IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004816

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Timothy Jeitz
Date of birth:	27 September 1970
Date of death:	22 January 2023
Cause of death:	1(a) Right Severe Middle Cerebral Artery Stroke
Place of death:	Wimmera Base Hospital, Horsham
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 22 January 2023, Timothy Jeitz (**Mr Jeitz**) was 52 years old he died at Wimmera Base Hospital from a severe stroke.

2. At the time of his death, Mr Jeitz was a National Disability Insurance Scheme (**NDIS**) participant. He received funding for Supported Independent Living (**SIL**) through Aruma Foundation Limited and to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling.[1]

3. Mr Jeitz's family lived close by in town. He received support to access the community and to attend personal appointments. His NDIS plan outlined that he enjoyed playing bingo and frequenting the local pub where he could catch up with others.

THE CORONIAL INVESTIGATION

4. Mr Jeitz'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 receiving funding for SIL and residing in an SDA enrolled dwelling immediately prior to his death.

5. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

6. 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.

[1] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of the death, is a permanent dwelling that provides long-term accommodation for one or more SDA residents, that is enrolled as an SDA dwelling under relevant NDIS (Specialist Disability Accommodation) Rules in force at the relevant time. An SDA resident means a person who is an NDIS participant funded to reside in an SDA enrolled dwelling, or who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program). The definition of SDA resident was amended on 1 July 2024 pursuant to the *Disability and Social Services Regulation Amendment Act 2023* to extend to include persons who are residing, or propose to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement.

7. 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.

8. This finding draws on the totality of the coronial investigation into the death of Timothy Jeitz, including information from the National Disability Insurance Agency (**NDIA**) and the NDIS Quality and Safeguards Commission, as well as a Medical Certificate Cause of Death (**MCCD**) completed by a medical practitioner at Wimmera Base Hospital.

9. 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]

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

Circumstances in which the death occurred

10. On 18 January 2023, Mr Jeitz suffered a severe stroke at home and was transferred to Wimmera Base Hospital. Mr Jeitz continued to decline and passed away on 22 January 2023.

Identity of the deceased

11. On 22 January 2023, Timothy Jeitz, born 27 September 1970, was identified by Medical Practitioner Dr Zena Barakat via review of medical records.

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

Medical cause of death

13. On 22 January 2023, Dr Barakat reviewed Mr Jeitz's complete medical history, conducted an examination on the body and completed a MCCD. Dr Barakat provided an opinion that the medical cause of death was Right severe Middle Cerebral Artery stroke.

[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.

14. On 17 August 2024, a Medical Liaison Nurse (**MLN**) at the Victorian Institute of Forensic Medicine, reviewed the MCCD at my direction and confirmed that the cause of death was due to natural causes.

15. I accept Dr Barakat's opinion and am satisfied that the death was due to natural causes.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Timothy Jeitz born 27 September 1970;

    b) the death occurred on 22 January 2023 at Wimmera Base Hospital, Horsham, from Right severe Middle Cerebral Artery stroke; and,

    c) the death occurred in the circumstances described above.

17. The available evidence does not support a finding that there was any want of clinical management or care on the part of the SIL provider, or clinical staff at Wimmera Base Hospital, that caused or contributed to Mr Jeitz's death.

18. Having considered all the available evidence, I find that Mr Jeitz's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into the death and to finalise the investigation of Mr Jeitz's death in chambers.

I convey my sincere condolences to Mr Jeitz's family, friends and carers for their loss, and acknowledge the distress caused by the delay in the reporting and investigation of Mr Jeitz's death.

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:

Josephine Smith, Senior Next of Kin
Aruma Foundation Limited
Grampians Health Horsham

Signature:

Date : 9 December 2024

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.