



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2024 004668**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

Findings of:	Coroner David Ryan
Deceased:	Domenico Joseph Palma
Date of birth:	23 August 1965
Date of death:	11 August 2024
Cause of death:	1(a) Complications of diffuse large B-cell lymphoma
Place of death:	Northern Hospital 185 Cooper Street Epping Victoria
Keywords:	In care – natural causes

## INTRODUCTION

1. On 11 August 2024, Domenico Joseph Palma was 58 years old when he passed away at the Northern Hospital. At the time of his death, Mr Palma resided in a residential care facility in Tullamarine managed by Scope Australia. His medical history included intellectual disability, diffuse B-cell lymphoma, iron deficiency and gout.

## THE CORONIAL INVESTIGATION

2. Mr Palma'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. Mr Palma was a person in care at the time of his death as he was a Specialist Disability Accommodation (**SDA**) resident living in an SDA dwelling pursuant to Regulation 7 of the *Coroners Regulations 2019*. However, an inquest was not required to be held pursuant to section 52(3A) of the Act given that Mr Palma's death was from natural causes.
3. 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.
4. 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.
5. This finding draws on the totality of the coronial investigation into Mr Palma's death, including information obtained from his medical records. While 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.<sup>1</sup>

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<sup>1</sup> 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

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

### **Circumstances in which the death occurred**

6. On 29 July 2024, Mr Palma was admitted to the Northern Hospital with dyspnoea, fatigue and weakness. A computed tomography (CT) scan revealed a large right plural effusion, pericardial effusion, extra pleural lesions and lung lesions suggestive of lymphoma recurrence. He was progressed to comfort care in consultation with his family and he passed away on 11 August 2024.

### **Identity of the deceased**

7. On 11 August 2024, Domenico Joseph Palma, born 23 August 1965, was visually identified by his sister, Carmel Palma.
8. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

9. Dr Vianney Rajakarunanaïke, a legally qualified medical practitioner and specialist pathology fellow from the Victorian Institute of Forensic Medicine, conducted an examination on 14 August 2024 and provided a written report of her findings dated 26 August 2024.
10. There was no evidence of any injuries found which may have caused or contributed to the death. Dr Rajakarunanaïke expressed the opinion that the death was due to natural causes.
11. Dr Rajakarunanaïke provided an opinion that the medical cause of death was 1(a) Complications of diffuse large B-cell lymphoma.
12. I accept Dr Rajakarunanaïke's opinion.

## **FINDINGS AND CONCLUSION**

13. Pursuant to section 67(1) of the Act, I make the following findings:
  - a) the identity of the deceased was Domenico Joseph Palma, born 23 August 1965;

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evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

- b) the death occurred on 11 August 2024 at Northern Hospital  
185 Cooper Street, Epping, Victoria, from complications of diffuse large B-cell  
lymphoma; and
- c) the death occurred in the circumstances described above

14. As noted above, Mr Palma's death was reportable by virtue of section 4(2)(c) of the Act because, immediately before his death, he was a person placed in care as defined in section 3 of the Act. Section 52 of the Act requires an inquest to be held, except in circumstances where someone is deemed to have died from natural causes. In the circumstances, I am satisfied that Mr Palma died from natural causes and that no further investigation is required. Accordingly, I exercise my discretion under section 52(3A) of the Act not to hold an inquest into his death.

I convey my sincere condolences to Mr Palma'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:

Teresina Palma, Senior Next of Kin

Scope Australia

National Disability Insurance Agency

The Northern Hospital

Constable Jack Miller, Coronial Investigator

Signature:



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Coroner David Ryan

Date : 30 October 2024

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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.

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