IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003509

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	John James Taylor
Date of birth:	09 May 1949
Date of death:	05 July 2021
Cause of death:	1(a) Unascertained natural causes
Place of death:	225 Clarendon Street, Thornbury, Victoria, 3071

INTRODUCTION

1. On 05 July 2021, John James Taylor was 72 years old when he was found deceased at his residence. At the time of his death, John lived in supported disability accommodation in Clarendon Street, Thornbury.

2. John is remembered as having a great sense of humour. He was well respected, loved having a barbeque and social time with his housemates, watching horse racing and football, and sitting in the peace of his backyard.

3. John was born with an intellectual disability, later diagnosed as Fragile X Syndrome. The syndrome was characterised by a developmental delay, poor balance and a shuffling gait, hand tremors, and behavioural changes.[1] His other medical conditions included gout, hypercholesterolaemia, hypertension, cataracts and atrial fibrillation.[2]

4. At 9 years old, John was placed in the care of Kew Residential Services by his family. He lived there full-time until 1999, when he moved to a St John of God Accord Community Residential Unit at Mansfield Street, Thornbury. In 2000 he moved to Clarendon Street, where he lived until his death.[3]

5. John had a good relationship with his fellow residents at Clarendon Street, some of whom became his close friends. John enjoyed helping out around the house and particularly liked cooking breakfast on the weekend, earning him the nickname 'Cookie'.[4]

6. John worked washing cars for approximately 20 years, a job he loved. In around 2007, he left the role after his mobility became more limited. Plenty Valley Disability Care provided John with retirement transition services, with programs such a cooking, music and community inclusion.[5]

7. John appeared to slow down with age, and the symptoms of his disability became more apparent. Around 2018, his tremors seemed more pronounced, and his balance and stability became more of a concern, though he had no falls. John began not wanting to attend longer outings he used to enjoy such as horse racing and fishing.[6]

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[1] Coronial Brief (**CB**), Statement of Matthew Stenning, dated 12 February 2022.
[2] CB, Statement of Dr Daniel Lipson, dated 13 December 2021.
[3] CB, Statement of Gaynor Wright, dated 20 January 2022.
[4] Ibid.
[5] Ibid.
[6] CB, Statement of Matthew Stenning, dated 12 February 2022.

THE CORONIAL INVESTIGATION

8. John's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury and also include the death of a person who immediately before death was a person placed in custody or care.

9. Since 2019, funding for disability services in Victoria has shifted from the Department of Families, Fairness and Housing to the National Disability Insurance Scheme. This shift meant that the definition of person placed in custody or care in section 3(1) of the Coroners Act 2008 to include 'a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health' was no longer sufficient to capture the group of vulnerable people in receipt of disability services that the legislature had intended.

10. While John was not formally 'in care' at the time of his death, he was an SDA resident residing in an SDA-enrolled dwelling at the time of passing. If reported today, his death would be considered to be an 'in care' death.[7] As such, I determined to investigate John's death as I would any other person who was 'in care' at the time of their death.

11. 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.

12. 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.

13. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of John's death. The Coroner's Investigator conducted inquiries on my behalf, including taking

[7] The Coroners Regulations 2019 were amended on 11 October 2022 to create a new category of person considered to be 'in care' under Regulation 7 of the Coroners Regulations 2019, being a 'person in Victoria who is an SDA resident residing in an SDA enrolled dwelling'.

statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

14. This finding draws on the totality of the coronial investigation into the death of John James Taylor 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.[8]

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

Circumstances in which the death occurred

15. On 4 July 2021, John ate his dinner as usual and spoke to his housemates and carers. There were no concerns for his welfare or signs that he was unwell. He had been in good spirits.[9]

16. At around 10pm, John was watching sport on television and asked carer Lawrence Nagbe if he could turn the television off for him. Lawrence told him the remote was next to him and he could do so himself. Lawrence then said good night to John, who ordinarily slept on the couch in the loungeroom.[10]

17. At around 6:05am, Lawrence woke up and observed John on the couch. He called out John's name to no response and noticed that he was not breathing. He immediately called for an ambulance, commencing cardiopulmonary resuscitation (**CPR**) on the instructions of the operator.[11]

18. Paramedics arrived shortly thereafter, though sadly John was unable to be revived. He was declared deceased at 8am.

Identity of the deceased

19. On 5 July 2021, John James Taylor, born 09 May 1949, was visually identified by his carer, Lawrence Nagbe, who completed a Statement of Identification.

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[8] 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.

[9] CB, Statement of Lawrence Nagbe, dated 19 January 2022.

[10] Ibid.

[11] Ibid.

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

Medical cause of death

21. Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on the body of John Taylor on 6 July 2021. Dr de Boer reviewed the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**) scan and medical records of St John of God Hospital and provided a written report of his findings dated 14 July 2021.

22. The post-mortem examination revealed features in keeping with the clinical history. The post mortem CT scan showed buckle fractures of the ribs in keeping with CPR, severe coronary artery calcifications, moderate peripheral artery calcifications and pleural effusion in the left thoracic cavity.

23. Toxicological analysis of post mortem blood samples identified the presence of citalopram (~ 0.05mg/L) and valproic acid (~ 18mg/L).[12]

24. Dr de Boer provided an opinion that the medical cause of death was 1 (a) UNASCERTAINED NATURAL CAUSES.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was John James Taylor, born 09 May 1949;

    b) the death occurred on 05 July 2021 at 225 Clarendon Street, Thornbury, Victoria, 3071;

    c) I accept and adopt the medical cause of death as ascribed by Dr Hans de Boer and I find that John James Taylor died of unascertained natural causes;

2. AND, having considered all of the circumstances, I find that John James Taylor died from natural causes and there is no evidence of any causative link between his cause of death and the fact that his level of care was analogous to a person 'in care', as defined in the Coroners Act 2008.

I convey my sincere condolences to John's friends and loved ones for their loss.

[12] Toxicology Report of Loredana Monforte, Forensic Toxicologist, dated 3 August 2021.

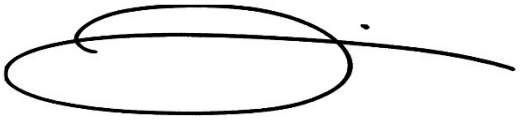
Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

National Disability Insurance Scheme Quality and Safeguards Commission

Constable Shaun Murray, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 18 December 2023

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.