Constable Sheldon Malcolm, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert
Date: 29 July 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.