IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005486

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Sushant Padhye
Date of birth:	28 May 1967
Date of death:	2 October 2023
Cause of death:	RECURRENT ASPIRATION PNEUMONIA IN A MAN WITH CONGENITAL DISABILITY AND COGNITIVE IMPAIRMENT
Place of death:	University Hospital 272-322 Ryrie Street, Geelong Victoria 3220
Keywords:	In care, natural causes

INTRODUCTION

1. On 2 October 2023, Sushant Padhye was 56 years old when he died at University Hospital Geelong following a period of palliative care. At the time of his death, Mr Padhye lived in Leopold, Victoria, in a specialist disability accommodation (**SDA**) facility operated by Scope Australia. Mr Padhye had been living in this residence since 2019.

2. Mr Padhye had diagnoses of microcephaly, congenital intellectual and physical disability, epilepsy, hypothyroidism, dysphagia, and carbamazepine-induced neutropenia. He was non-verbal, non-ambulant, and used a wheelchair to mobilise. He received nutrition and medications through a Percutaneous Endoscopic Gastrostomy (PEG) tube and required support for all daily living activities.

3. Mr Padhye suffered from recurrent aspiration pneumonia which increased in frequency in the months preceding his death.

THE CORONIAL INVESTIGATION

4. Mr Padhye'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. The death of a person in care or custody is a mandatory report to the coroner, even if the death appears to have been from natural causes. Mr Padhye was a "person placed in custody or care" within the meaning of section 4 of the Act, as he was "a prescribed class of person"[1] due to his status as an "SDA resident residing in an SDA enrolled dwelling".

5. Sergeant Jacob Horvath was assigned as the Coronial Investigator for the investigation of Mr Padhye's death. Sgt Horvath conducted inquiries on my behalf and compiled a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Mr Padhye 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]

[1] Section 4(2)(j)(i), *Coroners Act 2008* (Vic).

[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

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

Circumstances in which the death occurred

7. On 28 September 2023, Mr Padhye was seen by Dr Ernest Cheng for review of his persistent cough, on the background of recent episodes of recurrent aspiration pneumonia. Dr Cheng advised Mr Padhye's carers that if Mr Padhye deteriorated further, he should be taken to hospital. Dr Cheng completed a referral to the Barwon Health Palliative Care team with consent from Mr Padhye's sister.

8. Following the appointment with Dr Cheng, Mr Padhye's carers observed Mr Padhye to be agitated, distressed, and having difficulty breathing. They contacted emergency services and Mr Padhye was conveyed to the University Hospital Geelong Emergency Department in the company of a carer.

9. Medical investigations undertaken at the hospital demonstrated right middle lobe lung consolidation and Mr Padhye was commenced on intravenous fluids and antibiotics and admitted to a ward.

10. Given Mr Padhye's recurrent aspiration pneumonia on the background of significant congenital disability, treating clinicians considered palliative management to be appropriate. They consulted with Mr Padhye's sister with respect to his condition and goals of care, and Mr Padhye was transitioned to palliative care with her consent.

11. At 1.20pm on 2 October 2023, Mr Padhye passed away.

Identity of the deceased

12. On 6 October 2023, Sushant Padhye, born 28 May 1967, was visually identified by his sister, Sujata Joshi.

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

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

Medical cause of death

14. Forensic Pathology Trainee Dr Kaitian Yeo, under the supervision of Forensic Pathologist Dr Gregory Young, from the Victorian Institute of Forensic Medicine conducted an examination on 4 October 2023 and provided a written report of their findings dated 9 October 2023.

15. The post-mortem external examination revealed no unexpected signs of trauma. A post-mortem examination computed tomography (CT) scan showed pneumonia involving the right lung and small pleural effusions bilaterally. A percutaneous gastrostomy feeding tube was in situ with its tip within the gastric cavity.

16. Dr Yeo provided an opinion that the medical cause of death was "1(a) recurrent aspiration pneumonia in a man with congenital disability and cognitive impairment".

17. Dr Yeo further opined that Mr Padhye's death was due to natural causes.

18. I accept Dr Yeo's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Sushant Padhye, born 28 May 1967;

    b) the death occurred on 2 October 2023 at University Hospital, 272-322 Ryrie Street, Geelong, Victoria, from 1(a) recurrent aspiration pneumonia in a man with congenital disability and cognitive impairment; and

    c) the death occurred in the circumstances described above.

20. There is nothing to suggest that the care (including the medical care) provided to Mr Padhye was anything other than appropriate.

I convey my sincere condolences to Mr Padhye's family for their loss.

I thank the Coronial Investigator and those assisting for their work in this investigation.

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:

Sujata Joshi, Senior Next of Kin

Scope Australia

Barwon Health

Sergeant Jacob Horvath, Coronial Investigator

Signature:

Coroner Paul Lawrie

Date: 13 January 2026

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.