



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2024 004853**

**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:	Leah Pollauszach
Date of birth:	8 July 1968
Date of death:	25 June 2023
Cause of death:	1(a) Aspiration pneumonia 1(b) Oropharyngeal dysphagia 2 Trisomy 21
Place of death:	Northern Hospital 185 Cooper Street Epping Victoria 3076
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

## INTRODUCTION

1. On 25 June 2023, Leah Pollauszach (**Ms Pollauszach**) was 54 years old when she died at Northern Hospital following an aspiration event.
2. At the time of her death, Ms Pollauszach was a National Disability Insurance Scheme (**NDIS**) participant. She received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling<sup>1</sup> situated in Pascoe Vale.
3. Ms Pollauszach had Trisomy 21 – colloquially known as ‘*Down Syndrome*’ – and received support for her daily activities. She enjoyed relaxing and watching television, she also enjoying creative pursuits such as drawing and colouring. Ms Pollauszach received support from her brother, Serge.

## THE CORONIAL INVESTIGATION

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

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<sup>1</sup> SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Ms Pollauszach’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 Leah Pollauszach, 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 Northern 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.<sup>2</sup>

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

### **Circumstances in which the death occurred**

5. In the lead-up to her death, Ms Pollauszach experienced a decline in her health, including through poor oxygen saturation levels.
6. Ms Pollauszach was admitted to Northern Hospital and it was determined she was experiencing aspiration pneumonia and provided assistance using a ventilator.
7. Ms Pollauszach's condition continued to decline and she passed away on 25 June 2023.

### **Identity of the deceased**

8. On 25 June 2023, Leah Pollauszach, born 8 July 1968, was identified by Medical Practitioner Dr Busra Alpay (**Dr Alpay**) via of medical records.
9. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

10. On 25 June 2023, Medical Practitioner Dr Alpay reviewed Ms Pollauszach's complete medical history, conducted an examination on the body and completed a MCCD. Dr Alpay provided an opinion that the medical cause of death was aspiration pneumonia, oropharyngeal dysphagia with a significant contributing condition of Trisomy 21.

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<sup>2</sup> 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.

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 Alpay'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 Leah Pollauszach, born 8 July 1968;
  - b) the death occurred on 25 June 2023 at Northern Health 185 Cooper Street, Epping Victoria 3076, from aspiration pneumonia with antecedent causes of oropharyngeal dysphagia and a significant contributing condition of Trisomy 21.
  - 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 Northern Hospital, that caused or contributed to Ms Pollauszach's death.
15. Having considered all the available evidence, I find that Ms Pollauszach'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 Pollauszach's death in chambers.

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

Serge Pollauszach, Senior Next of Kin

Northern Health

Signature:



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Date: 6 January 2025

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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.

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