IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 002599

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**KEVIN SUARES**
Date of birth:	13 January 1968
Date of death:	10 June 2016
Cause of death:	1(a) COMPLICATIONS OF METASTATIC SQUAMOUS CELL CARCINOMA OF LARYNX
Place of death:	Olivia Newton John Cancer and Wellness Centre, Austin Hospital, Heidelberg, Victoria

HER HONOUR:

Background

1. Kevin Suares was born on 13 January 1968. He was 48 years old when he died from natural causes.

2. Mr Suares was one of five children. One of his siblings died in infancy, another as a teenager, and the remaining two siblings were adopted. Mr Suares had no contact with his siblings. He was raised by his mother Inez Suares and grandmother in his grandmother's home in Carlton. His mother died approximately three years before his death.

3. Mr Suares was born with Fragile X syndrome and had a moderate intellectual disability. He was illiterate, had limited numeracy skills and required assistance with most aspects of living.

4. In 1998 Mr Suares was placed in shared supported accommodation in London Road, Broadmeadows and lived there until shortly before his death. He was a client of Broadmeadows Disability Services and attended their day placement five days a week.

The coronial investigation

5. Mr Suares's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Mr Suares's death was reportable because he was in the care of the State immediately before the time of his death.[1] Deaths of persons in the care of the State are reportable to ensure independent scrutiny of the circumstances surrounding their deaths. If such deaths occur as a result of natural causes a coronial investigation must take place but the holding of an inquest is not mandatory.

6. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to

[1] See s 4(2)(c) of the *Coroners Act* 2008 (Vic); Mr Suares's London Road accommodation is a facility administered by the Department of Health and Human Services.

the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[2]

7. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

8. 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.

9. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Suares's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses, and submitted a coronial brief of evidence.

10. Having considered all the materials obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required. I also determined that as Mr Suares's care was reasonable and he died of natural causes there was no public interest in holding an inquest.

11. 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.

Circumstances in which the death occurred

12. Mr Suares was diagnosed with metastatic supraglottic squamous cell carcinoma in March 2016.[3] He was given a life expectancy of 12 months.

13. Following this diagnosis, Mr Suares deteriorated quickly. He suffered rapid weight loss, increased fatigue and pain. He was provided palliative care by Melbourne City Mission, and a plan was developed to admit him to the Olivia Newton John Wellness Centre at the Austin Hospital once he stopped eating or his pain became unmanageable at home.

---

[2] In the coronial jurisdiction facts must be established on the balance of probabilities 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.

[3] Throat cancer.

14. On 5 June 2016, Mr Suares was admitted to the Austin Hospital after becoming progressively unwell, generally refusing to eat and drink, and choking when attempting oral intake. He was also suffering pain, hiccups and an inability to sleep. On admission, it was suspected that Mr Suares was suffering aspiration pneumonia. In consultation with Mr Suares's family and carers, he was treated oxygen and medication for comfort. Mr Suares had an intense phobia of needles, so his symptoms were controlled by medication delivered via skin patches and sublingual formulations.

15. At approximately 7.55pm on 7 June 2016, Mr Suares had an unwitnessed fall with a headstrike. He suffered a laceration above his left eye, but there was no evidence of intracerebral haemorrhage. His overall condition remained unchanged.

16. Given his condition and general distress, it was decided by the on call doctor and consultant that a CT scan was not warranted. Mr Suares was given comfort measures. He died on 10 June 2016 in the presence of a carer from his residence.

17. There are no public health and safety or prevention issues arising from the circumstances of this death.

Identity of the deceased

18. Mr Suares was visually identified by carer Simon McDowell on 10 June 2016. Identity was not in issue and required no further investigation.

Medical cause of death

19. On 13 June 2016, Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of the body of Kevin Suares after reviewing a post mortem CT scan. The CT scan suggested pulmonary metastases. There was a 2 cm laceration above Mr Suares's left eye consistent with a recent headstrike, but no skull fracture or intracranial haemorrhage.

20. Toxicological analysis of post mortem specimens taken from Mr Suares identified morphine, clonazepam and its metabolite, diazepam and its metabolite, midazolam, haloperidol and lignocaine, all consistent with his therapeutic use during his hospital admission.

21. After reviewing toxicology results, Dr Lynch completed a report, dated 14 June 2016, in which he formulated the cause of death as '1(a) complications of metastatic squamous cell carcinoma of larynx'. I accept Dr Lynch's opinion as to the medical cause of death.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was Kevin Suares, born 13 January 1968;

(b) Mr Suares died on 10 June 2016 at the Austin Hospital, Heidelberg, Victoria, from complications of metastatic squamous cell carcinoma of larynx;

(c) his death was due to natural causes; and

(d) the death occurred in the circumstances described above.

Publication

I direct that this finding be published on the internet pursuant to section 73(1B) of the *Coroners Act 2008*.

I convey my sincere condolences to Mr Suares's family and carers.

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

Robert Suares, Senior Next of Kin

Pauline Chapman, Austin Health

Department of Health and Human Services

First Constable Ryan Bayly, Coroner's Investigator, Victoria Police

Signature:

ROSEMARY CARLIN
CORONER
Date: 13 June 2017

Coroners Court of Victoria