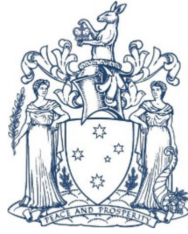

IN THE CORONERS COURT OF VICTORIA AT MELBOURNE	**COR 2024 004825**

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:	Sonya Marshman
Date of birth:	18 March 1970
Date of death:	26 March 2023
Cause of death:	1(a) Recurrent Aspiration Pneumonitis 2 Cerebrovascular Accident and Congenital Rubella
Place of death:	7/9 Noall Street, Warracknabeal Victoria 3393
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 26 March 2023, Sonya Marshman (**Ms Marshman**) was 53 years old when she died at her residential supported accommodation- Steinmeyer Villa, Woodbine.

2. At the time of her death, Ms Marshman 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 Marshman was receiving these supports due to her disabilities.

3. Ms Marshman had three sisters who were very important to her, especially Simone as she was her guardian. Ms Marshman enjoyed looking at bright lights, listening to jazz music and going for a walk in her wheelchair out in the sun for coffee. She enjoyed living at Steinmeyer Villa, Woodbine,[2] where she would receive daily support in everyday activities.

THE CORONIAL INVESTIGATION

4. Ms Marshman'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

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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 Marshman'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] A residential accommodation facility run by Woodbine Inc, which is a Warracknabeal based non-profit organisation that provides accommodation, day services and supported employment programs to people with intellectual disabilities.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

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 Sonya Marshman, including information from the National Disability Insurance Agency (**NDIA**) and the NDIS Quality and Safety Commission, as well as a Medical Certificate Cause of Death (**MCCD**) completed by a medical practitioner at Wheatfields Family Medical. 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. Ms Marshman's health began to decline on the 21 February 2023 when she refused food and drink.

9. Her general practitioner, Dr Franklin Butuyuyu was called by her carers. Because of Ms Marshman's condition, Dr Butuyuyu admitted her to the Rural Northwest Hospital in Warracknabeal for re-hydration on the 22 February 2023.

10. On 1 March 2023 a referral was made to the palliative care team regarding Ms Marshman, who was still in hospital receiving treatment. Ms Marshman's family requested that she spend this remaining time in the comfort of her **SDA**.

11. On 7 March 2023 a meeting was held with Dr Butuyuyu, staff and management to discuss arrangements for Ms Marshman to undertake palliative care in the comfort of her home.

[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.

Directions were made for medication, fluids and food to be offered to Ms Marshman if it could be tolerated.

12. On about 8 March 2023, Ms Marshman returned to Steinmeyer Villa, Woodbine where she spent just over two weeks surrounded by fellow residents and received visits from family and friends.

13. On 24 March 2023, emergency services were called as Ms Marshman was struggling to breath and appeared to be in a state of confusion. Following assessment by paramedics and conversations with family members, Ms Marshman remained in her home for comfort palliative care.

14. On 25 March 2023, Dr Butuyuyu organised nursing staff to provide Ms Marshman with palliative medication to assist in the pain and discomfort she was experiencing. Ms Marshman was monitored every 4 hours.

15. On 26 March 2023 at 22.53pm, Ms Marshman passed away.

Identity of the deceased

16. On 26 March 2023, Sonya Marshman, born 18 March 1970, was identified by Medical Practitioner Dr Franklin Butuyuyu via review of medical records and visual identification by Ambulance Victoria paramedics, who declared Ms Marshman deceased at 22.53pm.

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

Medical cause of death

18. On 26 March 2023, Medical Practitioner Dr Franklin Butuyuyu reviewed Ms Marshman's complete medical history and completed a MCCD. Dr Butuyuyu provided an opinion that the medical cause of death was *recurrent aspiration pneumonitis,* secondary to *cerebrovascular accident* and *congenital rubella*.

19. 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.

20. I accept Dr Franklin Butuyuyu's opinion and am satisfied that the death was due to natural causes.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Sonya Marshman born 18 March 1970;

    b) the death occurred on 26 March 2023 at her **SDA-** Steinmeyer Villa, Woodbine 7/9 Noall Street, Warracknabeal in Victoria from *recurrent aspiration pneumonitis* secondary to a *cerebrovascular accident and congenital rubella*; and

    c) the death occurred in the circumstances described above.

22. 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 the Rural Northwest Hospital, Warracknabeal or Wheatfields Family Medical, that caused or contributed to Ms Marshman's death.

23. Having considered all the available evidence, I find that Ms Marshman'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 Marshman's death in chambers.

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

Simone Lindsay, Senior Next of Kin

Woodbine Inc

Wheatfields Family Medical

NDIS Quality and Safeguards Commission

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.