IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004822

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:	Stephen T Easter
Date of birth:	22 May 1958
Date of death:	26 November 2022
Cause of death:	1a : HEPATOCELLULAR CARCINOMA
Place of death:	Monash Health, McCulloch House 246 Clayton Road, Clayton Victoria 3168
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 26 November 2022, Stephen T Easter was 64 years old when he died from hepatocellular carcinoma (liver cancer) at McCulloch House, an inpatient palliative care/hospice unit[1].

2. At the time of his death, Mr Easter was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[2] operated by Wallara Australia Ltd. Mr Easter was receiving these supports due to an acquired brain injury he sustained at a young age.

3. Mr Easter enjoyed visits from his sister and girlfriend. He also enjoyed participating in social and recreational activities in the community with his best friend, who was a co-resident.

THE CORONIAL INVESTIGATION

4. Mr Easter'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 Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling immediately prior to his death. 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.

5. 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.

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[1] McCulloch House operates under Monash Health.

[2] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Mr Easter's 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.

6. 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.

7. This finding draws on the totality of the coronial investigation into the death of Stephen T Easter, 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 Monash Health. 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]

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

Circumstances in which the death occurred

8. Mr Easter was diagnosed with liver cancer 12 months prior to his death.

9. About three months before Mr Easter's admission to McCulloch House, support staff noticed a decline in his health.

10. On 23 November 2022, Mr Easter was admitted to McCulloch House for palliative care. He passed away on 26 November 2022.

Identity of the deceased

11. On 26 November 2022, Stephen T Easter, born 22 May 1958, was visually identified by Medical Practitioner Dr Andrew Kuen via review of medical records and visual identification.

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

[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.

Medical cause of death

13. On 26 November 2022, Medical Practitioner Dr Andrew Kuen reviewed Mr Easter's complete medical history, conducted an examination on the body and completed a MCCD. Dr Kuen provided an opinion that the medical cause of death was

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 Kuen's opinion, and am satisfied that the death was due to natural causes.

FINDINGS AD CONCLUSION

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

    a) the identity of the deceased was Stephen T Easter, born 22 May 1958;

    b) the death occurred on 26 November 2022 at Monash Health, McCulloch House, 246 Clayton Road, Victoria 3168, from hepatocellular carcinoma; 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 McCulloch House, that caused or contributed to Mr Easter's death.

18. Having considered all the available evidence, I find that Mr Easter'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 his death and to finalise the investigation of Mr Easter's death in chambers.

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

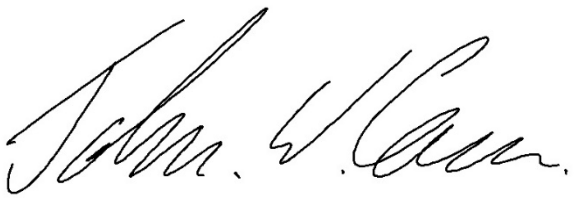
I direct that a copy of this finding be provided to the following:

Karen Burles, Senior Next of Kin

Wallara Australia Ltd

Monash Health

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.