

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004852

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:	Lachlan Rayner
Date of birth:	22 February 1979
Date of death:	8 June 2023
Cause of death:	1(a) Airways obstruction with mucous plugging 1(b) Quadriplegia post accident
Place of death:	Austin Health, 147 Studley Road, Heidelberg Victoria 3084
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths

INTRODUCTION

1. On 8 June 2023, Lachlan Rayner was 44 years old when he passed away at the Austin Hospital.
2. At the time of his death, Mr Rayner was a National Disability Insurance Scheme (NDIS) participant. He received funding to reside in a Specialist Disability Accommodation (SDA) enrolled dwelling¹ provided by the then-Department of Health and Human Services. Mr Rayner was receiving these supports due to quadriplegia following an injury that occurred in January 2019. Mr Rayner also had a history of recurrent chest infections, sacral stage 4 pressure wounds and chronic pain. He was known to Austin Health's Hospital in the Home (HITH) program for regular vacuum assisted closure (VAC) dressing changes. Mr Rayner also received in-home care and support from Exceptional Care For You (ECFY) and Healthcare Australia (HCA).
3. Prior to his injury, Mr Rayner enjoyed travelling around Australia with his dog, Ned, for months at a time. He was supported by his parents, brother Alex, and uncle Ash, and enjoyed spending time with them.

THE CORONIAL INVESTIGATION

4. Mr Rayner'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.
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

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

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 comments or recommendations in appropriate cases about any matter connected to the death under investigation.
7. This finding draws on the totality of the coronial investigation into the death of Lachlan Rayner, 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 the Austin 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

8. Mr Rayner was referred to the HITH program by the Spinal Unit and Spinal Outreach Service (SOS) nurse on 9 May 2023. He was admitted under the HITH program on 16 May 2023 for a stage 3 sacral pressure area, requiring negative pressure wound therapy management. On 19 May 2023, Mr Rayner was transitioned to the ‘Need2Heal’ service, at ECFY’s recommendation. Need2Heal conducted regular wound checks, VAC dressing changes and calf wound management.
9. On 7 June 2023, ECFY staff documented that he slept on and off throughout the morning and had low urine output. Staff encouraged him to increase his fluid intake. He reported pain and was administered oxycodone and ketamine to assist with pain management. The 9.00pm to 6.00am (8 June 2023) ECFY staff member documented that Mr Rayner was awake most of the night and was “*extremely rude and verbally abusive*”. The carer provided diazepam for

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.

agitation and oxycodone for pain relief. The carer noted “*Appears unwell will handover to continue to monitor him*”.

10. At 6.30am on 8 June 2023, an ECFY carer, Lianne O’Reilly, called the ECFY Director, Dianne Geddes, to discuss her concerns about Mr Rayner’s presentation. Ms O’Reilly told Ms Geddes that Mr Rayner’s urine output was low and he did not sleep well overnight, however his breathing was normal. Ms Geddes recommended that Ms O’Reilly empty Mr Rayner’s urine bag and see if that would assist. Ms O’Reilly called back and advised that Mr Rayner’s blood pressure was low (85/65) and there was no urine draining. Ms Geddes instructed Ms O’Reilly to call for an ambulance. Ms Geddes instructed Ms O’Reilly to explain to the 000 call-taker that Mr Rayner “*presented with hypotension and minimal to no urine drainage from his SPC [suprapubic catheter] which indicated a life-threatening condition*”.
11. Ms O’Reilly first called 000 at 7.39am. It is unclear what information was conveyed to the 000 call-taker, however Ms O’Reilly told Ms Geddes that the call-taker “*would not send an ambulance and would get a nurse to speak with her*”. The nurse called Ms O’Reilly and advised that an ambulance would be dispatched. An hour transpired without an ambulance arriving, so Ms Geddes called 000 and reaffirmed Mr Rayner’s condition was life-threatening. The ambulance was dispatched at 9.28am and arrived in Mr Rayner’s apartment at 10.30am.
12. When paramedics arrived, they called Ms Geddes to advise that Mr Rayner’s oxygen saturation levels were 40% and they would be transferring him to the Austin Hospital.
13. At some point during the morning, Need2Heal staff also attended Mr Rayner’s address and observed that he was experiencing difficulty breathing and had decreased oxygen saturations. Need2Heal staff explained that Mr Rayner initially refused transfer to hospital, however, was convinced by paramedics.
14. On arrival at the Austin Hospital Emergency Department, Mr Rayner underwent a chest x-ray which demonstrated severe lower left lobe collapse, secondary to a sputum plug with likely underlying infection along with associated acidosis, hyperkalaemia, hyponatraemia and confusion. Clinicians were unable to remove the mucous plug, and his condition continued to deteriorate.
15. Upon consultation with clinicians and Mr Rayner’s carers and family, a decision was made to transition him to end of life care. Mr Rayner passed away that afternoon.

Identity of the deceased

16. On 8 June 2023, Lachlan Rayner, born 22 February 1979, was identified by Medical Practitioner Dr Mohammadali Taher via review of medical records and visual identification.
17. Identity is not in dispute and requires no further investigation.

Medical cause of death

18. On 8 June 2023, Medical Practitioner Dr Mohammadali Taher reviewed Mr Rayner's complete medical history, conducted an examination on the body and completed a MCCD. Dr Taher provided an opinion that the medical cause of death was airways obstruction (mucous plugging), secondary to pneumonia with quadriplegia as a significant contributing factor.
19. On 20 September 2024, Forensic Pathologist Dr Paul Bedford, at the Victorian Institute of Forensic Medicine (**VIFM**) reviewed the MCCD and the medical records at my direction. Dr Bedford agreed that the deceased experienced respiratory issues on a background of quadriplegia. Dr Bedford provided an opinion that the medical cause of death was *airways obstruction with mucous plugging secondary to quadriplegia post-accident*. Dr Bedford explained that as the accident caused quadriplegia, which contributed to the death and the death was therefore reportable pursuant to the Act, regardless of the deceased's status living in an SDA enrolled dwelling
20. I accept Dr Bedford's opinion.

FINDINGS AND CONCLUSION

21. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - a) the identity of the deceased was Lachlan Rayner, born 22 February 1979;
 - b) the death occurred on 8 June 2023 at Austin Health, 147 Studley Road, Heidelberg Victoria 3084, from *airways obstruction with mucous plugging secondary to quadriplegia post accident*; 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 SIL provider or clinical staff at the Austin Hospital,

that caused or contributed to Mr Rayner's death. I note the delay in ambulance attendance, however given the severity of Mr Rayner's condition, I am satisfied that this did not materially contribute to his death.

23. Having considered all the available evidence and taking into account my finding that there is no want of clinical management or care, and as I can see no public interest in holding an inquest (public hearing) into the death, I have determined that I will finalise the investigation of Mr Rayner's death in chambers.

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

Pursuant to section 49(2) of the Act, I direct the Registrar of Births, Deaths and Marriages to amend the cause of death to the following "1(a) AIRWAYS OBSTRUCTION WITH MUCOUS PLUGGING; 1(b) QUADRIPLÉGIA POST ACCIDENT".

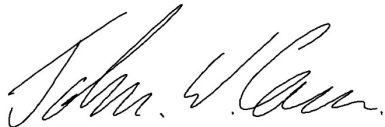
I direct that a copy of this finding be provided to the following:

Wendy Rayner, Senior Next of Kin

Austin Health

Exceptional Care For You (C/- Barry Nilsson)

Signature:



Judge John Cain
State Coroner
Date: 15 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.
