IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004856

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:	Kevin Parkhill
Date of birth:	23 September 1957
Date of death:	2 June 2023
Cause of death:	1a : Multiple organ failure of unknown origin 2 : Type 2 diabetes mellitus, chronic kidney disease, chronic liver disease and congestive cardiac failure
Place of death:	Box Hill Hospital, 8 Arnold Street, Box Hill Victoria 3128
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 2 June 2023, Kevin Parkhill was 65 years old when he died at Box Hill Hospital.

2. At the time of his death, Mr Parkhill was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by The Trustee for Summer Housing Impact SDA Trust.

3. Mr Parkhill had a medical history including Type 2 Diabetes, stroke, neuropathy, congestive cardiac failure, chronic renal failure, vision impairment, recurrent skin injuries and osteomyelitis.

4. Mr Parkhill had three adult children and was regularly visited by his friend, Andrea. He enjoyed learning the guitar and watching TV. Mr Parkhill came from a sporting background and had competed in various sporting events such as triathlons, cricket, football, baseball and table tennis.

THE CORONIAL INVESTIGATION

5. Mr Parkhill'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.

6. 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 Parkhill'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.

7. 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.

8. This finding draws on the totality of the coronial investigation into the death of Kevin Parkhill, 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 Box Hill 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

9. On 14 April 2023, Mr Parkhill moved to his new SDA apartment in Blackburn from Chestnut Garden Aged Care. Mr Parkhill was supported by his long-term provider Magical Care Pty Ltd (**Magical Care**) for personal assistance and nursing and La Vita Care for concierge support.

10. Magical Care nursing staff reported that at the time of his discharge from Chestnut Garden Aged Care, Mr Parkhill had a Stage IV[3] wound in his heel. Despite active management by the nurses, Mr Parkhill's wound deteriorated. It is reported that Mr Parkhill was advised multiple times to go to hospital for examination, but he declined. An appointment was arranged with his general practitioner and a wound specialist.

[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.

[3] A stage IV wound involves full thickness tissue loss with exposed bone, tendon or muscle.

11. On 4 May 2023, Mr Parkhill's General Practitioner reportedly called Mr Parkhill and strongly advised him to go to hospital as his platelets was low and Methicillin-resistent Saphylococcus aureus (**MRSA**), an antibiotic-resistant infection, was identified on his wound.

12. On 5 May 2023, Mr Parkhill attended Box Hill Hospital. On review, it was identified that Mr Parkhill had developed an infection in his leg as a result of his diabetes, and was admitted for treatment.

13. During his stay at the Box Hill Hospital, his health deteriorated, and he had multiple organ failure. Mr Parkhill reportedly made the decision to cease active treatment and was referred for palliative care for comfort care. He passed away at the Box Hill Hospital on 2 June 2023.

Identity of the deceased

14. On 2 June 2023, Kevin Parkhill, born 23 September 1957, was identified by Medical Practitioner Dr Kalubowilage Don via review of medical records and visual identification.

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

Medical cause of death

16. On 2 June 2023, Medical Practitioner Dr Udara Devinda Kalubowilage Don reviewed Mr Parkhill's complete medical history, conducted an examination on the body and completed a MCCD. Dr Kalubowilage Don provided an opinion that the medical cause of death was multiple organ failure of unknown origin, with other significant contributing conditions of Type 2 diabetes mellitus, chronic kidney disease, chronic liver disease and congestive cardiac failure.

17. 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.

18. I accept Dr Kalubowilage Don's opinion, and am satisfied that the death was due to natural causes.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Kevin Parkhill, born 23 September 1957;

b) the death occurred on 2 June 2023 at Box Hill Hospital, 8 Arnold Street Box Hill Victoria 3128, from multiple organ failure of unknown origin with significant contributing conditions of type 2 diabetes mellitus, chronic kidney disease, chronic liver disease and congestive cardiac failure; and

c) the death occurred in the circumstances described above.

20. The available evidence does not support a finding that there was any want of clinical management or care on the part of the SIL providers, or clinical staff at Box Hill Hospital, that caused or contributed to Mr Parkhill's death.

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

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

Amy Sellitti, Senior Next of Kin

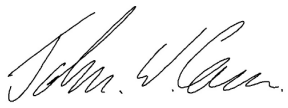
The Trustee for Summer Housing Impact SDA Trust

La Vita Care

Magical Care Pty Ltd

Box Hill Hospital

Signature:



Judge John Cain, State Coroner

Date: 08 January 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.