IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004847

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Amended pursuant to section 76 of the Coroners Act 2008 on 13 March 2026 by order of the State Coroner, Judge Liberty Sanger[1]

Findings of:	Judge John Cain, State Coroner
Deceased:	Mark Andrew Harvey
Date of birth:	26 October 1967
Date of death:	17 July 2023
Cause of death:	1(a) End stage renal failure
Place of death:	Latrobe Regional Hospital Cnr Princes Highway & Village Ave Traralgon Victoria 3844
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

[1] This finding was amended on 13 March 2026 to amend a typographical error with the date of Judge Cain's signature on page 5.

INTRODUCTION

1. On 17 July 2023, Mark Andrew Harvey (**Mr Harvey**) was 55 years old when he died at Latrobe Regional Hospital due to end stage renal failure.

2. At the time of his death, Mr Harvey was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[2] provided by Community Housing Limited located in Sale. Mr Harvey received support for his daily functions, including for the management of his ileostomy.

3. Mr Harvey had goals to maintain and develop friendships, become involved in his local community including through group activities. He received support from his sister, Kerryn Harvey, who he frequently spoke to.

THE CORONIAL INVESTIGATION

1. Mr Harvey'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.

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.

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

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 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 Mark Andrew Harvey, 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 Latrobe Regional 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.[3]

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

Circumstances in which the death occurred

5. In the three months prior to his death, Mr Harvey experienced end stage renal failure. He was admitted to Latrobe Regional Hospital where he passed away on 17 July 2023.

Identity of the deceased

6. On 18 July 2023, Mark Andrew Harvey, born 26 October 1967 was identified by Dr Ahmed Nagla (**Dr Nagla**) via review of medical records.

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

Medical cause of death

8. On 18 July 2023, Medical Practitioner Dr Nagla reviewed Mr Harvey's complete medical history and completed a MCCD based on the advice of another medical practitioner who examined Mr Harvey's body, and using their own knowledge of Mr Harvey's clinical course. Dr Nagla provided an opinion that the medical cause of death was end stage renal failure.

[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.

9. 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.

10. I accept Dr Nagla's opinion and am satisfied that the death was due to natural causes.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mark Andrew Harvey, born 26 October 1967;

    b) the death occurred on 17 July 2023 at Latrobe Regional Hospital Cnr Princes Highway and Village Ave Traralgon Victoria 3844, from end stage renal failure; and

    c) the death occurred in the circumstances described above.

12. 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 Latrobe Regional Hospital, that caused or contributed to Mr Harvey's death.

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

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

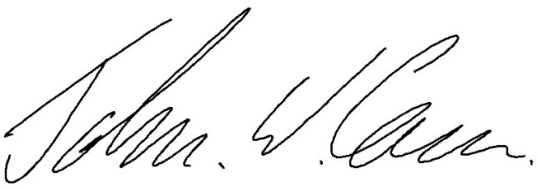
I direct that a copy of this finding be provided to the following:

Kerryn Harvey, Senior Next of Kin

Latrobe Regional Hospital

Community Housing Limited

Signature:



Judge John Cain
State Coroner
Date: 8 April 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.