IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2024 004823**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

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| Findings of: | Judge John Cain, State Coroner |
| Deceased: | Mark Ruth |
| Date of birth: | 14 January 1972 |
| Date of death: | 11 January 2023 |
| Cause of death: | 1a : SEPSIS OF UNKNOWN ORGANISM IN RESPIRATORY |
| Place of death: | Monash Health<br>Monash Medical Centre<br>246 Clayton Road,<br>Clayton Victoria 3168 |
| Keywords: | Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes |

## INTRODUCTION

1. On 11 January 2023, Mark Ruth was 50 years old when he died at Monash Medical Centre (MMC) due to sepsis of an unknown mechanism of respiratory cause(s).

2. At the time of his death, Mr Ruth was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] operated by Scope (Vic) Ltd due to multiple comorbidities, including cerebral palsy and an intellectual disability.

3. Mr Ruth also had a medical history of chronic hyperkalaemia, hypothyroidism, chronic dysphagia, obstructive sleep apnoea and epilepsy, for which he was prescribed PRN[2] valproate and levetiracetam. He was wheelchair-bound, non-verbal and legally blind.

4. Mr Ruth underwent a jejunostomy[3] in 2021, and had since not taken any food or medication orally.

5. Mr Ruth normally spent his weekends at home with his family. He enjoyed weekly outings, visiting the pier and feeding the seagulls.

## THE CORONIAL INVESTIGATION

6. Mr Ruth'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

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

[2] Pro re nata (PRN) means that the administration of medication is not scheduled. Instead, the prescription is taken as needed.

[3] Jejunostomy is a surgical procedure by which a tube is situated in the lumen of the proximal jejunum, primarily to administer nutrition.

is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

7. 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.

8. 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.

9. This finding draws on the totality of the coronial investigation into the death of Mark Ruth, 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.[4]

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

### Circumstances in which the death occurred

10. Mr Ruth had a chest infection in January 2022, which subsequently developed into aspiration pneumonia in April 2022.

11. Mr Ruth's health began to decline in the months prior to his death, and he had six hospitalisations in 2022.

12. On the afternoon of 11 January 2023, Mr Ruth's mother visited him at his accommodation and noted he was "not too unwell looking". No fever was noted.

[4] 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.

13. On the same evening, Mr Ruth's carers observed him in respiratory distress, and they called for an ambulance. He was then conveyed to MMC.

14. Upon arriving at the Emergency Department, Mr Ruth's skin was observed as mottled and the air entry to his left lung was reduced. Treating physicians provided a differential diagnosis of severe chest sepsis.

15. Mr Ruth was commenced on intravenous antibiotics and intravenous fluids and ventilated with a non-rebreather.

16. Despite treatment, Mr Ruth's condition continued to deteriorate. After a discussion between his treating physicians and family, his goal of care was changed to comfort care.

17. Mr Ruth passed away after the commencement of comfort care.

### Identity of the deceased

18. On 11 January 2023, Mark Ruth, born 14 January 1972, was identified by Medical Practitioner Dr Cian Lenihan via review of medical records and visual identification

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

### Medical cause of death

20. On 11 January 2023, Medical Practitioner Dr Cian Lenihan reviewed Mr Ruth's complete medical history, conducted an examination on the body and completed a MCCD. Dr Lenihan provided an opinion that the medical cause of death was sepsis of an unknown organism in the respiratory.

21. 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.

22. I accept Dr Lenihan's opinion, and am satisfied that the death was due to natural causes.

## FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mark Ruth, born 14 January 1972;

b) the death occurred on 11 January 2023 at Monash Health, Monash Medical Centre, 246 Clayton Road, Clayton, Victoria 3168, from sepsis of unknown organism in respiratory; and

c) the death occurred in the circumstances described above.

24. 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 Monash Health that caused or contributed to Mr Ruth's death.

25. Having considered all the available evidence, I find that Mr Ruth'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 Ruth's death in chambers.

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

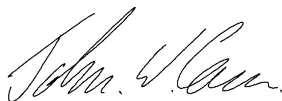
I direct that a copy of this finding be provided to the following:

Elizabeth Ruth, Senior Next of Kin

Scope (Vic) Ltd

Monash Health

Signature:



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Judge John Cain, State Coroner

Date: 08 January 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.