IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 6579

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Coroner
Deceased:	John Gorman Maltman
Date of birth:	9 September 1946
Date of death:	Between 26 December 2017 and 29 December 2017
Cause of death:	I(a) Coronary artery atherosclerosis
Place of death:	56 Strathmerton Street, Reservoir, Victoria

INTRODUCTION

1. John Gorman Maltman was a 71-year-old man who lived in Furlong House, a Disability Interim Justice Accommodation Service in Parkville, at the time of his death.

2. Mr Maltman left Furlong House on 26 December 2017 and did not return. He was reported to Victoria Police as a missing person the following day. He was located deceased in the back seat of a car on 29 December 2017.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mr Maltman's death was reported to the Coroner as Mr Maltman was immediately before his death a 'person placed in custody or care' under the *Coroners Act 2008* and so fell within the definition of a reportable death.

4. 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.

5. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist who examined Mr Maltman and investigating officers.

6. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established on the balance of probabilities.[1]

IDENTITY

7. On 4 January 2018, the Fingerprint Branch of the Victoria Police Forensic Services Department matched Mr Maltman's right middle finger impression to that held on record for John Gorman Maltman, born 9 September 1946.

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

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[1] This is 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.

CIRCUMSTANCES PROXIMATE TO THE DEATH

9. Mr Maltman moved into Furlong House around three months prior to his death. He had an intellectual disability and, according to care worker Luke Tunks, '*it wasn't diagnosed but [Mr Maltman] had started to show signs of early Alzheimer's*'.[2]

10. His medical history also included hypertension and heavy smoking and drinking, although reportedly he slowed his drinking after moving into Furlong House.[3]

11. On 26 December 2017 at around 3.00pm, Mr Maltman asked Mr Tunks to turn on the heater. Mr Tunks states that, as it was approximately 35 degrees, he '*explained to [Mr Maltman] it was hot and the best I could do was turn the air conditioning fan down*'.[4]

12. According to Mr Tunks, at this time '*John then told me he was going to sleep at the park, he picked up some of his effects and left the house, this was about 3.30pm. At Furlong House the residents can come and go so I had no reason to stop him from leaving*'.[5]

13. When Mr Tunks finished his shift at around 10.00pm, he informed night staff at handover that Mr Maltman had not returned. Mr Tunks states that '*I believe at ... midnight the night staff contacted the PSOs at Royal Park ... Train Station and provided them with [Mr Maltman's] description which is what we usually do when a client doesn't return*'.[6]

14. Mr Tunks was on duty the following day and, as Mr Gorman had not returned after 24 hours of the time he left the previous day, he contacted Police at around 4.05pm to inform them that Mr Maltman was missing.[7] Mr Tunks states that '*We have a protocol at Furlong House that we report a client missing after they have been gone for 24 hours.*'[8]

15. Mr Tunks informed Constable Elise Wood of Melbourne North Police Station that Mr Maltman had been missing since 3.30pm. According to Constable Wood:

    '*[Mr Tunks] told me that they did not hold any concerns for [Mr Maltman] to self-harm or threaten suicide. They were concerned for his welfare due to his age and mental capacity. ...*

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2 Statement of Luke Tunks dated 13 March 2018, Coronial Brief.
3 Statement of Diane Webster dated 27 December 2017, Coronial Brief; Medical Records, Coronial Brief.
4 Statement of Luke Tunks dated 13 March 2018, Coronial Brief.
5 Ibid.
6 Ibid.
7 Statement of Luke Tunks dated 13 March 2018, Coronial Brief; Statement of Constable Elise Wood dated 15 February 2018, Coronial Brief.
8 Statement of Luke Tunks dated 13 March 2018, Coronial Brief.

There were also concerns that [Mr Maltman] was out in the heat with no food or water. He did not carry a mobile phone or wallet.'[9]

16. Mr Tunks provided a description of Mr Maltman to Constable Wood as well as a photo. He provided contact information for several family members and mentioned that Protective Service Officers had located Mr Maltman on a previous occasion when he had been missing.[10]

17. Constable Wood attempted to contact the family members using Mr Tunks' information and provided a photo of Mr Maltman to Melbourne North Protective Service Officers. Constable Wood then submitted a missing persons report for Mr Maltman as well as a number of further actions to ensure Police would attempt to locate him.[11]

18. According to Constable Wood, on 28 December 2017:

'*Constable Natasha REID and Acting Sergeant Gio LAZZARO had organised a thorough line search over all park land in Parkville including Royal Park, the Melbourne Zoo and the surrounding area where multiple members attended including the K9, air wing, highway patrol and bicycle units. Local hospitals were also contacted. Jobs had also been dispatched for units to attend [family members' addresses] to find [Mr Maltman]. Police media had also been contacted and requested to release the missing person report with attached family consent*'.[12]

19. On 29 December 2018, Police attended the home of Mr Maltman's sister and asked if anybody present had seen Mr Maltman, which they had not. However, several hours later a friend of Mr Maltman's niece, Tina Glew, walked behind the house to see if Mr Maltman was there.[13]

20. Ms Glew found a body which appeared to be Mr Maltman's in the back seat of a white Hyundai which had been parked behind the house for several years.[14]

21. At around 5.26pm Mr Maltman's niece contacted Police and reported that Mr Maltman had been found deceased.[15]

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[9] Statement of Constable Elise Wood dated 15 February 2018, Coronial Brief.
[10] Ibid.
[11] Ibid.
[12] Ibid.
[13] Statement of Tina Glew dated 8 March 2018, Coronial Brief.
[14] Ibid.
[15] Statement of Constable Elise Wood dated 15 February 2018, Coronial Brief.

CAUSE OF DEATH

22. On 4 January 2018, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon Mr Maltman's body and provided a written report, dated 5 February 2018. In that report, Dr Lynch concluded that a reasonable cause of death was '*I(a) Coronary artery atherosclerosis*'.

23. Toxicological analysis identified the presence of ethanol (alcohol) at a blood concentration of 0.04 g/100mL, however Dr Lynch commented that '*some or all of this ethanol may represent post mortem formation*'.

24. Dr Lynch concluded:

    '*Based on the information available to me at the time of completing this report, there is no evidence to suggest death is due to anything other than natural causes.*'

25. I accept Dr Lynch's opinion as to cause of death.

FINDINGS AND CONCLUSION

26. Mr Maltman was 'a person placed in custody or care' for the purposes of the *Coroners Act 2008* as he was considered to be under the control, care or custody of the Secretary to the Department of Health and Human Services.[16] Section 52(2)(b) of the Act requires that I hold an inquest into his death, however section 52(3A) states that no inquest is required if I consider that his death was due to natural causes.

27. Based on Dr Lynch's report, I consider that Mr Maltman's death was due to natural causes. I am satisfied that an inquest is not required to make the findings required by section 67(1) of the Act.

28. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that John Gorman Maltman, born 9 September 1946, died between 26 December 2017 and 29 December 2017 at Reservoir, Victoria, from I(a) Coronary artery atherosclerosis in the circumstances described above.

29. Pursuant to section 73(1B) of the *Coroners Act 2008*, I direct that this finding be published on the Internet.

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[16] Correspondence from Lillian Kearney (DHHS) to the Court dated 27 July 2018.

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

Ms Diane Webster

Senior Constable Ryan Johansen, Victoria Police, Coroner's Investigator.

Signature:

CAITLIN ENGLISH

CORONER

Date: 26 October 2018