IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004601

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Julie Anne White
Date of birth:	19 January 1965
Date of death:	9 August 2024
Cause of death:	Complications of a pseudo-obstruction on a background of previous anterior resection of sigmoid volvulus
Place of death:	Queen Elizabeth Centre 102 Ascot Street South, Ballarat Central, Victoria
Keywords:	In care, natural causes, Support Disability Accommodation, SDA

INTRODUCTION

1. Julie Anne White was 59 years old when she passed away on 9 August 2024 at the Ballarat Base Hospital after a short period of palliative care.

2. Ms White was diagnosed with an intellectual disability at an early age and moved into a group home through McCallum Disability Services when she was 17 years old (1982). She received care from the neuropsychiatry team at the Royal Melbourne Hospital for schizophrenia and depression.

3. Ms White's medical history also included frontoparietal dementia, chronic constipation and colonic dysmotility, recurrent sigmoid volvulus, a cervical spine fracture, and a subdural haematoma. Ms White's bowel issues had previously been treated with an anterior resection with sigmoid anastomosis.

4. On 20 September 2022, Ms White began receiving care from Aussie Life Care, a registered provider with the National Disability Insurance Scheme. She resided in a supported independent living home until 6 June 2023. Ms White was then assessed as requiring full-time care and she transitioned into a Specialist Disability Accommodation facility run by Aussie Life Care.

5. In June 2024, Ms White was admitted to the Ballarat Base Hospital suffering from abdominal bloating and was diagnosed with sigmoid volvulus.[1] She was discharged home after three days.

THE CORONIAL INVESTIGATION

6. Ms White'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 is a mandatory report to the coroner, even if the death appears to have been from natural causes. Ms White was a "person placed in custody or care" within the meaning of section 4 of the Act, as she was a "prescribed class of person"[2] due to her status as an "SDA resident residing in an SDA enrolled dwelling".

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1 Twisting of the sigmoid colon.

2 Section 4(2)(j)(i), *Coroners Act 2008* (Vic).

7. First Constable (FC) Benjamin Hemingway acted as the Coroner's Investigator for the investigation of Ms White's death. FC Hemingway conducted inquiries on my behalf and compiled a coronial brief of evidence.

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

Circumstances in which the death occurred

8. On 21 July 2024, Ms White was transported to the Ballarat Base Hospital suffering a distended abdomen. On 22 July 2024, she underwent a flexible sigmoidoscopy and bowel decompression by general surgery. No mechanical obstructions were identified and there were no complications with the procedure.

9. On 1 August 2024, Ms White underwent a colonoscopy and laparoscopic formation of diverting loop colostomy. There were no surgical complications, but the admission itself was complicated by a suspected aspiration pneumonia.

10. On 5 August 2024, Ms White experienced a further bowel obstruction with no improvement despite maximal care. On 6 August 2024, a palliative care review was conducted. This involved clinicians and Ms White's medical decision maker, and a discussion concerning end-of-life care. On 7 August 2024, Ms White was transitioned to palliative care.

11. Ms White passed away at 4.00am on 9 August 2024.

Medical cause of death

12. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine performed an examination on 12 August 2024 and provided a written report of her findings dated 20 August 2024.

13. The post-mortem examination showed features in keeping with the clinical history.

14. The post-mortem CT scan revealed dilated small bowel loops, distended stomach, and a small left pleural effusion.

15. Dr Ho provided an opinion that the medical cause of death was due to natural causes and specified as *"1(a) Complications of a pseudo-obstruction on a background of previous anterior resection of sigmoid volvulus"*.

16. I accept Dr Ho's opinion.

CONCLUSION

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

    a) the identity of the deceased was Julie Anne White, born 19 January 1965;

    b) the death occurred on 9 August 2024 at Queen Elizabeth Centre, 102 Ascot Street South, Ballarat Central, Victoria 3350; and

    c) the cause of death was complications of a pseudo-obstruction on a background of previous anterior resection of sigmoid volvulus; and

    d) the death occurred in the circumstances described above.

18. I am satisfied that Julie's death was due to natural causes and there is nothing to suggest that the care received by Ms White, either at her Supported Disability Accommodation or at the Ballarat Base Hospital, was anything other than appropriate.

ACKNOWLEDGEMENTS

I extend my sincere condolences to Ms White's family for their loss.

I thank the Coroner's Investigator and those assisting for their work in this investigation.

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:

Jenny Lyle, Senior Next of Kin

First Constable Benjamin Hemingway, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 24 February 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.