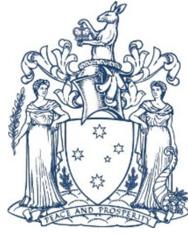

IN THE CORONERS COURT	**COR 2024 004846**
OF VICTORIA	
AT MELBOURNE	

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:	Paul Munt
Date of birth:	3 December 1958
Date of death:	21 July 2023
Cause of death:	1(a) ACUTE RENAL FAILURE 2 STROKE
Place of death:	Austin Health 147 Studley Road Heidelberg Victoria 3084
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 21 July 2023, Paul Munt (**Mr Munt**) was 64 years old when he passed away at Austin Hospital in Heidelburg, due to acute renal failure.

2. At the time of his death, Mr Munt was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] situated in Bellfield. He received support in his daily activities as a result of a severe acquired brain injury (**ABI**) sustained following a stroke.

3. Mr Munt was well supported by family and friends, including by his sister, Christine Ownes, who resides in the United States and regularly returned to Australia.

THE CORONIAL INVESTIGATION

1. Mr Munt'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 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.

2. 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.

3. 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

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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 Munt'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.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

4. This finding draws on the totality of the coronial investigation into the death of Paul Munt, 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 Austin 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

4. On 17 July 2023, Mr Munt attended a regularly scheduled appointment with his general medical practitioner (**GP**) at the Bellfield Medical Centre. It was known to Mr Munt's treating team that his health had been declining for some time.

5. During the appointment, Mr Munt's GP held concerns regarding his health, and he was transferred to the Austin Hospital. Upon his arrival, Mr Munt was assessed and owing to the severity of his illness, medical practitioners determined it suitable to transfer him to the Palliative care unit.

6. On 21 July 2023, Mr Munt passed away peacefully.

Identity of the deceased

5. On 21 July 2023, Paul Munt, born 3 December 1958, was identified by Medical Practitioner, Dr Gordon Chen (**Dr Chen**), via review of the medical records and visual identification.

6. 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

7. On 21 July 2023, Medical Practitioner, Dr Gordon Chen, reviewed Mr Munt's medical history, conducted an examination on the body, and completed a Medical Certificate Cause of Death (**MCCD**). Dr Chen provided an opinion that the medical cause of death was acute renal failure, with the significant contributing condition of a stroke.

8. On 18 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.

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

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was Paul Munt, born 3 December 1958;

   b) the death occurred on 21 July 2023 at Austin Health 147 Studley Road, Heidelberg, Victoria, 3804, from acute renal failure with a significant contributing condition of a stroke; and,

   c) the death occurred in the circumstances described above.

8. 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 Austin Hospital, that caused or contributed to Mr Munt's death.

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

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

Ms Christine Owens, Senior Next of Kin

Austin 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.