IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004824

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:	Rose Gajica
Date of birth:	8 October 1956
Date of death:	17 December 2022
Cause of death:	1(a) Right middle cerebral artery and posterior cerebral artery stroke
Place of death:	Monash Health- Casey Hospital, 62-70 Kangan Dr, Berwick Victoria 3806
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 17 December 2022, Rose Gajica (**Ms Gajica**) was 66 years old when she died at Monash Health- Casey Hospital following two major strokes.

2. At the time of her death, Ms Gajica was a National Disability Insurance Scheme (**NDIS**) participant. She received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by the then-Department of Health and Human Services. Ms Gajica was receiving these supports due to advanced multiple sclerosis.

3. Ms Gajica was regularly supported and visited by her sister, Maria and mother, Tina. She enjoyed spending her time at home watching television, and once had a love for reading books. Ms Gajica enjoyed discussing movies and books with her carers who visited each day.

THE CORONIAL INVESTIGATION

4. Ms Gajica's death fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as she 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 her 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] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Ms Gajica'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 Rose Gajica , 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- Casey Hospital. 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

8. On 11 December 2022, Ms Gajica suffered two strokes whilst showing at her supported independent living accommodation.

9. Emergency services were immediately called by Ms Gajica's carers.

10. Ms Gajica was transported to Monash Health- Casey Hospital for medical treatment and care.

11. Despite treatment, Ms Gajica's condition continued to deteriorate, and she passed away seven days later, on the 17 December 2022.

Identity of the deceased

12. On 17 December 2022, Rose Gajica, born 8 October 1956, was identified by Medical Practitioner Dr Chathuri Indunil Rathnayake Herath Mudiyanselage via review of medical records and visual identification.

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

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[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.

Medical cause of death

14. On 17 December 2022, Medical Practitioner Dr Chathuri Indunil Rathnayake Herath Mudiyanselage reviewed Ms Gajica's complete medical history, conducted an examination of the body and completed a MCCD. Dr Chathuri Indunil Rathnayake Herath Mudiyanselage provided an opinion that the medical cause of death was *a right middle cerebral artery and posterior cerebral artery stroke*.

15. 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.

16. I accept Dr Chathuri Indunil Rathnayake Herath Mudiyanselage's opinion and am satisfied that the death was due to natural causes.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Rose Gajica, born 8 October 1956;

    b) the death occurred on 17 December 2022 at Monash Health- Casey Hospital, 62-70 Kangan Drive, Berwick in Victoria from *a right middle cerebral artery and posterior cerebral artery stroke*; and

    c) the death occurred in the circumstances described above.

18. 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-Casey Hospital, that caused or contributed to Ms Gajica's death.

19. Having considered all the available evidence, I find that Ms Gajica'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 her death and to finalise the investigation of Ms Gajica's death in chambers.

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

Maria Windley, Senior Next of Kin

Empowered Liveability Pty Ltd

Monash Health- Casey Hospital

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.