IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004858

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:	Jeffrey Leigh Campbell
Date of birth:	20 June 1969
Date of death:	30 August 2023
Cause of death:	1(a) Streptococcus septicaemia 1(b) Aspiration pneumonia 2 Down's Syndrome
Place of death:	Casey Hospital, 52 Kangan Drive, Berwick, Victoria, 3806
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 30 August 2023, Jeffrey Leigh Campbell (**Mr Campbell**) was 54 years old when he died at Casey Hospital.

2. At the time of his death, Mr Campbell 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 then-Department of Health and Human Services. Mr Campbell was receiving these supports due to living with Down's Syndrome. He had also been diagnosed with dementia prior to his death.

3. Mr Campbell was close with his family and visited them regularly. He loved to have fun and joke around and enjoyed keeping busy and helping people.

4. Mr Campbell was very involved in community activities and was a lifetime member of the local Swifts football club. He often attended matches and helped the team wherever he could. He also enjoyed going to the cinema, shopping and attending local events, and was a supporter of the Collingwood Football Club.

THE CORONIAL INVESTIGATION

5. Mr Campbell'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

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

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.

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 Jeffrey Leigh Campbell, 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 Casey 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. Mr Campbell attended his regular swimming session on 28 August 2023. After returning home and showering, he began struggling to breath, made wheezing sounds and was shivering. Paramedics were called and attended at his home before conveying him to Casey Hospital, where he was diagnosed with aspiration pneumonia and admitted to the palliative ward.

10. Whilst at Casey Hospital, Mr Campbell presented with frequent seizures and a high body temperature. He was treated with antibiotics.

11. At 2pm on 29 September 2023, on medical advice and after discussion with Mr Campbell's family, the decision was made to discontinue active treatment and to make him comfortable. He passed away the following day at 1:30pm, with family by his side.

[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.

Identity of the deceased

12. On 30 August 2023, Jeffrey Leigh Campbell, born 20 June 1969, was identified by Medical Practitioner Dr Udeshi Withanage via review of medical records and visual identification.

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

Medical cause of death

14. On 30 August 2023, Medical Practitioner Dr Udeshi Withanage reviewed Ms Johnston's complete medical history, conducted an examination on the body and completed a MCCD. Dr Withanage provided an opinion that the medical cause of death was streptococcus septicaemia and aspiration pneumonia with the significant contributing condition of Down's Syndrome.

15. 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.

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

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Jeffrey Leigh Campbell, born 20 June 1969;

    b) the death occurred on 30 August 2023 at Casey Hospital, 52 Kangan Drive, Berwick in Victoria from streptococcus septicaemia and aspiration pneumonia in the setting of Down's Syndrome; and

    c) the death occurred in the circumstances described above.

18. 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 Casey Hospital, that caused or contributed to Mr Campbell's death.

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

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

Audrey Vorwerk, Senior Next of Kin

Scope Australia

Casey Hospital

Signature:

Date : 11 November 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.