IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 3008

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Jacqui Hawkins
Deceased:	Reece Arthur Hyde
Date of birth:	17 February 1958
Date of death:	12 June 2019
Cause of death:	I(a) Complications of metastatic colorectal carcinoma in a man with multiple medical comorbidities
Place of death:	Colac Area Health, 2-28 Connor Street, Colac, Victoria, 3250

BACKGROUND

1. Reece Arthur Hyde was 61 years old at the time of his death. He lived in Colac and was under the care, control and custody of the Department of Health and Human Services (**DHHS**) in a high-level support facility. He was known to enjoy puzzles, watching cartoons and having dogs visit him.

2. Mr Hyde suffered from a severe intellectual disability and was non-verbal, however communicated via body language and gestures. He also suffered from severe epilepsy and osteoporosis and broke his leg approximately four years prior to his passing, which did not heal and required personal support and bracing. Mr Hyde was occasionally fed using a percutaneous endoscopic gastrostomy (**PEG**) tube at times when he was non-compliant with food and/or fluid intake.

3. A short time before his passing, Mr Hyde was diagnosed with metastatic colorectal cancer.

4. Mr Hyde passed away at Colac Area Health on 12 June 2019.

5. Mr Hyde's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008.*

6. The role of a coroner is to independently investigate reportable deaths to establish, 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 the death. The law is clear that coroners establish facts; they do not lay blame or determine criminal or civil liability.[1]

7. In writing this Finding, I do not purport to summarise all the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

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

Identity of the deceased

8. Reece Arthur Hyde was visually identified by a DHHS carer, Jackie Phillips, on 13 June 2019. Identity was not in issue and required no further investigation.

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[1] 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.

Medical cause of death

9. On 14 June 2019, Dr Victoria Francis, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed an external examination on the body of Mr Hyde and reviewed the Form 83 Victoria Police Report of Death, medical deposition from Colac Area Health and the post mortem computed tomography (**CT**) scan.

10. Dr Francis commented that the external examination showed an adult male with no significant external evidence of trauma. The post mortem CT scan showed calcified pelvic nodules and multiple peripheral lung nodules with increased bilateral lung markings.

11. Dr Francis opined that Mr Hyde's death was due to natural causes.

12. Dr Francis provided an opinion that the medical cause of death was 1(a) Complications of metastatic colorectal carcinoma in a man with multiple medical comorbidities.

Circumstances in which the death occurred

13. On 9 June 2019, Mr Hyde was admitted to Colac Area Health with sepsis and per rectal bleeding due to his metastatic colorectal carcinoma.

14. He was admitted to the ward the following day. Medical clinicians at Colac Area Health provided a presumed diagnosis of a perforated colorectal cancer, causing sepsis and treated Mr Hyde palliatively as discussed with his sister and her husband.

15. Mr Hyde was treated with morphine and midazolam with the intention to ease pain.

16. Mr Hyde passed away peacefully at Colac Area Health on the evening of 12 June 2019.

17. Having considered the evidence I am satisfied that no further investigation is required.

FINDINGS

18. Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

    (a) the identity of the deceased was Reece Arthur Hyde, born on 127 February 1958;

    (b) Mr Hyde died on 12 June 2019 from 1(a) *Complications of metastatic colorectal carcinoma in a man with multiple medical comorbidities*; and

    (c) in the circumstances described above.

19. I wish to express my sincere condolences to Mr Hyde's family. I acknowledge the grief and devastation that you have endured as a result of your loss.

I order pursuant to section 73(1B) of the *Coroners Act 2008*, that this finding be published on the Coroners Court of Victoria website.

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

The family of Mr Hyde;

Information recipients; and

Coroner's Investigator, Victoria Police

Signature:

JACQUI HAWKINS
Coroner
Date: 12 November 2019