IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004838

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:	Robert Easter
Date of birth:	20 July 1960
Date of death:	29 July 2023
Cause of death:	1a: Aspiration pneumonitis 2: Ischaemic gut, dysphagia and cerebral palsy
Place of death:	Geelong Hospital McKellar Centre IRC 272-322 Ryrie Street Geelong Victoria 3220
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 29 July 2023, Robert Easter was 63 years old when he died at the Geelong University Hospital McKellar Centre following a choking event and recent decline in health.

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[1] provided by Scope Australia. Mr Easter was receiving supports due to the impact of cerebral palsy, intellectual disability, blindness and hearing impairment.

3. Mr Easter lived in a Home @ Scope residence at 6-8 Stradbroke Street, Norlane, and attended day program activities four days a week. He was supported by care staff with all activities of daily living and to access social and community activities. Mr Easter loved getting out into the community and swimming, which he did twice a week. He also enjoyed having stories read to him and used an iPad to access sensory books and games that he engaged with.

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

[1] 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.

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 Robert 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 the McKellar Centre. 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 25 July 2023, Mr Easter was admitted to the University Hospital Geelong following a choking episode and recent history of vomiting, lethargy and apparent abdominal distension. A CT scan showed significant portal venous gas without a clear cause, but which was thought to reflect bowel ischaemia. Given Mr Easter's medical background and concerns for his quality of life, he was not considered appropriate for surgical management.

9. After a trial of ward-based care with intravenous antibiotics, fluids and pain management, Mr Easter's condition deteriorated further.

10. On 28 July 2023, after discussions with his family, he was transferred to the McKellar Centre for comfort care by the palliative care team, and he passed away on 29 July 2023.

[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.

Identity of the deceased

11. On 29 July 2023, Robert Easter, born 20 July 1960, was identified by Medical Practitioner Dr Frances Crotty via review of medical records and detailed knowledge of the circumstances surrounding his death.

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

Medical cause of death

13. On 29 July 2023, Medical Practitioner Dr Frances Crotty reviewed Mr Easter's complete medical history and, having regard to her own detailed knowledge of the circumstances surrounding his death, completed a MCCD. Dr Crotty provided an opinion that the medical cause of death was aspiration pneumonitis, with other significant contributing conditions of ischaemic gut, dysphagia and cerebral palsy.

14. On 18 August 2024, a Medical Liaison Nurse 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 Crotty's opinion and am satisfied that Mr Easter's death was due to natural causes.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Robert Easter, born 20 July 1960;

    b) the death occurred on 29 July 2023 at Geelong Hospital McKellar Centre IRC, 272-322 Ryrie Street, Geelong Victoria 3220, from 1(a) aspiration pneumonitis, 1(b) ischaemic gut, 1(c) dysphagia, and 1(d) cerebral palsy.

    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 Geelong University Hospital 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.

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 Hayes, Senior Next of Kin

Scope Australia

Barwon 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.