IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 003360

**FINDING INTO DEATH WITHOUT INQUEST**

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

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| Findings of: | Sarah Gebert, Coroner |
| Deceased: | JBL |
| Date of birth: | 1950 |
| Date of death: | 16 June 2024 |
| Cause of death: | 1(a) Multiorgan dysfunction in the setting of severe heart failure in a man with multiple medical comorbidities |
| Place of death: | Caulfield Hospital, 260 Kooyong Road, Caulfield, Victoria |
| Key words: | Fragile X syndrome, Barrett's oesophagus, in care |

## INTRODUCTION

1. On 16 June 2024, JBL was 73 years old when he died in hospital following a deterioration in his health.

2. At the time of his death, JBL lived in specialist disability accommodation in Elsternwick managed by Life Without Barriers.

## THE CORONIAL INVESTIGATION

3. JBL'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. 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.[1]

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 Constable Megan Cook to be the Coroner's Investigator for the investigation of JBL'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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[1] 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 JBL'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.[2]

**Background**

8. JBL's medical history included intellectual disability, Fragile X syndrome, Barrett's oesophagus, incontinence, epilepsy, obsessive compulsive disorder, and anxiety.

9. JBL had lived at home until the late 1990s. At about this time, JBL's mother passed away and his father was unable to care for JBL alone.

10. JBL went on to reside at the specialist disability accommodation in Elsternwick with two other residents where he received around the clock care. JBL had a love of music, particularly Elvis, and had previously visited Graceland.

11. JBL's general practitioner, Dr Many Atchison at Brighton Medical Clinic, conducted a comprehensive medical review on 15 May 2023. It was noted that JBL had lost some weight but was otherwise doing well in the context of his medical conditions. Dr Atchison planned to refer JBL for a swallowing review as it was noted JBL was holding food in his cheeks.

12. In the months preceding his death, JBL's mobility became limited, and he began experiencing falls and generalised pain. He also began losing weight, likely partly due to his dislike of his pureed diet on which he had been placed during a hospital admission in mid-2023 following a bout of aspiration pneumonia.

13. By November 2023, JBL was eating regular food again but was experiencing swallowing issues. His physical health decline continued and while Dr Atchison was concerned that JBL was still on a regular diet, she noted that the normal diet was provided for quality-of-life reasons and to ensure JBL remained nourished.

[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

14. In April 2024, JBL was hospitalised due to aspiration pneumonia and later developed acute decompensated heart failure.

15. Over the following weeks, JBL's condition continued to decline, and toward the end of May 2024 it was determined he would transition to palliative care for end-of-life care at Caulfield Hospital.

16. On 8 and 9 June 2024, there were MET calls for clinical deterioration and a decision was made to manage JBL's symptoms on an end-of-life pathway.

17. JBL subsequently passed away at 4.20am on 16 June 2024.

### Identity of the deceased

18. On 16 June 2024, JBL, born 1950, was visually identified by his carer.

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

### Medical cause of death

20. Forensic Pathologist, Dr Joanne Ho, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 19 June 2024 and provided a written report of her findings dated 11 July 2024.

21. The post-mortem CT scan revealed encephalomalacia in the right occipital region; bilateral pleural effusions (almost complete white out); coronary calcifications, pleural calcifications, and fatty liver.

22. Dr Ho provided an opinion that the medical cause of death was *"1(a) Multiorgan dysfunction in the setting of severe heart failure in a man with multiple medical comorbidities".* Dr Ho attributed the death to natural causes.

23. I accept Dr Ho'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 JBL, born 1950;

(b) the death occurred on 16 June 2024 at Caulfield Hospital, 260 Kooyong Road, Caulfield, Victoria, from multiorgan dysfunction in the setting of severe heart failure in a man with multiple medical comorbidities, which was a natural cause of death; and

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

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

Pursuant to section 73(1B) of the Act, I order that this finding be published (in redacted form) 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:

Senior Next of Kin
Life Without Barriers (care of Barry Nilsson Lawyers)
NDIS Quality and Safeguards Commission
Alfred Health
Constable Megan Cook, Victoria Police, Coroner's Investigator

Signature:


Coroner Sarah Gebert
Date: 11 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.