IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004851

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:	Marie Therese Brolan
Date of birth:	1 April 1959
Date of death:	21 May 2023
Cause of death:	1(a) Cholecystitis 2 Secondary progressive multiple sclerosis
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 May 2023, Marie Therese Brolan (**Ms Brolan**) was 64 years old when she died at the Austin Hospital in Heidelberg in the context of declining health.

2. At the time of her death, Ms Brolan was a National Disability Insurance Scheme (**NDIS**) participant. She received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by MS Plus Ltd. Ms Brolan had multiple sclerosis and experienced a deterioration in her mobility, strength, motor function and independence. She required assistance for all her daily tasks, particularly as her physical ability declined and she lost the ability to ambulate.

3. Ms Brolan is fondly remembered as a feisty, gracious and stoic woman, who enjoyed spending time with her family, community and friends. She was supported by her sister, Anne, and son, Simon, whom she often visited on the weekends.

THE CORONIAL INVESTIGATION

1. Ms Brolan'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.

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

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

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 Marie Therese Brolan, 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

5. On 15 May 2023, Ms Brolan was unrousable by her disability support worker. Staff contacted emergency services and Ms Brolan was transported to hospital and treated with antibiotics for recurrent gallbladder infections.

6. On 19 May 2023, clinicians determined that Ms Brolan was not a suitable candidate for surgical intervention. They liaised with her family regarding her poor prognosis, and it was determined to transition Ms Brolan to a comfort pathway.

7. Ms Brolan was transferred to the Palliative Care unit and passed away on 21 May 2023.

Identity of the deceased

8. On 21 May 2023, Marie Therese Brolan, born 1 April 1959, was identified by Medical Practitioner Dr Nicholas Orritt (**Dr Orritt**) via review of medical records.

[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.

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

Medical cause of death

10. On 21 May 2023, Medical Practitioner, Dr Orritt, reviewed Ms Brolan's complete medical history, and based on her clinical course, completed a MCCD. Dr Orritt provided an opinion that the medical cause of death was cholecystitis with a significant contributing condition of secondary progressive multiple sclerosis.

11. 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.

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

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Marie Therese Brolan, born 1 April 1959;

    b) the death occurred on 21 May 2023 at Austin Health, 147 Studley Road, Heidelberg Victoria 3084, from cholecystitis with a significant contributing condition of multiple sclerosis; and,

    c) the death occurred in the circumstances described above.

14. 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 Ms Brolan's death.

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

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

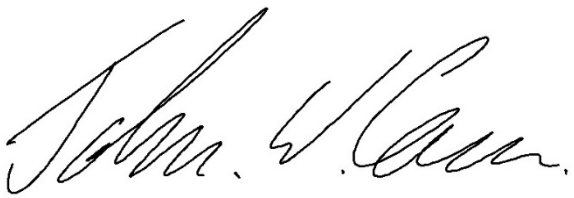
I direct that a copy of this finding be provided to the following:

Simon Brolan, Senior Next of Kin

MS Plus Ltd

Austin 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.