IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005786

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Dimitra Dubrow
Deceased:	Joan Pauline Skillen
Date of birth:	24 September 1931
Date of death:	1 October 2024
Cause of death:	1(a) Pneumonia
Place of death:	375 Murray Street, Colac, Victoria 3250
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 1 October 2024, Joan Pauline Skillen was 93 years old when she died at her home in Colac, Victoria from pneumonia.

2. At the time of her death, Joan resided at 375 Murray Steet, Colac, a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**). Joan received funded daily independent living support due to her intellectual disability. She was non-verbal, was unable to stand independently and was required support for all activities of daily living. She received support from Scope Australia for all indoor and outdoor mobilisation, meal preparation, nutrition care, hygiene, medication administration and continence management.

3. Information provided by Scope suggests that Joan resided in foster care as a child and was admitted to several care facilities over her lifetime. From 1992 to 2019, she lived at Colanda Residential Services, before moving to the Murray Street address in 2019. Joan's medical history included dysphagia, heart disease, constipation, osteoporosis, skin integrity issues and fungal infections.

4. Prior to Joan's 90th birthday, she attended a day program at genU in Colac, five days per week. She participated in group activities involving music, attended the movies, enjoyed pampering sessions and engaged in creative/artistic activities. She retired from genU to enjoy more time at home shortly before she turned 90.

THE CORONIAL INVESTIGATION

5. Joan's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as she was a 'person placed in custody or care' within the meaning of the Act, as a person with disability who received funded daily independent living support and resided in an SDA enrolled dwelling immediately prior to her death.[1] 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.

[1] This class of person is prescribed as a 'person placed in custody or care' under the *Coroners Regulations 2019* (Vic), r 7(1)(d).

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 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 Joan Pauline Skillen including evidence contained in the coronial brief. 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 9 August 2024, Scope carers observed a milky-coloured discharge from Joan's mouth and noted that her breathing sounded "*wet*". Staff followed guidance from 'Nurse on Call' to monitor her closely and requested that she be reviewed by her general practitioner (**GP**).

10. Joan's GP, Dr Fahad Hussain, reviewed Joan on 10 August 2024 and noted that Joan was alert, afebrile, her chest was clear, and she had a slight cough. Dr Hussain instructed staff to monitor Joan for signs of deterioration and call an ambulance if she experienced shortness of breath, additional secretions and/or lethargy.

11. On 10 September 2024, Scope staff again observed a white foamy secretion from Joan's mouth and called Ambulance Victoria (**AV**). AV paramedics transported Joan to the Colac Area Health where she was diagnosed with a chest infection. Joan received intravenous antibiotics, and she was admitted for further treatment and monitoring. Unfortunately, Joan

[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.

did not respond well to the treatment and her condition deteriorated. Joan was discharged home on 18 September 2024 with a referral to a palliative care team.

12. A palliative care nurse reviewed Joan at home on 20 September 2024 and discussed implementing an end-of-life care plan. The nurse also arranged for a palliative care doctor to attend on 3 October 2024 to discuss a 'Hospital in the Home' referral.

13. On 30 September 2024, Scope staff observed that Joan was coughing and producing sputum. When her breathing became laboured, staff contacted the palliative care team, who instructed staff to contact emergency services. Scope staff called AV and paramedics attended to assess Joan. Paramedics contacted the Victorian Virtual Emergency Department (**VVED**) for a consultation. Joan received treatment for nausea and was administered morphine for pain management.

14. Also on 30 September 2024, Scope staff worked with Dr Hussain to cease all regular medication and administer palliative care medications, to ensure Joan remained pain free and comfortable.

15. At about 11.00pm on 1 October 2024, Scope carers were with Joan in her room when they observed her breathing became shallow. One of her carers placed her hand on Joan's chest and observed she stopped breathing at 11.17pm. The carer notified her manager, who called emergency services.

16. AV and Victoria Police arrived shortly after midnight on 2 October 2024. AV paramedics confirmed that Joan was deceased and signed a Verification of Death form, noting the time of death as 11.17pm on 1 October 2024. Police investigated the scene and did not identify any suspicious circumstances or evidence of third-party intervention in relation to Joan's passing.

17. From enquiries made, it appears that Joan had no known family or relatives at the time of her death. Scope staff were by her side at the time of her passing.

Identity of the deceased

18. On 2 October 2024, Joan Pauline Skillen, born 24 September 1931, was visually identified by a Scope worker/carer, David Seabright.

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

Medical cause of death

20. Forensic Pathologist Adjunct Associate Professor Sarah Parsons (**Adj A/Prof Parsons**), from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 3 October 2024 and provided a written report of her findings dated 17 October 2024.

21. Examination of the post-mortem computed tomography (**CT**) scan demonstrated patchy bi-basal pneumonia in keeping with the clinical history.

22. Toxicological analysis of post-mortem samples was not indicated and was therefore not performed.

23. Adj A/Prof Parsons provided an opinion that the medical cause of death was *1(a) Pneumonia.* She provided an opinion that the death was due to natural causes.

24. I accept Adj A/Prof Parsons' opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Joan Pauline Skillen, born 24 September 1931;

    b) the death occurred on 1 October 2024 at 375 Murray Street, Colac, Victoria 3250 from pneumonia; and

    c) the death occurred in the circumstances described above.

26. The available evidence does not support a finding that there was any want of clinical management or care on the part of the disability service provider, that caused or contributed to Joan's death.

27. Having considered all the available evidence, I find that Joan'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 Joan's death in chambers.

I convey my sincere condolences to Joan's fellow residents, friends and carers for their loss and acknowledge the care and support provided by many over Joan's long life.

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:

State Trustees

Scope Australia

Senior Constable Stephanie Ward, Coronial Investigator

Signature:

Coroner Dimitra Dubrow

Date: 04 July 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.