IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 006515

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Therese McCarthy
Deceased:	FBN
Date of birth:	6 September 1969
Date of death:	8 November 2024
Cause of death:	1(a) Unascertained
Place of death:	The Alfred Hospital 55 Commercial Road, Melbourne, Victoria
Keywords:	Unascertained Causes; Intensive Care; Multiorgan Failure; Possible Hyperthermia

INTRODUCTION

1. On 8 November 2024, FBN was 55 years old when he died in hospital after being found unconscious in a spa the day prior. At the time of his death, FBN was homeless and was known to couch surf, and he had become estranged from his family.

2. FBN's medical history included human immunodeficiency virus (**HIV**) (diagnosed in 2020) and cervical spine canal stenosis with cord impingement. He had also recently been investigated for a rash with possible causes being neurogenic related or scabies.

3. Damien Graieg, an acquaintance of FBN's, described him as a very charismatic and confident person.

THE CORONIAL INVESTIGATION

4. FBN's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

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

7. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of FBN's death. The Coronial Investigator conducted inquiries on behalf of the Court, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. In July 2025, I assumed carriage of the investigation into FBN's death after the retirement of then Coroner John Olle for the purpose of finalising the investigation and making findings.

9. This finding draws on the totality of the coronial investigation into the death of FBN 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.[1]

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

Circumstances in which the death occurred

10. Sometime in mid-2024, Damien heard that FBN had been quite seriously assaulted and that he was left severely injured.[2]

11. Damien ran into FBN around 10 days before FBN's death and reported that FBN was walking with a limp, had a back issue, and appeared to be withdrawn. The pair exchanged numbers and Damien told FBN that he was welcome to have a bath at his house if he needed. In the week prior to his passing, FBN would come and go from Damien's place but would not stay overnight.

12. On 7 November 2024, FBN went to Damien's house in South Yarra in the afternoon. Damien reported that FBN was in a good mood and was talking about staying over for a few nights. FBN did not appear to be unwell or in any pain.

13. At approximately 7.30pm, Damien ran FBN a bath and then left to do some shopping. Damien called FBN around 8.30pm but FBN did not answer. Damien returned around 9.00pm and heard FBN groaning but thought he was just enjoying the bath. After 10 minutes, Damien went to check on FBN and found him stiff and unresponsive in the bath making mumbling noises, but he was not submerged. Damien pulled FBN out of the water, which he reported to be very hot, put him into the recovery position and contacted emergency services.

14. When Ambulance Victoria paramedics arrived, FBN was unconscious and completely unresponsive. He had an increased heart rate and low blood pressure, and was tachypnoeic (in respiratory distress), hypoxic (inadequate oxygen supply to the body), and hyperthermic. Paramedics intubated FBN and administered medications including metaraminol, ketamine,

---

[1] 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.

[2] Coronial Brief, Statement of Damien Graieg.

fentanyl, rocuronium, midazolam and noradrenaline before transporting him to the emergency department at the Alfred Hospital where they arrived at 12.10am on 8 August 2024.[3]

15. Investigation and treatment were directed towards a provisional diagnosis of sepsis, while also exploring potential diagnoses for shock and hyperthermia.

16. Around 3.00am, FBN was transferred to the Intensive Care Unit (**ICU**) as he was deteriorating with worsening hypotension (low blood pressure) requiring increased support with noradrenaline and was bleeding from cannula sites and all orifices. He was mechanically ventilated and remained hypotensive despite the administration of noradrenaline and vasopressin. A dialysis vascular catheter was inserted, and high-dose continuous renal replacement therapy (**CRRT**) was commenced.

17. It was ICU specialist Dr Andrew Hooper's impression that FBN was in profound multiorgan failure with disseminated intravascular coagulation (**DIC**)[4] but with unknown cause and that he was unlikely to respond to any treatment.

18. As FBN was deteriorating despite maximal supports and there were no further therapeutic options, it was agreed by the medical team to transition FBN to palliative care. Mechanical ventilation, CRRT and critical care medications were ceased and FBN sadly passed away at 9.05am.

Identity of the deceased

19. On 8 November 2024, FBN born 6 September 1969, was visually identified by his close friend, .

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

Medical cause of death

21. Forensic Pathology Registrar Dr Daniel Hussey, under the supervision of Forensic Pathologist Adjunct Associate Professor Hans de Boer, from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 13 November 2024 and provided a written report of his findings dated 1 April 2025.

---

[3] Coronial Brief, Statement of Dr Andrew Hooper, Alfred Health.

[4] A rare but serious condition that causes abnormal blood clotting within blood vessels exhausting clotting factors and leading to severe bleeding. DIC can be triggered by sepsis, severe trauma, cancer, and severe reactions.

22. FBN's clinical diagnosis was shock with multiorgan failure and DIC. The post-mortem examination revealed features indicative of shock including subendocardial haemorrhages, bilateral pleural effusions, ascites, and cerebral oedema. However, the cause of shock, multiorgan failure and DIC was unclear.

23. The post-mortem examination also revealed mild coronary artery atherosclerosis of the left anterior descending artery.

24. When FBN was assessed by attending paramedics, his temperature was recorded as 40 degrees celsius which prompted a possible diagnosis of hyperthermia. Dr Hussey commented that such a diagnosis would be entirely dependent on circumstantial evidence as there were no specific autopsy findings suggestive of hyperthermia. Hyperthermia can be caused by environmental heat exposure, drugs, and infections.

25. Dr Hussey did not identify any evidence of substantial natural disease which may have caused death, such as infection or sepsis, nor was there any evidence of substantial trauma or any injuries from an assault.

26. Toxicological analysis of post-mortem samples identified the presence of methylamphetamine and its metabolite amphetamine.[5] However, it is particularly rare that the quantity of methylamphetamine detected (~0.7 mg/L) would, alone, be sufficient to cause death. Fentanyl, morphine, midazolam, ketamine, laudanosine, lignocaine, rocuronium, and acyclovir were also detected but were medications administered to FBN for medical treatment.

27. Although FBN presented with multiorgan failure following DIC and shock, Dr Hussey noted that the cause of death is unascertained because the cause of these conditions remains unknown. He commented that hyperthermia—due to methylamphetamine use, environmental exposure, or a combination of the two—could be a possible cause.

28. Dr Hussey provided an opinion that the medical cause of death was '*1(a) Unascertained*'.

29. I accept Dr Hussey's opinion.

---

[5] Methylamphetamine is the N-methyl derivative of amphetamine and has no legitimate therapeutic use in Australia. Adverse effects of methylamphetamine use include dizziness, headache, cardiac arrhythmias, and tremor.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was FBN born 6 September 1969;

    b) the death occurred on 8 November 2024 at The Alfred Hospital, 55 Commercial Road, Melbourne, Victoria, from unascertained causes; and

    c) the death occurred in the circumstances described above.

31. Although the cause of FBN's death has not been definitively determined, I have considered the surrounding circumstances, exhaustive post-mortem examination, and ancillary tests, and I am satisfied that there were no suspicious circumstances or third-party involvement in the death.

I convey my sincere condolences to FBN's family and friends for their loss.

Pursuant to section 73(1A) 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:

Senior Next of Kin

Senior Next of Kin

Alfred Health

Constable Alexandra Gunn, Coronial Investigator

Signature:

Coroner Therese McCarthy

Date: 03 June 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.