IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 000809

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge Liberty Sanger, State Coroner
Deceased:	Stephen Ross Stronach
Date of birth:	19 September 1967
Date of death:	10 February 2025
Cause of death:	1(a) Pneumonia <u>Contributing factor(s)</u> Epilepsy and congestive cardiac failure due to tetralogy of fallot (repaired)
Place of death:	Hamilton Base Hospital 20 Foster Street Hamilton Victoria 3300
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 10 February 2025, Stephen Ross Stronach was 57 years old when he passed away at Hamilton Base Hospital.

2. At the time of his death, Stephen resided at 131 Kent Road, Hamilton, a Specialist Disability Accommodation (**SDA**) dwelling enrolled under the National Disability Insurance Scheme (**NDIS**). Stephen received funded daily independent living support due to his intellectual disability, which was provided by disability service provider, Southern Stay Disability Services.

3. Stephen's medical history included intellectual disability, vision impairment, epilepsy, high blood pressure, congestive cardiac failure (**CCF**) and mobility issues with a history of fractures. Stephen's CCF was secondary to a congenital Tetralogy of Fallot, a rare cardiac condition in which affects the structure of the heart.

THE CORONIAL INVESTIGATION

4. Stephen's death fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**) as he 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 his 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.

5. 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.

6. 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

[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).

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. State Coroner, Judge John Cain (as his Honour then was) originally held carriage of this matter, prior to his retirement in August 2025. I assumed carriage of this investigation on 1 September 2025.

8. This finding draws on the totality of the coronial investigation into the death of Stephen Ross Stronach 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

Identity of the deceased

9. On 11 February 2025, Stephen Ross Stronach, born 19 September 1967, was visually identified by his brother, Peter Stronach.

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

Medical cause of death

11. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 13 February 2025 and provided a written report of his findings dated 17 February 2025.

12. The post-mortem examination showed documented pneumonic changes on a background of epilepsy and chronic congestive cardiac failure.

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

[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.

14. Dr Bedford provided an opinion that the medical cause of death was 1(a) Pneumonia with contributing factors of epilepsy and congestive cardiac failure due to tetralogy of fallot (repaired)

15. Dr Bedford provided an opinion that the cause of death was due to natural causes.

16. I accept Dr Bedford's opinion as to the medical cause of death.

Circumstances in which the death occurred

17. On 5 February 2025, Stephen attended his general practitioner, Dr Amy Lim, in the company of his brother, Peter. Dr Lim documented that Stephen had been unwell that afternoon with increased lethargy, so his carers called Nurse-on-Call and paramedics. Peter was concerned about his brother's presentation, so he decided to bring him to Dr Lim for further review.

18. Stephen denied experiencing chest pain or new symptoms suggestive of an infection, however Dr Lim noted that his lungs "*sound bit crackly*". Dr Lim recommended that Stephen present to an emergency department (**ED**), given his complex medical history. Dr Lim called the Hamilton Base Hospital to advise them of Stephen's impending presentation.

19. Stephen presented to Hamilton Based Hospital later that day. Initial investigations suggested pneumonia and fluid overload. Clinicians commenced him on intravenous (**IV**) antibiotics. On 7 February 2025, staff observed abdominal distention and were concerned that Stephen might have an obstruction. Stephen underwent a CT scan and enemas, which resulted in his bowels opening. He also experienced a seizure, which was treated with IV sodium valproate.

20. On 9 February 2025, staff called a 'Code Blue' due to Stephen becoming unresponsive. On 10 February 2025, Stephen experienced another seizure. Following consultation between Stephen's family and staff, Stephen was transitioned to comfort care. He passed away peacefully that evening.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Stephen Ross Stronach, born 19 September 1967;

b) the death occurred on 10 February 2025 at Hamilton Base Hospital, 20 Foster Street Hamilton Victoria 3300 from pneumonia with contributing factors of epilepsy and congestive cardiac failure due to tetralogy of fallot (repaired); and

c) the death occurred in the circumstances described above.

22. 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, or clinical staff at Hamilton Base Hospital, that caused or contributed to Stephen's death.

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

I convey my sincere condolences to Stephen's family, friends and carers for their loss.

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:

Peter Stronach, Senior Next of Kin

Senior Constable Rowan Pratt, Coronial Investigator

Signature:

Judge Liberty Sanger, State Coroner

Date: 09 October 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.